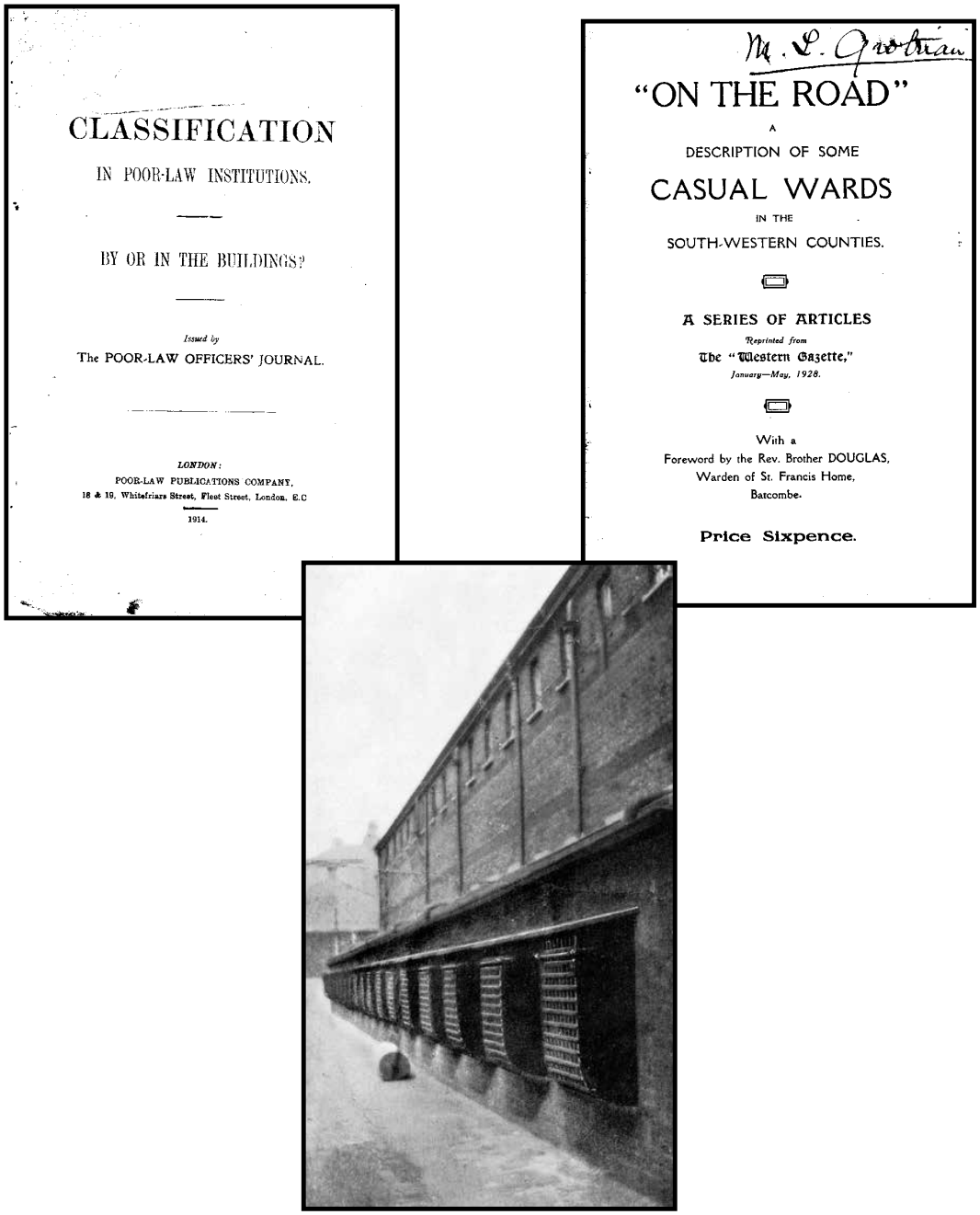

CLASSIFICATION

IN POOR-LAW INSTITUTIONS.

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1914.

M. L. Grotrian

"ON THE ROAD"

A

DESCRIPTION OF SOME

CASUAL WARDS

IN THE

SOUTH-WESTERN COUNTIES.

A SERIES OF ARTICLES

Reprinted from

The "Western Gazette,"

January—May, 1928.

With a

Foreword by the Rev. Brother DOUGLAS,

Warden of St. Francis Home,

Batcombe.

Price Sixpence.

A view of stone-breaking cells in an old London workhouse reception ward yard where temporary inmates had to labour, in order to be lodged and fed. Note the grids through which the casuals had to push the required size of stone. The Poor Law existed till 1948 until the coming of the National Health Service. Graylingwell did NOT employ stonebreaking for its sick patients (see C.4. Vagrant Joe) : but, nearby Chichester Workhouse (as ALL workhouses) did have its casuals so employed in its back yard - to complete this task under the watchful eyes of a parish overseer. (Source of pic; *The Monasticism of the Casual Poor*, by J.R. Battley; F.R.S.A. Westminster. 1940.)

Chapter Three
Amberley One Ward

‘ The human body consists of about 60 trillion cells, and each cell has about 10,000 times as many molecules as the Milky Way has stars. ... Every person has nearly 400, 000 radioactive atoms disintegrating into other atoms in his or her body each second . But there’s no need to worry about falling apart. Each body cell contains an average of 90 trillion atoms - 225 million times that 400,000.’ [1]
Isaac Asimov. Facts & Trivia. 1979.

15th October 1967 to 11th February 1968

Amberley One Ward—Initiation—Regulations 1897—Meet the Patients—Staff—The Night Nurse—Reception Ward—Nausea—The Drug Round—Staff Breakfast—The Beds—Act of Attainer—The Mental Welfare Officer—New Admission—Essential Reference—Duty of Care—Felo de se—Efficacy of Care & Treatment—Detoxification, Antibuse & Aversion Therapy—Steve Antibuse—Flower Power—International Times & Playboy 1967—Spider—Methadone—Khalid—Incident—Irish—Shaun—Domestic—Blind Spot—The Blanket—Pad—Routine

Monday, October 15th 1967
Initiation

At a quarter-to-seven, on a cold Monday morning I reported to The Charge Nurse in the office of Amberley One (MA1) ground-floor male Admission (Reception) Ward; the large long-stay ward overhead was called Amberley Two. The patients’ breakfasts were delivered for eight o’clock; before this time all patients were expected to be up dressed and washed - ready seated for the meal and early medication. Amberley’s dormitories and sideroom occupants were roused at seven o’clock but, before this time, between six-forty and seven o’clock, the duty Night Nurse would formally hand over the ward to the morning duty Charge Nurse and his day staff, reporting on the night’s events and any new situations.

After duly accounting for each bed and each patient, the night ward report was signed by the Night Nurse and the Day Charge nurse, and the report was then taken to the General Nursing Office. This ritual was repeated twice daily,

Night Report and Day Report (at the end of the day shifts), and produced each day of the year, every year - to date. Many thousands of old Notes and Reports were stored in the attic above Patients' Affairs - Medical and Nursing Records shelved on ground level - behind the Clerks front *Enquiries* office.

From all reports, medical, nursing and legions of administrative ephemera, the Hospital had audited and constructed an Annual Report. Copies of its *FIRST ANNUAL REPORT,* [2] dated for the year ending 31st March 1898, were still held in the attic over Medical Records. Regular reports have continued ever since, recording the day to day events of the hospital's staff and their dependent patient charges. Reports due - today.

As customary I was placed with one Charge Nurse and his shift to generally work with his opposite on days off, or be transferred to another ward during an emergency or staff sickness. Essentially there were three working shifts in 1967; two day shifts and one night shift, consisting of staff hours of day duty - Morning duty Six-forty am - to Two pm (twenty minutes for breakfast break) for six days a week. The Afternoon duty rota was One-forty-five pm to Five-past-nine (twenty minutes tea break) - for Six days a week. And Night duty; 9pm to 7am - three nights one week and four nights the following week.

There was seldom enough staff to back-up shifts covering all holidays and sickness and so from Charge Nurse to Student, one was contracted to work *both* shifts on that one day per week, known as *The Long Day* for it meant you worked, a minimum, from morning Six-forty am - to Five-past Nine at night (odd times to allow the shifts to overlap at The Handover), and our Time-sheets recorded this duty.

As a first year student I was off the ward one day each week, which was known as the study or School Day, when I would join up with my intake at the nursing school. At the Ward Handover staff arrived from within and without the hospital grounds. Within the life-time working memories of both Charge Nurses, staff formerly slept on their wards (off duty) and, ate, washed and dressed on the same wards with their patients during very long shifts. As an admission and observation ward Amberley One received a wide canvas of referrals whose patients initial diagnosis would invariably include somatic and psychiatric symptoms. On investigation an outcome could lead to a transfer to a local General Hospital, a Neurological Unit, or other Specialist treatment — outside the remit of a deemed Psychiatric Hospital *per se*., or to an early discharge.

Dr. M. a long serving Graylingwell Consultant Psychiatrist said to Admin Baz: 'It is not unusual for relatives with a cantankerous relative (patient) to expect 'Recovered' to mean a much nicer person.' The doctor would then quietly explain that with treatment he could only overcome the episode problem and return them to their former self — whatever that was. (What was their normal pre-morbid self, might actually have been unpleasant rather than affable or sanguine. Can't make a silk purse out of a sow's ear!)

Regulations 1897

The hospital's Social History (albeit all social history) was of interest to me; and a salutary reminder how long and hard our predecessors worked. Hospital staff *Asylum Regulations*[3] were kept in the Admin Office and available for all staff and visitors to see on request. From the mandatory regs I read that, in 1897, as a rule the following leave will be granted:

(1.) Daily - from 8pm to 10pm (except when on Reserve Duty).
(2.) Weekly - Half a day, from 2pm to 10pm.
(3.) Monthly - One whole day, from 6am to 10pm.

All nursing *staff* had, *had* to be in bed, in those late Victorian and Edwardian days, with lights out at 10.30 pm (or else?), and up again, on duty at 6 am till 10 pm. Although official meal breaks were detailed it was *not* a matter of *How Many Hours* you worked, rather, when you were ever *Not On Duty*. And, given that you slept on your ward, too ...

Clearly, this could easily compare to employees of most past Institutions, Armed Forces, Abbeys and Monasteries, yes, even Hospitals, and at another level as house domestic servants. All were *'In Service'*, to Masters who were the employers, and servants as employees.

The point was you were *not,* in those Asylum days, allowed away from your place of employment *at all,* even when not working and off-duty, unless on official business. And, *no way,* could you anticipate matrimony, for married staff could not both be employed in the same institution: and, as customary, if a person *did* wish to get married, in any employment, you *had* to gain official permission or it was a no-no — and this meant you or your spouse had to leave your occupation if, of course, able to do so. I would meet numerous retired and present staff who confirmed this rigid mandate.

I was informed that this formal requirement for all employees. To obtain permission to get married applied to *all* staff as late as post-war 1945 and into the 1950s as in HM Forces and the Civil Service. As Baz of *Patients Affairs* confirmed, he too had had to ask permission in this Hospital. Indeed, as pre-war records show, most public institutions had this absolute requirement of employment — masters and servants in common law.

In retrospect, the foregoing description of day-to-day life in the asylum and its austere regime sounded quite depressing. But I found it useful to realise patients-and-staff were effectively 'all in the same boat' creating a warm community family relationship, removed from the outside demands of society — what we now call a therapeutic community — despite the relative harsh times they lived in before the war.

Doctor Joyce (not his real name) was an icon of integrity, a Consultant Psychiatrist for Horsham, later Worthing and District area. He was also years later to be a close colleague of mine working in The Community and Hospital. Dr. Joyce recalled to me, that back in the early 1950s it greatly increased your chance of entering employment if you were able to say you played a musical instrument, or played a sport of any sort. He chuckled when he recalled his first interviewer, a Dr. Rice, who was oiling a cricket bat whilst he was being interviewed. Dr. Joyce, then a young physician, ex-Major of Burma and recently demobbed from the RAMC service (he said), 'told a fib, that he enjoyed playing cricket, and Dr. Rice' face lit up,because he was a keen sportsman. Nineteen-sixties folk singer Bob Dylan sang, in the ballad *Gotta Serve Somebody;* 'Everyone has got to serve' (even surrender to) 'somebody', abstract anthropomorphic. To rightly submit to God - and shaped man or woman, which probably included any new employer.

Meet the patients

Initially, what struck me, coming on that first duty, was the homely air of normality about the ward. There were no media described screaming idiots or stereotyped aspects of lunacy, nor any 'stand to attention' militant staff to greet me behind a white coat.

As I entered the Amberley ward passage, I met a patient carrying a tray with teapot, milk and sugar, and walking behind him apace was the white gowned Night Nurse, who was carrying several large clean white mugs. The patient delivering tea was, I learnt, an often vied for, self-appointed duty that, if it worked, allowed him to continue for their duration in the hospital — or

at least whilst resident on the one ward. On several of the long-stay wards the same nurse-and-patient had been resident for years. A safe factor for transient occupants; some dependency was essential, to acutely depressed, hallucinated, paranoid or deluded residents, patients in their own inner-worlds of sometime chaos, who experienced their ward as a warm haven.

To show *how* to survive was an expected first-aid function of all caring psychiatric staff. To rehabilitate sick patients, where possible; and to always, give old-fashioned altruistic care — whatever prescribed clinical treatment. I realised that many working relationships between staff and patients in this long-stay hospital had evolved over many years and built-up trust and dependency.

Gently, I knocked on sideroom doors before putting the lights on. And our patients, called by their Christian name, one-or-two by Mr, known to be more appropriate. Most patients were roused quite cheerily but several irritated, not surprisingly, at being disturbed from their sleep, though they accepted this inevitability.

Staff

The Admission (Reception) Ward's day-time staff were supervised by two Charge Nurses. Charge Nurse Bob, and his opposite, Charge Nurse Norman (both staff ex-RAMC). Two truly gentle giants with the latter's sometimes gruff tones often veiling true genteel emotions. Both Charges' wives were serving Ward Sisters in this hospital.

Two regular Staff Nurses covered the two day shifts. On Bob's shift was Tom, medium height, small moustache, athletic build, very humorous, intelligent and, dependable. And, his opposite number, on Norman's shift, was Harold, taller less athletic, more intense. As a number of other RMNs both Tom and Harold were double-qualified, with an SRN (State Registered Nurse) qualification.

There were two posted RMN students. I was one student on duty with Bob and Tom, and my opposite colleague, was Jacques, a tall, lean, lively tanned Mauritian; a third year student RMN who played the guitar. Sam was our witty cheerful brown-coated ward orderly. He always accompanied the morning shift. And last, but absolutely not least, was our ward's worldly, white-coated evening, volunteer, Astro Tony (his daughter practised astrology readings). He was a Chichester day-time shoe salesman - who would briefly, be-friend Sara and I. Astro Tony completed the daytime staff compliment.

Not forgetting the lone, staff - Night Nurse.

The Night Nurse

To the North of the E shaped MA1 ward the observatory dormitory accommodated sixteen acute beds; at the end of this long-room three single side-rooms. Two patients presently occupied two rooms. In the right-hand corner one converted side-room housed Gerald the duty Night Nurse; a Staff Nurse who kept a watchful eye on all new admission cases. Within Gerald's minute white-painted room were locked side cupboards with medical equipment, and a table and chair, with a green-cloth shaded sidelight. Just outside, against the wall, located between the two side rooms and nurse's corner-room, were other locked white cupboards with red warning lights which switched on automatically when opened. These cupboards held some drugs and stored clinical apparatus.

Each bed-space had a ceiling supported steel curtain-rung around its bed area, with dark-green moveable curtains against the wall (ward curtains funded by the charitable hospital's *League of Friends*). These curtains could be drawn by the patient during the night for privacy, if desired. The opposite, South-end of the observatory dormitory looked out onto the ward-gardens, and one early morning I saw a deer close to the window which had during the night strayed from the nearby hills. This turned out to be a rare event but also an early reminder of how close the northern perimeter of the hospital's estate was to the verdant South Down hills, woodland, and scattered copses.

Reception Ward

The long narrow dayroom had a variety of furniture, scattered rugs but no carpet, and included old long-back bamboo-cane chairs, around its periphery. At one end, the west-end, was a full-size billiard-table room. And at the entrance before the billiards room, outside a single room in one corner stood a black-and-white 17" television set, which sat on a low wooden table. Charge Bob told me that television was permanently introduced into the wards at the time of the Queen's Coronation in 1953. And television, tannoy radio, and weekly cinema shows in the Main Hall popular in the 1950s and 1960s (at the turn of the century there were occasional Biograph slide-shows and silent movies) were regular facilities.

In front of the television were three well-worn armchairs, which suggested late occupants of the night before. Close by the wall on another table was a much used portable record player, and a disorderly pile of gramophone records,

long-playing 33 rpm vinyls, seven-inch 45 rpm's, and brittle 78 rpm's including, Elvis Presley soul; rock-'n'- roll Bill Haley; and lively Scot Jimmy Shand and his accordion band. Several battered paper-backed books accompanied the records. One book was open and placed face-down on an indented arm-chair and a partially filled mug of what looked like stale tea sat next to a white plastic portable radio — both items on top of the television set. Evidence perhaps of one patient who could not sleep and wanted to sit up during the night, in company with a cuppa from Gerald, the sympathetic night nurse.

On the south-side, off the ward's dayroom and adjacent to it, were two spaced doors and a wooden partition which led into a separate, outside enclosed verandah, which dated back to pre world war one days when open-air treatment was mandatory for certain types of illness such as consumption; and for patients in need of convalescence - and it had once housed a number of beds. The verandah had a ramp and steps giving easy access to the gardens it overlooked.

During the first world war, when Graylingwell was a designated war hospital, a number of photographs were taken showing recovering soldiers on this verandah but now, fifty years later in 1967, it was used by the ward as a dining-room area with tubular steel tables and chairs within the verandah space.

Early every morning around six o'clock a patient was woken up by the night-nurse and the kitchen opened up (it was locked late in the evening) so that he could lay the tables ready for breakfast — it was presently the same gentleman who brought us morning tea into the handover. I later learnt that Bill was, for various reasons, unable to reside in the community and normally as a long stay patient should have been placed on a more appropriate long-stay ward, but at his own request he had asked to stay (at least for a while) on Amberley One. A few months later, bureaucracy prevailed and our friend, to his consternation, was moved to a more 'appropriate' long-stay ward, because it was an Admission ward bed he had occupied. But, until then, Amberley Bill resided in one of the much sought after side-rooms, with its own door to close - and which provided a measure of privacy - and security.

Ward Residents

Our patients were slow to get up, which was hardly surprising, since many were suffering from depression, *deep* depression, a dark-black personal swamp that I had yet to learn about. This clinical state which had at some point made some of them attempt suicide or self-mutilation on at least one occasion in the recent past. Thus our entering with a purely cheery appearance was not sufficient

a social posture - but it helped. And jokingly punching cracks with individuals, who were known by us, to create response, we worked our way around the two dormitories and every side room.

Most ward patients were ambulatory, but one man was bedridden in the observatory room, his legs bandaged around the calves due to severe ulceration. He was in his early forties a married man suffering from acute depression. I was duly detailed to every morning henceforth change his dressings and assist Depressed John with his breakfast and toilet ablutions; a student nurse using recently taught knowledge. I enjoyed this basic task, and he was content to talk about himself and his life.

The age range of patients on the Reception ward was between seventeen years and mid-60s — this a topical problem. At The Handover the Night Nurse related how one drug addict had jokingly threatened one of the older patients on an issue, and then challenged the night nurse that one night he would unite the d.a.'s (drug addicts) to raid the drug cupboards at the end of the observatory ward and close by the night-nurse station. Charge nodded his head and said that for some weeks he and Norman, his opposite, had strongly recommended that all drug addicts and alcoholics being *dried out* (both, off their supplies) should be separated from the other older patients, who often felt frightened, intimidated by specific individuals — but insisted they were *not* all of this disposition.

On my entry to the ward as first year student there were six drug addicts resident on the admission ward and before my three months would be up there would be a total of nine, a high proportion, too high. The Magistrate courts asked probation for medical and social reports, and thus numbers of drug offenders would be either in hospital pending a Crown court hearing for their particular offence or, offered a Section 26 1959 Mental Health Act section (being at risk) and required to stay in hospital for treatment of up to a maximum (subject to a possible Mental Health Review Tribunal) one year's duration — of which *no* d.a. to my knowledge, ever remained on a Section for that time. This was by most d.a.'s seen as a soft option, a placement of an open-ward — as opposed to the alternative, a more bleak formal locked-in stay in prison, probably Lewes. There were in residence both users and the dealers — the 'pushers' who made new uses of cocaine, heroin and its derivatives, cocktails (a mixture of drugs) and barbiturates.

A number of Section 26 addicts were in due to an overdose, including LSD cocktail offences. Several suffered dangerous after effects, including episodic

flash backs, which often triggered a spell of psychotic behaviour; and less exaggerated physical symptoms as hallucinations, nausea, and other unpleasant experiences. They called these episodes 'bad trips' — which led for some, who were hell bent on self-destruction, to sudden death.

Nausea

From the outset, Kafkan and Sartrean *Nausea* displayed itself as a dominant symptom, for many of our psychiatrically ill patients. Nausea with or without actual sickness, for those with acute depression, paranoia, phobic complaints, alcohol or drug abuse poisoning — or, an extreme negative state of mind - a diagnosed affective disorder. A much lesser degree of nausea I had myself experienced, as physical *per se* sickness and nausea — but, surely never as these sufferers.

Another range of psychiatric illnesses found amongst our angst, young and old alike patients, were those experiencing one of the diagnosed schizophrenic (aka dementia praecox) illnesses. This disorder proved much more difficult for me to learn to nurse and understand, for whilst depression was not uncommon to my knowledge, schizophrenia was new to my world of experience.

And, finally, a third arbitrary class of new patient resided on our reception ward. These were aged persons who, *in addition* to diagnosed psychiatric symptoms, also displayed symptoms of senile-dementia, pre-dementia, or brain-damaged trauma — which needed observation and a differential diagnosis. On admission in the 1970s, most patients had some (or all) prescribed drugs suspended — surprisingly a number showed improvement.

The Drug Round

From that first morning I assisted in essential chores. At breakfast time the small medicine trolley was unlocked and wheeled out of the clinic into the dayroom verandah space by the Staff nurse and, as per regulation, with-one-nurse-to-check-in-attendance, prescribed medication was handed out to those who queued at the trolley. Initially, I found the prospect of handling with exaction over two dozen and more patients drug prescriptions at each meal-time rather daunting. A knowing patient would say helpfully; 'I-know-what-I-have-two-big-white-ones-and-a-small-blue-one' (two largactil and one stelazine in his case) or; 'one-large-white-pill-and-a-little-yellow-one,' (largactil and orphenadrine aka disipal).

This was but one vital routine, The Drug Round. Numbers of patients would be reluctant to take their medication; and needed gentle persuasion. The right dosage was of paramount importance at all times, and I learnt to not only identify *all* the current drugs and name all the patients but, like a milkman, memorise each persons medication and *always* to check, according to the written prescription sheets, and witness each signature by the qualified nurse as each patient received their medication. In time, my own signature would be witnessed when *I* came to measure out the medication.

After breakfast was served and early medication completed, the trolley was wheeled back to the main Clinic room off the ward corridor. It was then chained up, and the clinic door was kept locked when it was not in use. Then, there was clearing up, both by patients and staff. A daily duty washing-up roster was posted up weekly by the charge nurse, when two patients would be expected to clear up and wash up the dirty crockery. The list was always staggered throughout the week to keep it fair and reasonable, patients could swop names around as long as it was achieved. Always, I experienced in human institutions, there were slackers and skivers with the pressure from peers to effect results. And, of course, there were those who were genuinely too ill or depressed to execute any ward duty.

Whilst washing-up was being done, a number of the patients prepared to go to the hospital shop, occupational therapy, social therapy, or one of the industrial therapy workshops. Individual patients would be asked 'to remain on the ward' so that their Consultant Psychiatrist, or (if he had one) his Senior Registrar, could examine them, in the ward clinic and interview them, with the Charge Nurse present in the nursing office.

Staff Breakfast

The ward nursing staff prepared for their own breakfast. If a staff member wished to go to the staff restaurant for their twenty minutes, they could do so. Most staff members remained on the ward for a bowl of cereal, boiled eggs, and toast and marmalade, with a pot of tea — supplies bought in by the nursing staff (and they were!). It was another ward routine, the Staff Breakfast.

Amberley Ward's Staff breakfast location was in the corner night staff station off the large observatory dormitory, where there was a phone extension. A precautionary ritual was allocated to the junior nurse. It was mandatory to count up all the knives, forks and spoons, particularly the knives, *after every meal*, and after the rota patients had completed their washing up. This routine

had been executed for many years, Charge Bob informed me, because of occasional depressed patients stealing the articles with intent to use them for attempts at suicide. Sure enough, on several occasions in the months ahead knives or forks were found missing, and such attempts at suicide were feared.

In addition, each article of crockery to be used by the staff for breakfast was re-washed and sterilized as it was placed under the scalding hot water from the urn jet. This habit originated from an awareness that occasional patients had, in the past, exercised some rather unusual uses for the crockery, and cutlery, and earlier vivid recollections of contagious diseases — therefore, no risks were to be taken. It was left to my imagination as what such uses there could be... It was probably, I concluded, just to confirm they were clean; a matter of common sense really, not a superstition.

Each day, for *The Staff Breakfast,* a pristine white table-cloth was used. During their 'formal break' staff were able to be available to patients still about the ward, whilst having their own meal and, sure enough, were frequently interrupted by anxious patients. The breakfast also provided an informal discussion of the expected day's work ahead, any anticipated problems, and the personal anecdotes with peppered topical conversation gleaned table talk from the daily press or TV shows of the night before. After I washed and cleaned up the crockery of our staff breakfast I joined the charge and staff nurse in the ward nursing office off the ward corridor.

Close by the office, off the ward corridor was a larder and clothing cupboard; several doctors' consulting rooms; the ward clinic; and a minute room with patients clothing and suitcases stored for the patients duration stay in hospital. At the other end of the ward corridor, the kitchen with its two doors at a right-angle, one into this corridor and the other into the dayroom. Another door linked the ward-corridor with the male admission dayroom and it was this door, and the kitchen doors, that was locked each night and unlocked when the day staff arrived, and left open during the day. It was as an open ward; thus the layout of the reception ward facilities.

During breakfasts our male brown-coated ward orderly arrived, and after first joining us for a cup of tea, began his domestic duties — with segregated wards, female staff rarely worked on male wards, and vice-versa. Although the ward orderly naturally exchanged amicable conversation with staff and patients; his specific duties were cleaning and polishing about the ward, but this was *not* cast in concrete and he could help out when common sense prevailed as well as when any ward crisis came about. (Not long before this time, and the

coming of hospital orderlies — ward maids on the female side — all cleaning had remained the duty of the nursing staff.) Each ward was generally inspected *daily* by a Charge nurse and the hospital cleaning Supervisor. Admin Baz recalled that in one hospital an orderly / cleaner *formally* joined the Therapeutic Team, as their availability to converse with the patients was recognised.

The Beds

Unless a particular patient or situation required attention, the next routine, after breakfasts were completed and cleared away and patients directed to their various groups or occupational therapies, was The Beds. Although there was no longer a formal hospital wards daily inspectorate, in earlier times the Charge Nurse (under a rigid inspection by the Medical Superintendent, the Head Male Nurse (Matron, on the female side) and entourage) expected his ward to be clean and smart in appearance, and with no obnoxious odours — at least those that could be cancelled out.

Few patients bothered to re-make their beds and most were restless, although night sedation secured a reasonable nights rest, and bed clothing was found all over the place in the morning. Smoking in bed was actively discouraged as a severe fire risk, as well as risk of self-injury if suddenly dropping off to sleep, but I regularly found a number of beds were heavily soiled with tobacco ash, one or two holes and even crushed cigarettes located amongst tangled sheets and blankets. Several beds were also usually saturated with urine, and faecal stains.

One bed remained occupied at ten o'clock in the morning, in the Non-observatory dormitory adjacent to the billiard room. Ron was in the depth of a black depression (melancholia in an earlier diagnosis), had refused his breakfast, only wanting his medication, and said he wanted to be left alone. For a while this asylum would be granted, before we slowly talked him up and out of it.

Unless a bed in being remade was found soiled, when bedding was of course changed for clean linen, *both* sheets were changed minimally once a week, as in most homes or institutions. Not many years past, it would have been regular changes of straw and dry rushes.... I recall being issued an empty cloth-sack palliasse and straw in peacetime 1950s army huts and, as a teenager, I daily changed straw in the chicken-shed back in our home backyard.... What about the obvious, legions who had only hard dark dank earth, sand, or gathered leaves and bracken to lay down on ...

Twice a week on Amberley, Tuesday and Friday mornings, the treatment of ECT - Electro Convulsion Therapy (previously known as Electro Shock Therapy) was conducted for selected patients. Beds were specially made up with rubberised under sheets to receive anaesthetized and then recovering patients. The ward observatory dormitory was, during this treatment, closed off to other patients and staff, not involved in the event. And, contrary to public opinion, ECT was popular to many patients, as a form of physical treatment for depressed, who found it really did improve their morale even though memory was for a short time inhibited after recovery.

When a patient vacated a bed returning to the community, or transferred to another ward, or deceased (rare on this ward) a new admission bed would be made up, with the top sheet turned over at its bottom. This meant that the bed was made ready to receive a, possibly unconscious, patient.

A New Admission was another hospital routine to be quickly learned, as I would admit hundreds of patients (and assist in discharge) in months and years ahead. At face value, resident patients would be in old-fashioned terms, certified or uncertified, unwilling or willing, following a primary diagnosis which was presently either compulsorily into hospital by a Section of the *1959 Mental Health Act*, or informally under its Section 5 arrangements with no compulsory papers required. This procedure depended on the degree of *insight* and control an individual had over their *diagnosed* psychiatric illness, or disorder. If a patient was clearly *at risk*, a danger to themselves or to others in the community, *and* they were considered mentally ill then a hospital admission, a Place Of Safety, was deemed the appropriate place for immediate treatment and care. But to a patient wilfully moved against their will... Well, *their* feelings on the matter can only be imagined....

Act of Attainer

In an 1815 'Law Dictionary' by Thomas Potts, Gent; a work Charles Dickens would certainly have been acquainted with twenty years on in his early writings; Potts defines:

> 'Attainer, is property where sentence is pronounced against a person convicted of treason or felony: he is then tainted or stained, whereby his blood is so much corrupted, that by the common law his children or other kindred

> cannot inherit his estate, nor his wife claim her dower, and the same cannot be restored or saved but by act of parliament'.

Quoting Potts again, in looking up *Lunacy* 'lunatic', he refers directly to his entry, 'See Idiot':

> 'Idiots, an idiot is a fool or madman from his nativity, and one who never has any lucid intervals; therefore the King has the protection of him and his estate, during his life, without rendering any account; because it cannot be presumed that he will ever be capable of taking care of himself or his affairs...'

I found Dickens, always sympathetic to disabled and elderly people throughout his lengthy novels. So it was Mr Dick (Mr Richard Babley), who 'was a little mad',was cared for by Betsey Trotwood, David Copperfield's great Aunt, in his wonderful novel *David Copperfield*.

Statutes, in some form or other, have been in operation in Courts and public life, at least, since the Thirteenth century, for *idiots*[4] and deemed *lunatics*. Inherited *property* of idiots and lunatics was put in trust to a Monarch, or other notable. Post-diagnosis a lunatic body was put in the care of a named individual or imprisoned, or hospitalised, through common law, written law, or even private mandate — as shown by King Henry the Eighth (1491-1547) who instigated a *private bill* to escape interference with his judgement on the young Queen Katherine Howard and deemed conspirators. King Henry's' private bill read:

> 'AD 1541 - Cap. XX - *How Treason committed by a Lunatick shall be punished, and in what Manner he shall be tried.'*[5]

I queried in what *original* writing, this bill had first used the word *lunatick,* when first drafted as a formal *legal* document was it in Latin or English, and was it an early *social* use in Tudor Law of the word *Lunatick*?

In retrospect, an act was passed in 1540 which reflected the *duties of care*, as it were, of the *Royal Prerogative*[6], which laconically read as:

> 'Cap. XLV. The Erection of The Court of Wards, and Names and several Duties of the Officers thereof, in the Governance of the King's Wards, and their Estates .'[7]

I wondered at what age a Ward ceased to be so. Was it laid down or variable? Erm! If a person was under 21 or 18 or 16 years old and married at that age did you owe, technically, a duty of care to them as both a Ward and as a Spouse and, when applicable. as a Sick individual? Perhaps I am being fatuous. This beneficial *Court of Wards Bill* was on Statute until the reign of Charles the Second[8], when the office of the *Royal Prerogative* over idiots and lunatics was transferred from the *Court of King's Ward* to the *Lord Chancellor.* (In the 1960s this was known as Chancery Lane, *Court of Protection*.)

King Henry was able to *legally* dispose of his Queen, and Lady Rochford (who was examined and declared *compos mentis*, at the time of her treason, conspiring as Lady in Waiting on behalf of the Queen) by invoking, in 1542, An *Act of Attainer* [9] in which Parliament bypassed the need for a public (democratic?) *Trial for Treason* by judge and jury, using the Bill and 'supplanting' a judicial verdict. This *Act of Attainer* had been in use at least since the 14th century when King Edward Second's parliament deposed the DeSpencers, who were executed when Queen consort Isabella, who in turn was usurped by son Edward Third in 1330, and her lover Roger De Mortimer overthrew Edward II. This *automatic* use of a Statute was used when a monarch or standing parliamentary body wished to defeat a foe *without a trial* and be able to dispose of their properties and titles if the accused were *compos mentis*, and even after the offender's execution. If they were deemed idiot or lunatic then any property, et cetera, was held in trust while in life, and after death any residue passed to entitled family descendents.

The above research presented a *so-what* question I shared with tutor Mr Ilford from our first lectures; when did a *clinical* judgement differ from a *social* view on being a lunatic? I pursued this historical conundrum, specific use (or abuse) of the word *Lunatick* as integrated in Dr. Johnson's English from Latin origins. This was a reliance on the work of scholars (whatever profession), from early Greek (i.e. Galen) and subsequent Roman and Arabic, or more latterly in legal French translations. The *somatic* origins of *diagnosed* insanity, a madness believed, caused by internal humoral imbalances manifested in a patient's behaviour as a '*frenzy, mania, melancholy and or fatuity*' (from the Latin). What caused insanity? Ideocy (*fatuitas a nativitate*) was seen as more obvious, and deemed clinically untreatable, as well as in need of care and compassion;

but to be insane. Why? Why historical interest in this term of *Lunatick*. Because of its implications, and being guilty ... but of what?

Katherine Howard (born 1521, Nineteen-year old fifth Queen of Forty-nine year old, and ailing King Henry the Eighth) within one year of marriage was accused, and found guilty of treason, in that she was *not* 'pure' before her nuptials (married 28th of July 1540) and unwisely been in the company of young Thomas Culpepper *since* the marriage. Her lady in waiting, Lady Rocheford, acted as a go-between for the Queen with Thomas Culpepper, and was found guilty of treason for her complicity but 'she went mad on the third day of her imprisonment, recovering her reason now and then ...'

This questionable fact, was she *malingering,* in '*feyning madness or not*', initially proved a legal problem for Henry who was determined to put Lady Rocheford, sane or insane, on the scaffold with her mistress, for she had already confessed her guilt *before* at the King's Council and found proven of High Treason:

> 'but, happened to "fall to madness or lunacye" (and) should be the subject of a special Commission of Oyer and determiner of Treasons.' [10]

King Henry's - self-appointed Head of Church and State - answer was the 1541 Act; and Lady Rocheford was subsequently executed on the green of the Tower Of London - after her Queen - on February 13, 1542.

It's one thing to observe, diagnose and treat a natural (medical) body phenomena, such as ideocy, or a 'decayed' person in organic dementia (non compos mentis) no longer, as previously, being in control of his or her mind and subsequent actions, and quite another for a human in authority to designate a socio-political cause (reason?) as being insane (unreasonable) - and removal of an other to an asylum, prison, hospital - or destroy for hearsay or worse an culpable act of treason. Being deemed 'insane' itself appeared at times to be a crime (in society) and in need of a trial or tribunal whether or not *and* be guilty - yet innocent of wilful intent - but still be placed in care or charge of an institution or designated responsible (for the idiot's actions).

On entrance in 1967 into Graylingwell Hospital, I accepted that many patients were in the long stay hospital (in its medieval use as a sanctuary) for not fitting (alienated) in the community and most in need of care and comfort as sheltered accommodation. If there was a vacancy on Amberley admission ward, it was

unusual for it to remain so for more than one day as the hospital *always* had a waiting list, especially for informal patients.

With out-patients visiting the hospital to maintain a course of electro convulsive therapy (aka ECT), there was no question of non-sectioned patients being forced to have treatment. A Form had to be signed by either the patient, or nearest relative (for a sectioned patient). In the years ahead I would learn of possible side-effects.

Ward nursing staff would receive a telephone call from one of the Consultant Psychiatrists or their Senior Registrar, the delegated Duty Medical Officer for that day. Each doctor formally attached to one of the three designated areas in West Sussex; Chichester District, Worthing District, and Horsham District. Within two years Horsham patients would be transferred to Mid-Sussex at Roffey Park - or on to Haywards Heath at St. Francis Hospital.

"Have-you-got-a-bed?" was the most loaded question relevant to whether or not appropriate acute psychiatric care could be given *when it was most wanted*. If the answer was 'Yes' then a booking was made and a set of Admission Papers were made to receive the patient. A little known fact to the public was that getting *into* a psychiatric hospital could be harder than getting discharged back into their community of origin.

A Sectioned patient usually arrived accompanied by two ambulance men and a local-authority *qualified* Mental Welfare Officer. Sometimes, relatives came with compulsory patients, but *not* very often. Voluntary patients, on the other hand, usually came to the ward with a close friend or relative, sometimes even on their own if they had been admitted before.

As a new patient was safely received on the ward, any legal section papers would have to be formally checked as being in order. If the papers did *not* check out then it would be illegal detention and have led to a purported wrongful incarceration, traditionally the most feared and media sensationalised experience imagined. There is considerable literature on this abuse.[11] Victorian novels reflected ongoing fear of illegal incarceration. In the twentieth-century global, media records are replete with people wrongfully 'locked up' or 'imprisoned' in state mental hospitals and prison wings, as in the USSR - and other foreign locations. [12]

The Mental Welfare Officer

To be detained in an hospital (as a Place of Safety) against one's will was a sad inevitability with a number of patients whose psychotic or gross suicidal

behaviour was loudly denied by the patient (unless mute - for whatever reason), whilst being visibly self-evident. A formal admission was arranged by the local authority duty MWO; The Mental Welfare Officer, a *duly authorised officer*, a local authority health man or woman employee based in the parish, the community. These previous beadle officers were re-named after The 1959 Mental Health Act. In earlier times such authorised Officers were also called Steward, Assistant Overseer, Relieving Officer and, more recently, re-named as Social Worker. Admitting officers worked in tandem (usually) with police, duty magistrates and two qualified physicians. Legally, one doctor's signature had, *had* to be an Alienist or at least an experienced Psychiatrist. If not a qualified physician, the section would be illegal, at least questionable.

Fortunately, for the majority of patients, admission proceeded without any particular problem. I learnt that *specific* written data on The Section papers had to be properly worded, *and* likewise the doctors and MWO's information, on their respected papers should be *identical,* or else *The Section* was deemed not legal (I was well aware it took away a person's Freedom - and, there *must* be a legal way back.)

In hospital, patients affairs would refer back to source if an irregular paper was realised. Serious errors were referred back to the MO, and informed the patient was not detained. The patient could then be discharged or agree and convert to a Voluntary (informal) admission (under Section Five of The 1959 act), if a compulsory admission could *not* be made at the time. (Years later I would sanction many Sections as a qualified MWO and, as an experienced Mental Welfare Officer, I found myself in such isolated situations on numerous occasions, a number in quite dramatic difficult scenarios, with a patient in dire need, to properly find and move them into a *legal* Place-of-Safety, as well as to resolve an emergency.)

It was also expected, but not always found possible in practice, that the MWO provide some basic written information about the patient's domestic circumstances. The doctor would be expected to provide Summary clinical data on the patient for the admission. I noted Charge nurses Bob and Norman, or other Senior nurse in-charge, *always* checked the admission papers, and these were referred to Patients Affairs if not correct, with the admission refused. If the patient was already known to the hospital then previous clinical notes (if it was in daytime and not weekend) would be brought to the ward from Medical Records. After section papers were sanctioned and the MWO departed, the papers would be taken off the ward (copy into ward case notes) and deposited

with the duty Nursing Officer to be *again* checked by The Office - then again onto Patients Affairs to be formally checked. It was at the point of accepted exchange between the MWO *and the ward staff* that the admission became legal, if the paperwork wording was complete, and correct.

Paperwork completed and, after accepted admission, the admitting nurse would attempt to gain any updates to add to the patient's case notes, if the new patient (mostly unknown) was able to communicate. If he was too sick and unable to give specific information, then he was taken directly into the ward, curtains drawn around his bed and then requested to change into pyjamas, or get ready for a bath; if he wanted, and of course if safe to do so. Later on the duty Medical Officer would interview the admission.

The hospital Clothing-and-Property Card itemised all personal articles which the patient wanted to be listed, if they were competent to acknowledge this event, and the items were then temporarily removed, not including the articles to be kept, at his own risk, in or on his bedside locker. When completed, the *Clothing Card* [13] required two ward signatures as a check with valuables, and on delivery to Patients Affairs signed by patient-and-nurse (plus another member of staff if patient unable) overseeing this routine duty.

Any prescribed pills brought into the hospital on admission were left in the nursing office to await the duty medical officer's appearance on the ward, when the customary admission physical examination produced the human map details to join the other admission paperwork in the patients hospital file notes. At the conclusion of the formal admission clinical examination a new written prescription, and the in-patient, medical certificate would be issued. Recommended physical tests required separate *Forms* (aka chits) in the paperwork[14], also sometime after admission the path lab representative came onto the ward to obtain the usual pinprick blood sample.

All hospital *Admission* procedures had *had* to be learnt — *Stat*....

The personal touch would invariably be determined by the timing of the admission. So, if the meal time was some way off, the admission would be offered a cup of tea or coffee, and a sandwich, if he was hungry. It was the personal re-assurance that the patient needed, and deserved; it confirmed he was here to be helped, and *not* placed in harm's way.

New Admission

The New Admission sometimes provoked a crisis situation as the patient arrived on the ward. Initially, before admission, the patient might have been sedated, but on coming to, became confused and disturbed to such a degree that it was deemed inappropriate to remain on the reception ward. They were then subsequently escorted up the corridor to Bramber Two - a secure ward.

At a severe crisis situation, and they did occur at any time, a green-rubber cork-padded side-room at the rear of the main dormitory on Bramber Two Ward would (in 1967) be used for a time. If that was inaccessible, a pad on Chilgrove One (very unusual), or Eastergate would be used. It was a sensitive operation.

If our new patient had made a recent 'Suicide' attempt, and was still at risk, then a nurse was allocated on a one-to-one basis to keep a special eye on him. Over and above this *specialising,* however, it was normal to observe *all* patients behaviour following admission, and as long as real risks were apparent a formal duty-of- care remained in place.

All existent long-stay psychiatric hospitals during their living history as Asylums and Licensed Houses, reflected previous eighteenth century Madhouse Acts, and latterly the thick 1890-1 Lunacy Acts, valid until the coming of the 1946 National Health legislation and *1959 Mental Health Act,* which existed in the 1960s and seventies. The acts had explicit and *mandatory* instructions how to treat (or not treat) their vulnerable inmates. From the hospital's inception in 1897, 'The West Sussex County Asylum. Chichester. *Regulations'*[15] - marked on page twelve paragraph 36[16], in respect of the suicidal patient, a legal and moral code, which to this day remained enshrined in the robust duty of care of its patients - applying to all outpatients and residents. As such the duty of care was ignored at both patient and carer's peril.

But in the 1960s, with few staff, and on a full ward upwards of thirty patients to observe and carry out ward routines, to be *only* able to special one patient itself became a logistical, management problem; and at such times another nurse might be drafted in for the duration of the crisis period, if available.

The 1897 Hospital Regulations list [17] had 'inked' markers against *mandatory* rules of conduct, and to wantonly abuse any of these instructions any staff offender risked prosecution *as acts of felony*. If the hospital administrators and their employed staff neglected legal care duties in facilitating current law,

especially if a fatality was a direct result of neglect, the authority otherwise risked a case-law prosecution. [18]

Lists like form filling will often draw a low groan when confronted with a task, and *what a bore* when references invoke labels, numerous laws, names and sundry forensic caselaw incidents. Yet, for thousands of years, ancient and recent manuscript written forms, stone tablets, papyri in need of decoding, disclosing fragments from someone's civic military or religious text enshrined as part of a recorded tedious list revealed a way of life in the distanced past. And investigating the day-to-day running of the hospital found numerous similar lists, especially a number of reference books from past Medical Superintendents' and general Administration Offices that were used since the 1890s and *still* on the Patients' Affairs shelves, in frequent use during the 1960s.

Essential Reference

I realised a revealing chronological list which was deemed *essential* reading in past Asylum hospital administration, by past and recent hospital administrators (including Superintendent Dr. Harold Kidd and his successors); Law Books, Journals and other necessary reference works for students, and professionally qualified Doctors, Nurses, and Admin staff, in their owed need of a due, duty of care to patients and junior colleagues. Without doubt first on the list was *The Law And Practice in Lunacy*, by A. Wood Renton. 1896.[19] valid and in use until the 1946 National Health Service Act and 1959 Mental Health Act. A supplement to Renton was *Law Aspects of Mental Illness Procedure* by William Gattie. 1933.[20]

And, from pre-war, *The Poor Law Code And The Law of Unemployed Assistance* by W. Ivor Jennings. 1936.[21]; and still in use in the 1960s was *Chalmers' Sale of Goods Act, 1893 including The Factors Acts 1889 & 1890* by Ralph Sutton. 1945 [22] ; *Law Relating To Hospitals And Kindred Institutions*. by S.R. Spelling 1947. [23]; valid until the 1959 M.H. Acts was the much used *Mental Health Services. A Handbook on Lunacy And Mental Treatment And Mental Deficiency* by F.B. Matthews 1950.[24] A Bible of Reference to nationwide hospital facilities, since Burdett in the 1890s was its successor; *The Hospitals Year Book. An Annual Record of the Hospitals of Great Britain and Northern Ireland.'* 1967. [25]

Last, in addition our *Patients Affairs* held a collection of published *Graylingwell Hospital Annual Reports* (copies for public perusal - on request, held in local public libraries). In another length of the library shelves - all past

relevant *HMSO Mental Health Acts* and numerous slim *Poor Law* paperback commentaries, and supplements to date.

Our United Kingdom government (in theory) guarantees its public, in its democratic society, that despite tight censorship and propaganda (encouraged by it) *any* controversial topics can be presented, at least debated, or acted in comedy, drama, documentary or by lampoon and satire, with libel not withstanding and free speech (not at all wanton aggression) without summary execution of politic dissenters - as in certain global dictatorships. Not so in U.K. legal contracts, and specialist textbooks, which reflect, in the small print, that instant resources *seldom* meet with new legislation. (Sociological jargon aka cultural lag.) Such ambiguity exists in exchanged Contracts and New legislation, and White and Green Papers, in the field of human care. Specifically in contracts paying for the care and wellbeing of others, mostly unable to care for themselves, and owed a duty of care. As I learnt.

Duty of Care

I do *not* recall in the 1960s and seventies ever hearing, or seen in writing, the term *duty of care,* which was to be mantra after 1980s towards *Community Care*[26]. Duty of care is deemed *implicit* in tenets of deemed 'qualified' professional memberships in Accountancy Education, Law, Medicine, Nursing, Social Work et cetera. The term *later* to become almost prolific in Nineteen-nineties and early 21st century in fictional Law scenarios, and Case-law courtroom dramas [27], suggesting all Organisations have legal responsibility for their own and members wilful actions.

Not till 2007, forty years on from my questions put to Admin Baz in Graylingwell in 1967-71 on *whose responsibility* is a duty of care?, would I see reference to a *National Health* administrative corporate body as *possible* perpetrators of *Corporate Manslaughter.* [28] On one National newspaper's Front Page, its Main Heading stated that:

> *'Hospital bosses could face charges after outbreak kills 90. MANSLAUGHTER BY SUPERBUG? '* [29]

A later report *officially* vindicated that named hospital Primary Care Trust of wilful irresponsible neglect.

Government State institutions *and* their Managers are subject to rigours of The Law; a Senior empowered person from government down to local body,

on retro enquiry deemed liable *if proven*, to be wilful abusing of their politic powers, for wilful read neglect, leading to predictable avoidable abuse, death, inflicted suffering, or wanton rank disorder, resultant from their written mandate? Junior staff not sacrificed as scapegoats; subsequently found guilty in neglecting a *Duty Of Care* of its public charges patients and caring staff.

One needed to differentiate between retro unwise but not wilful, human action, and deliberate advocated policy, whilst being well aware of its implications and responsibility. Case law in the 1990s specified that to prove such 'negligence' key elements had to be established, in a Court of law, to prove such *in extremis* negligence. A duty of care must be *owed* to the so-called victim (or victims); there must be a breach of that duty-of-care causing death or unwarranted suffering; and be proven, the breach sufficiently serious, to constitute actual damage by gross negligence. [30]

In the Twenty-first century it would not be uncommon to find the term Duty-Of-Care appearing in daily media; any assumption in neglect of DOC of any sick and vulnerable whatever their age or condition *may be* taken to task. For example:

> 'All schools have a 'duty of care' to safeguard pupils' welfare. Based on the "in loco parentis" principle.' [31]

But, the term duty-of-care was *not* found in 1960s initial enquiries. I noted the metaphor *shell-shock* was absent in Clinical Textbooks from early 1920s, but retained in existent *Dictionaries*, reflected in common language. Shell-shock resurrected as concept in Medicine *after* the second world war in 1980, as post traumatic stress disorder, aka PTSD. I found no *named* Statute headed 'Duty Of Care' (enshrined in the *Royal Prerogative*) in the Sixties.

Whilst I was not able to find in random searches any *early* direct references to abuse by gross negligence (worded) in a duty of care, I did find an old article in a Victorian 'Legal Guide' compendium dated 1839, a report on *Spring Assizes* held on the 'Norfolk Circuit at Bury St. Edmunds, April 2. Before Mr Baron Vaughan.' (Case) 'Mary Gleddall, By Her Next Friend v. Steggall.' (Abstract subheaded) '*Medical Men. - Their liability for negligence and want of skill*.' The action was presented in proxy, by a surgeon of the parish of Gedding, as the 'next friend' of the plaintiff, Mary Gleddall, who was too poor and unable to bring the action herself, and was only ten years old. It transpired that a doctor had maltreated a 'diseased' leg, and by proven negligence had

led to a later surgeon having to amputate the limb when it could easily have been saved by more prompt and pertinent treatment. The young plaintiff won the case. [32]

But, again, in the Nineteen sixties I would *not* find duty of care or PTSD listed in any textbook '*Table of Contents*', or in any 1960 textbook's rear '*Index*', yet it had been around for decades in small print and as legal (forensic and tort) case law footnotes. I asked Admin Baz to search his memories, and ask his retired senior hospital admin colleagues if they could recollect use of the term *in situ,* among our own hospital records.

Baz spoke with a former colleague, previously employed in the Supplies and Financial side of Graylingwell Hospital, who told me: 'Like me Roy M. does not recall the term of duty of care before the *Occupiers Liability Act* 1957[33] but there were standards below which no one could drop without reprimand or dismissal. These standards reflected the general expectancy of the local catchment area, hence they were often not so high in inner city areas.'

Following up these *bon mots,* Admin Baz suggested that an edition of Spellar might locate the term in use. He was right. I found a ref. in Spellar 1947 p87 [34] under the subheading: '*Liability of Hospital or Nursing Home For Acts Of Its Servants*.' Spellar quoted *proven* cases of negligence dating back to 1867 - and numerous other examples in the chapter:- 'A hospital or nursing home owes a duty of care to all patients ...'

I was puzzled. If the Law was so ambiguous about duties of care it owed to hospital's vulnerable charges, in writing, then apart from a proved individual's specific *neglect* of a patient or hospital staff member (or visitor on the premises) were The Laws to provide accommodation and sustenance for the afflicted enough. I pressed Admin Baz as to what source best provided such guidance; a law student would know immediately wouldn't he, or she? But I was a budding professional carer concerned about day-to-day-care of hospital residents and outpatients, not a barrister. Baz got my meaning. Straight off his loquacious tongue; 'No doubt. None at all. Most useful in Patients Affairs was *Chalmers. Sale of Goods Acts* .'[35] I looked bewildered. We were talking about people, patients. But of course, that was his point. Baz enlarged on the subject of *Contract law,* especially what was 'owed'; wordy but very useful:

> 'Briefly but simply it is a legally binding agreement made between two or more persons', by which the rights of patients (or whatever) are acquired, by one or more to acts or forbearance on the part of the other or others (Anson).

There must be offer and acceptance, capacity to contract, consideration (or deed), must be possible and legal genuineness of consent. In absence of one or more of above renders contract void or voidable. Contracts under seal had to be authorised formally by the HMC. Health authority et cetera. And Company seal must be kept under lock and key. Most hospital contracts related to purchase of goods (not overlooking contracts of employment).'

'I am *not* aware of any NHS hospital contract relating to patient care but there were contractual beds in Nursing Homes with formal nurse inspections to check that standards were maintained . Professional standards relating to standards are obvious to us , however, patient care involves all other staff as well as the hotel services, i.e. food, laundry, cleaning, et cetera. To monitor these services lay members of the governing body are required to make regular visits and to report back in writing. Adverse reports were acted upon by main body with remedial action taken subject to financial constraints. I realise we have *not* raised the subject of the law of negligence - as to how it applies to people *in care*. It involves a breach of a duty to take care owed to the person (plaintiff) by the carer (defendant).'

'Should a case reach court by a person claiming a lack of due care it will be decided by the ' law of reasonableness ' as seen by the foresight and caution of the ordinary person. To take this further - I found a reference to 'duty of care' back in 1932. This arose when Lord Atkin and Lord MacMillan discussed Donaghue v. Stevenson, 1932. This was a case of a woman suing the manufacturer for injuries suffered from drinking their ginger beer but it is a matter of tort' (private or civil case law) 'common also to care expected by patients which it is claimed was lacking.' [36]

Felo de se

Felo de se is a term of Anglo-latin origin, 'from Latin *felo*, felon plus *de*, of and *se,* oneself: formerly a Statute used in Criminal Law till a very late date, identifying 'a person who attempts - or succeeds - suicide'. Felon a now obsolete legal term indicating 'a wicked person'. In common law a person, a cruel evil one, who 'committed a felony' from old French; *villain* of medieval Latin origin of uncertain conjecture. [37]

Until 1961 any attempt at suicide as self-murder was formally treated as a statutory crime. How did police authority treat a *successful* suicide? Answer; possibly fault relatives or others, inferring neglect (by default) - in *complicity*. This to be proven in a court action? Any person deemed to assist in a suicide (whatever their motives) - after the 1961 Act, was and is still indictable. An accused *unsuccessful* suicide would have been formally charged with (attempted murder of self) as an act of felony pre-1961. And the unhappy criminal then

arraigned before a Magistrate in Court (accompanied by a policeman), and placed on probation for committing this offence. And...erm... probably instructed to receive formal care and therapeutic treatment for their affliction perhaps, even, deemed a *temporary act of insanity* and placed in a psychiatric hospital.

With no detail, an 1656 *Upper Bench Roll* of the Cromwellian Commonwealth protectorate, dated *before* the Great Plague and The Great Fire Of London[38] recorded deaths by suicide as acts of felony (in the absence of earlier complete Coroner's rolls) numbered fifty-males and twenty-six females, and one other of whom the sex was not identified. The Bench decided under the harsh criminal law of *felo de se* that of the seventy-seven prosecuted dead, it was said, they were: 'Indicted for that they did wilfully and feloniously kill and murder themselves.' And of the total only three bodies were named to be true 'cases of insanity'. The result under the law was not only every body was ignominiously buried, but that representatives of the deceased lost all claim to any property, which was forfeited, just as if an act of High Treason and consequent Act of Attainer was applied.[39] Why, I asked, the ignominious unchristian burial. It was deigned a crime against man, and God; a statute passed down into Twentieth Century psychiatric hospitals, and prisons until 1961. To name the infamy.... what happened to compassion?

Our so-called Christian Brotherhood (and *any* fundamental human sect which declares an un-believer was, or is ,not one of us, and criminalised) did not give consideration to a poor human-being who, *no threat to others*, felt *so* wretched and unhappy that life was not worth living and needed human charity. Instead, the *felo de se* sufferer was legally punished as being a heretic, committing a crime *against* an icon of *God* and image of The Family. And, if the poor imperfect soul succeeded in taking their own life, *then* burial inside any Christian churchyard was forbidden, with *only* unhallowed burial ground allotted to the corpse. It was customary to bury an *unholy* suicide at the centre of a crossroad where the Dracula devil (sum of all imperfection) could claim its own. And, although social changes occurred over the centuries relating to suicide - as I discovered for myself in the years ahead, on the surface few people expressed sympathy for the para-suicide (unsuccessful attempt). Mostly, it was short shrift for them as *malingerers,* taking a bed up, etc. etc. I suspected this attitude more likely to reflect an unconscious atavistic *fear* in most people - rather than a deliberate, derisive and unfeeling callousness.

This attitude to suicide, by any confused individual, or worse, lost soul, thus prevailed in our culture. If Suicide was no longer condemned by Statute as Self-murder and, *worse,* a moral sin against mankind, a sin *against* a legal God, surely such profound suffering was enough without criminalising it as an illegal act. *Felo-de-Se* (self-murder) in origin, I believed, the act derived from an adopted culture of the ancient Germanic Teutons. The Teutons set up altars at crossroads, a place where *criminals* sentenced to be sacrificed to their gods were executed. After Christian politics became established and heretics were criminalised, malefactors and suicides, along with innocent unbaptised children, heretics, and other victims of a fear-ridden and unsympathetic community were demonised and, of old, were buried during the night, to emphasise a heathen burial of the devil's own at a crossroads.

In our twentieth-century English psychiatric hospital, until 1961, specialising a deemed suicidal patient meant the need for a one-to-one staff and patient ratio, and formally signing of a hospital printed red SPECIAL CAUTION card.[40] The card was a mandatory receipt, used to monitor an *at-risk* (suicidal) patient's well being.

Efficacy of Care and Treatment

As with the majority of psychiatric admissions, what was required was unlimited patience and ability to talk, and listen, for hours at a time. Hours and hours of sitting or standing and talking, talking listening and listening, and feeling. This then was the backbone care and treatment of psychiatry. Other treatments, medication ECT or whatever, were but supportive and not intended to be curative in themselves.

On admission there were few incoming patients, however sick or disturbed, that did not respond to a treatment. Manic, hallucinated, paranoid, and deluded patients needed a different approach in psychiatric nursing on the ward, and I learnt to handle each case, to learn the gut action reaction which constituted professionalism.

A new admission in the 1960s was placed in pyjamas, and dressing gown (DGO - Dressing Gown Order); personal belongings temporarily removed to avoid a premature discharge. Confused patients sometimes wandered off the ward, outside into the hospital corridors, and even, into the grounds and gardens. Some patients reached the outskirts of town before being detected. Their pyjama-clad distressed bodies invariably advertising their condition and returned to hospital care.

Most new admissions were only too pleased to collapse into a chair or stay in bed and, let go ... accepting a necessary asylum, before beginning the long haul back to so-called normality and the pressures and pleasures of our community at large. After three days or so it was expected that the new admission could be given their clothes and be able to consider one of the Therapies — or other suggested course of treatment authorised by the Consultant, and the Charge nurse of his ward.

Patients on the road to recovery, would go for half-a-day or a single day's excursion out of hospital, before returning to the safety of the ward. The next stage was weekends; from Friday afternoon until eight pm Sunday evening; and then anticipate a planned hospital discharge. Sometimes long weekends were advised from Wednesday or Thursday through to the Sunday night or Monday morning. Finally, a week or two *On Leave* would be advised and, if found successful, a date for formal discharge arranged.

On Monday mornings, staff and other patients on the ward would experience the results of patients returning from home leave. Most patients who departed on leave, took medication with them. Leave medication constituted another basic ward routine, known as the TTOs, indicating medication *To-Take-Off* the ward on leave. TTOs were prepared by the nursing staff during Friday mornings, but anticipated the Monday or Tuesday before, to allow time for medication to be obtained from *The Pharmacy*. Another ward routine, 'Doing The Drugs', restocking the ward clinic supplies of medicine for the patients needs.

One morning each week the drug trolley stock was examined for empties to be refilled. In addition other clinical stock would be examined in the Cupboards, and deficiencies to be indented for from, the CSSD. (Central Sterilized Supplies Department), hospital dispensary and pharmacy. A large reinforced thick-cardboard locked box (one to each ward throughout the hospital) was collected by a porter with the wanted list, and duly taken for recharge to be returned filled later in the day.

Similarly, all laundry stock and other domestic ward supplies had a specified day when the nursing staff would organize replenishment of supplies. And surprise, there were *chits for everything*, all to be properly signed.

More routine work.

Detoxification, Antibuse, and Aversion Therapy

The Admission Ward accepted a limited amount of Alcoholic patients and Drug Abuse dependants who needed *Drying Out*, before being discharged or transferred to another ward. In the 1960s an experimental scheme encouraged a group of young DAs (there were no old addicts) to liaise with mature Alcoholics, often world-worn ex-professionals and long-service Naval and ex-RAF personnel from Tangmere, Portsmouth or Southampton, who were based at the *Therapeutic Community* of Sandown.

As a new student, I was soon acquainted with both groups of patients.

On the admission ward one programme selected patients (this was not compulsory) for conditioning behaviour under the direction of the Clinical Psychology Department. Treatment involved the prescribed *Antibuse,* using *scoline*, a neuromuscular paralysant drug, (similar to curare), whilst offering the subject a real heroin fix, or a measure of alcohol. As a Student, I was invited to help out at one of these traumatic experimental sessions.

The patient signed appropriate forms for treatment and, at a pre-arranged time, was met in The Clinic off the ward corridor. I remained with the patient throughout the experience. The Consultant (or his Senior Registrar - as I recall), entered with the Charge Nurse. On a table, adjoining a leather couch, was a CSSD clinical tray with two syringes, ampoules, cotton-wall-balls, and cleansing fluid. The doctor informed our patient *exactly* what to expect, and explained *before* he signed an agreement to the treatment. He again clarified whether he still wanted to undergo the antibuse test.

The drug-addict I first attended was a teenager, an ‘old’ Seventeen year old, hooked on heroin, currently on a methadrine preparation whilst being taken off the stuff. As with most of our drug addicts he had also tried acid (LSD) but was not specifically dependent on that mind-bending preparation - Heroin was a greater concern.

Aversion Therapy was a fashionable treatment offered to help him off his drug dependency. He did *not* have to undergo antibuse treatment but, it would help his case at Court when it was noted he had co-operated in a Treatment Programme. I call him Steve for this description.

Steve

Steve lay down on the ward clinic couch, and was encouraged to fill an empty CSSD syringe with a pellet of heroin and distilled water (as I recollect); but at this stage only allowed to contemplate its use. ...Then the doctor drew up a

second syringe with a measure of scoline, a drug that would, for a brief time, paralyse all muscle tone including his chest muscles, and thus oppress his breathing. (I stood close by with a face-mask off an oxygen cylinder to give instant first-aid if needed.)

Steve's right elbow was bent, and for some reason (not known to me), a piece of cardboard placed upright on his arm, to shield the injection of the scoline from his view as he lay on his back. Then, the scoline was given by the doctor. Steve had full consciousness throughout the experience. As an observer, I thought it might have been terrifying for him but, *compared* to horrors from drug addiction, probably not as I imagined the experiment. He was told he could then inject the *'Fix'* if he wanted to, but was inhibited and found it physically impossible. Subsequently, the idea was that each time he later craved a fix, he would associate the antibuse and scoline experience with his wish for a heroin dose, and suffer an inhibiting *nausea*. That was the theory anyway. (I believe *this* treatment was *not* adapted as a norm.)

Antibuse

Alcoholic patients, too, were offered behavioural aversion therapy as an emetic with their dependent beverage. I learnt that oft to-be quoted mantra, if an alcoholic hates their dependency, they hate life *more*, and loathed themselves most of all. Drink, an answer to forget and to be in denial of not coping and hide in a shroud, all obnoxious causes of their despair. Other Sixties fashionable aversions were designed for phobias; sex offenders; and, a variety of clinical disorders and anti-social criminalised behaviour, this latter group also overseered by The Hospital's Clinical Psychology Head of Department, Dr. Harrod.

This Pavlovian aversion as a topical subject was not new to me. I read in *The Sunday Times* [41] aversion therapy treatment programme was intended as a therapeutic clinical measure to improve the person's quality of life, *not* to be an addict, dependent on drugs or alcohol or on *any* anti-social, illegal activity. Working with drug-addicts on the admission ward opened-up other areas of insight to me. In observing our addicts after-effects of drug abuse and of aversion therapy, and revealed a horror, for me, that such dependencies were *no way* an escape.

Flower Power

I had no personal experience, or desire for taking unprescribed drugs. In Spring 1966, *The Sunday Mirror* front-paged '*Teenagers make hallucination snuff*.

Drugs. A Ban on Seed Sales'.[42] People of all ages, in an open consensus, admired the Peter Pan imagery of 'Flower Power'. To *Make Love Not War* . I bought a graphic Soho Carnaby Row red and black poster of a Cat & Mouse making love - not war. Other Flower Power posters and T shirts said 'Talk talk not War war.' Another '*Jaw not War*' displayed on one's chest, thus over the heart. Believers displayed *real* flowers, instead of metal bayonets. I admired genuine sixties Beautiful People, despite feelings that disciples were but naive Wellsian eloi, grazing on Establishment fields. Gentleness, naive or not, was experienced as a virtue when found to be genuine; a good happening.

But, with the public advent of the unprescribed, and manufactured, hallucinatory drugs, that image of peace and gentleness became for me, and others, a falsehood unreal in its surreality. Many illegal drugs consumers appeared *not* to offer peace to all men and women, but became aggressive, insular and anti-society; in a word, hostile, to any *real* practice of a brother sisterhood of mankind. The pure, icon folk like imagery of the flower people was becoming tarnished; fortunately, much of the music remained, and a number of true believers continued to attempt to work for '*A Good Life'* without the will to stamp on others to gain their narcotic supplies.

International Times and Playboy, 1967

It was customary for our ward drug addicts, sent by The Courts, to be regularly sent free copies of the so-called underground newspaper *International Times*. And, several of our ward patients regularly obtained copies of the American produced *Playboy* magazine. Both of these, IT and *Playboy*, often published letters and articles on psychiatry, or rather anti-psychiatry or subjects related to it. On my being given, by ward patients, 'spare' copies of the *IT* and *Playboy*, I noted these articles and letters, frequently evoked comment, especially on Aversion Therapies and ECT. Is cannabis harmless or a socially dangerous drug? At least illegal, at worst it tempted its consumers onto harder drugs, for greater kick; escapism into becoming a *pretentious* seeker; into their own heaven and hell. Inevitably, involvement as a student with our addicts accented my need-to-know *which* drugs were listed as forensic dangerous class A drugs, and to which a doctors prescription alone would allow legal consumption.

Under the *Dangerous Drugs Act,* opium morphine and their derivatives as pain killers were banned presently from public prescription, and used as recreation drugs. A few years ago, any dispensary could sell opium laudanum

and *mixtures* as easily as porter and wine were prescribed by the parish doctor and local hostelry.

Also listed as dangerous drugs were cocaine; pethidine, amidone (physeptone) and The Analgesics; as dromaron, dilandil, proladone; all drugs for which access meant authorised signatures in the DDA book. *The Poisons Acts* also included most of the alkaloids and barbiturates which similarly needed medical authorization to consume.

I realised it was important to recognise side-effects coming from listed drugs.

The major and minor tranquillizers were invaluable helping many of our chronic patients back into the community. But, the Tranquillizers could cumulatively of themselves give great distress; if they were not treated, controlled. Chlorpromazine (or Largactil its other name) was a powerful example, a great reducer of symptoms of stress, but with a number of side-effects as penalty, such as the shakes which affected motor regions of the brain — Parkinson's syndrome; rigidity, tremors; excessive salivation; mask-like faces; loss-of-power in walking gait; drowsiness — dyskinetic, dystonic reactions; epileptiform fits; disturbances in metabolic activities, increasing weight; affecting thirst, retention of micturation and constipation, jaundice, photo sensitivity and skin rashes.

Medicines were dispensed in pill form, liquid form or by injection from the medicines trolley on the ward; Largactil was given in either pill form or by liquid. After several weeks of dispensing medication on the admission ward I developed a strange (to me) rash on my hands and arms. Years ago, serving in HM. Forces on Christmas Island in the Pacific as a sapper in a transport troop, I developed a nasty rash from contact with diesel oil and from then afterwards kept away from direct handling of this fuel.

A visit to our staff doctor Dr. T. quickly diagnosed the probable cause as contact with liquid Largactil. For a short period, I wore white linen gloves to off-set contact with all liquid medication, but it was only a few days before the need for gloves ceased and this skin rash never reappeared.

Spider

Spider was the colloquial of one outspoken sixteen-year-old Amberley' patient, a tall dark-haired arm-tattooed broad-shouldered youth. He usually dressed in a black-singlet and worn torn blue-jeans, often in bare feet. Strong and cocky

in Sussex speech, a resigned d.a. in hospital on Section 26 of The *1959 Mental Health Act*. I liked Spider.

Why Spider? Not, perhaps, because he was tall and gangly, but, more likely due to the blotches and ugly blue-black-track-marks on his arms and legs and face and torso, marked by unattractive spots and acne. What I remember was his cheerful resilience. Spider was elected by his peers as ward-leader and spokesman of the nine drug addicts on Amberley during my three months stay on the ward. And, in fairness, he was pleasantness at all times towards myself, not at all to all other staff. One may say cynically it was to get round me, possibly true, but he had far more to gain by befriending other staff.

Gregarious Spider stayed the course, despite numerous hiccups and inevitable confrontations — with the community, courts, family, peers, and in Groups in therapy. In my recollection, he did not have the Aversion Therapy course of treatment; he may have declined the offer. Pre-section, he was first acquainted with cannabis reefers at school when 14 years old, tried LSD, and became dependent on cocktails of heroin-and-cocaine mixtures which, pre-admission, had almost killed him. Spider knew he was courting death with dependency.

Methadone

Methadone was a derivative given in hospital, in an attempt at breaking off illegal drugs dependency: In time, methadone, perhaps, was no less addictive as a DDA drug than other banned drugs. However well supported, going 'cold turkey', like Frank Sinatra in the 1956 film *The Man With The Golden Arm,* completely cut off from all drugs and nurturing back to good health, was the only way for many DAs. But, as l learnt, hard, so *much* depended on motivation. Addicts *must* want to get off drugs, and not *only* go into rehab through motions steered by courts, relatives or others.

Both Spider, and Kevin (who was a short-bum-fluff-beaded philosopher and intellectual 17 year old) chatted daily with me on the ward discussing various subjects including *New Age* exponents Gurdjieff,[43] Nicholl, Orage and Ouspensky, Indian music, Bob Dylan, psychedelia, artwork, buddhism, and other writings, as well as fragments of their personal domestic life. The patients openly admitted that cannabis supplies were delivered by friends and sometimes buried supplies in the hospital grounds for collection, as Cannabis to them in no-way represented any harm; cliche ridden 'just like your tea or coffee' (and of course, alcohol, a more loaded comparison).

The hospital was fortunate in having excellent medical staff, and one Consultant in particular was incredible. He developed rapport with all (or most) of the d.a.'s. I was privileged to sit in on a number of sessions when 'the issues' and specific patients were discussed with Dr. R. at ward meetings.

Khalid

Every ward had its characters; young, middle-aged and elderly; colourful and manic; bland and depressed; passive and defiant; single, isolated, married, divorced, separated and estranged. Local dialects and foreign accents peppered the ward population, with patients from distant counties of England, Scotland, Wales and Ireland. And, a small number of patients whose homes were one time abroad, including Polish, Italian and German, a few from the war years. Most European nations were represented among the hospital residents. Throughout most U.K. institutions, a similar spectrum of hospital residents were likely to be realised.

One quiet young man was Khalid, a common name like Smith, a lonely young man diagnosed suffering from florid schizophrenia. He was from Pakistan, and something of a mystery since we had so little information about his background. Due to the apparent severity of his symptoms; hearing voices, hallucinated and generally withdrawn, he communicated only with occasional monosyllables. About five-feet-four in height, usually clad in hospital pyjamas, he had broad shoulders and a round face. His eyes were dark, and to me reflected a hidden inner, and unknown man, rather than the seeming docile person he compared to other ward residents. But, how much was his behaviour cultural, and an obvious lack of English vocabulary, and how much stark illness. With physiological evidence it was difficult to diagnose.

Khalid was generally left alone by other ward patients and not placed in the role of buffoon, as some loners were, in the sub-culture of ward domestic day-to-day life. He had a habit of eating without utensils and piling lots and lots of food on his plate at every meal; eating as if he had starved in the past (or feared to in the immediate future) or, who knows, if these rituals were symptomatic of illness; or reflective of habits abroad and more so. Of what were his dietary habits at home, and where is, was, home?

What of his religious faith, Islam? *How* did he come to be in the hospital in the first place? I developed a particular soft spot for lonely Khalid whilst he was with us.

Some months later I learnt, through enquiries, that with the help of a Refugee Association Khalid had returned to Pakistan and I heard no more of him. Throughout my ward stay, as student, Khalid remained identified largely through the daily deliveries of prescribed drugs; Imipramine 50mg, Stelazine 3 mg, and Largactil 50 tds.

Incident

It was shortly after the patients had finished their mid-day lunch. Staff and Charge were in the nursing office. Two ward-patients were on rota turn for washing up and, as usual, the rest of the ward residents were yet to be dispersed about the hospital, prior to afternoon Industrial Therapy Occupation or other treatment programme. I had just gone off to the canteen and was in the queue waiting to order my meal.

'Quick, quick, return to the ward Barry. Trouble!'

Jack my opposite student colleague, due on the afternoon shift, had arrived, puffing and out of breath, on the ward as sounds of an on-going aggressive fracas in the billiard room became obvious.

Jacques had been sent by the Charge Nurse for my assistance.

On arrival at the ward billiard-room we were stopped at the door by Tom, our Staff, and cautioned. There, standing up on the middle of the billiard table, was an angry Alan, one of our recovering manic-depressives. He had been playing snooker with Dusty, a young d.a, when a contentious point led to an explosion of temper by Alan.

He had smashed the cue against the wall, and started throwing the hard coloured balls at random about the room. Two patients and our Charge had already been hurt by the ball missiles. Alan was *now* threatening to throw two remaining billiard balls, red and white, one clasped in each hand like hand grenades, staring down at the onlookers, bemused, and surrounding *his* island — the billiard table. What?

I assisted in ushering patients out of the room, Charge Bob directing traffic, and in sight of an angry, distressed and perplexed offender, Alan. His hurt victim Dusty, clasped his left elbow. Dusty, piqued and somewhat perplexed, also departed the billiard room, albeit reluctantly, and threatened to get his own back.

'It's okay Alan. All over now', said in-charge Bob, matter-of-factly.

We began picking the balls up off the floor. Bob limped from a leg injury where a green coloured missile had bounded off the wall, shattered a mirror and struck his thigh as it fast descended to the floor. His tone was reassuring, and certainly not threatening or reprimanding. Rather nervously, Jack and myself smiled and nodded agreement up at Alan following our Charge's example. Staff Tom sentinel at the doorway kept other patients away and outside and out of sight of Alan, beyond the doorway.

'Eh! Eh!' Alan was clearly puzzled. It was obviously *not* what he expected from the ward staff. In his surprise, and probably relief, the two balls dropped from his hands onto the now feet bruised green baize of the billiard-table.

The incident, my first, was over. I replaced the balls in the corner pockets. Not on the table, just in case! And, cautiously, we begun to pick up large pieces of broken mirror glass. I swallowed balls of saliva called up to wet my dry throat.

Suddenly, Alan jumped down off the table, and mumbled sheepishly, 'Sorry Nurse' - to Bob, on the way out, as he turned away and strode off into the toilets area.

Yes. It was over.

As Bob began walking away, he called me over and suggested I accompany him back to the ward office. As we sat down, he reached into a drawer and, from a collection of forms, pulled one out and placed it on the office desk before us.

'Right Barry. After any unusual event, whether it's an accident on the ward or an outbreak of fire causing damage to property, patients or staff, whatever it is, you will be required to write up a report as soon after the incident as possible and get a copy off to Patients Affairs and to the Duty Nursing Officer.'

He had my full attention. After all, surely most establishments and corporate institutions have a similar procedure, think of Case Law, Insurance and liability where there is severe damage, especially where the origin was *not* wilful but caused by an 'Act Of God', as some wits would have it. But this is, was, here! And Charge added, 'In this case I shall be writing up the incident. Fortunately, it sorted okay,' compassionate Bob concluded.

I noted Bob's slight limp from the hard billiard ball missile that had hit his right leg, but that was on a rebound and not thrown directly at him. Indeed, no-one had been hurt, except one or two bruised egos. And the other two patients who had received glancing blows from the thrown, hard, billiard balls had fortunately retained but minor bruises. And, yes of course, it might have easily

had another outcome; other past recorded 'incidents' certainly resulted in more serious repercussions.

As I watched Charge Nurse Bob fill in the relevant *Graylingwell Hospital* report (*Incident form*) in 1967, I was unaware of how many such reports on a patient's (clients) behalf I would myself write up, or witness, in the many years ahead as a student, RMN, and Psychiatric Social Worker, as well as, not much later, as a qualified *Approved Social Worker,* working thirty plus years outside in the community.

Apart from the Incident Form, numerous other hospital forms were stored in the office drawers, including an elastic bound supply of 'chits' for the various Engineering and other Trade departments — Stores, Upholstery, Painters, Plumbers, Electricians and other sundry departments *not* directly connected with the needs of the ward patients; and naturally each tradesman had in his office whatever reference textbooks to assist them in their labour.

But, most important, I had to learn and locate the variety of forms *essential* in the diagnosis care and on going treatment of all our ward patients. And well thumbed in use were a number of reference Legal Medical and Nursing books and pamphlets which adorned one shelf with several on the office desktop.

Sometime later, following, a number of late Nineteen sixties media reported severe fires in old Mentally Handicapped hospital institutions about the country — and one or two minor ward incidents when our own fire alarms had sounded. I asked learned Baz, in my student innocence, about possible outcomes to such incidents, both to people and property?

It was *not* a question of someone's guilt or purported felony, but a matter of State damage liability. Given that the Royal, rather Sovereign state *Prerogative* prevailed, I thought, this question addressed two aspects, about repair or replacement to property and about subsequent damage to people, staff patients and whoever. Ultimately, it demonstrated how this long stay psychiatric hospital was run as a *living* entity, an organic institution, the fabric and its occupiers, on a day to day basis.

I was amazed, when I was informed that State Hospitals were *not* insured. Indeed, no state hospitals, institutions, schools, prisons, in fact no government buildings were (was this true?). A matter of logistics, pure weight of numbers. And, of course, why the need; surely being of our elected and trusted Government (whatever the nuances of individual elected members, its formal representatives);

being of the government was *the* insurance backup; it shouldn't need belts *and* braces in support. This should be evidence of a true elected living democracy:;duties of care safeguarded.

Well, it ought to be; whatever the use of the legal, nebulous *Prerogative* web-like powers of Management by The Ministry of Health.

As I read and learnt, from both casework and day to day exchanges with colleagues, systems can always be abused, exploited in default or worse, through wanton misuse by people in positions of authority; *in extremis* even in a Democracy. In the robust memories of many staff and patients in the hospital, a number of postwar refugees that existed in the populace, on record, had been seduced (shackled) by obscene misuse, lies and propaganda, in prewar and wartime experience in Europe and elsewhere.

In Truth! *What is said,* and *what actually happens,* is often different to many survivors, in their subtle experience; as the following press statement directed at an aghast international press, with a subheading, 'Democracy As Camouflage:

> " The lie goes forth again that Germany tomorrow or the day after will fall upon Austria or Czechoslovakia. I ask myself always: Who can these elements be who will have no peace, who incite continually, who must so distrust and want no understanding? Who are they? ..." Hitler, Berlin, May 1, 1936.'[44]

Reality. So much suffering.

Irish

From that first day, on the Admission ward in autumn 1967, I could not miss the sight of sad figures sunk deep into worn-armchairs in furthest corners of the ward or, seeming to be endlessly asleep, sprawled on their beds or, hung in tortured states over the arms, seat, and back of corner ward-chairs. These were patient' postures of the depressed. Not relaxed, not passive. Not submissive. But, apathetic, alienated and lost - catatonic in their misery.

'Irish' was one of our newly admitted depressed. In early middle-age, grey-hairs amongst an untidy hay of brown hair, lean face unshaven and, today, unwashed (without staff persuasion). The dirt off of several past meals mapped out, stained, about his once white-shirt — now, grey. And, dressed in shabby black-creased trousers met at his feet in an old pair of ward-slippers long-ago left by a ward predecessor, no socks on unwashed feet. He was admitted one

week ago, accompanied by a taut straight faced wife in a neat, dark, suit, a surfeit of tears long dried-up in their shared sorrow. But Kate had held the family together, as she loved both of them.

Kate suffered in silence, when Irish was given early retirement due to ill health. His long reactive depression dated back to the loss of their second child in an accident. And, exacerbated by his due promotion passed over, to a younger less qualified man. And, finally, the break-up of their sexual life. They slept in separate beds for at least two years prior to admission. But, still she cared and treasured her man, her husband, and father to Eric, their fifteen-year-old son, who too recollected his previously so capable, so confident dad.

And most of all, worst of all, was Irish's loss of dignity and self-respect. This led to self-neglect, and ultimately led to a suicide attempt with an overdose of prescribed medication and a filled up bath. Kate found him just in time. Irish was fortunate in receiving regular visits from Kate and Eric, and would recover and be discharged back home, during my ward placement of three months.

Shaun

One of our more active residents was a colourful, slim young patient named Shaun. Aged twenty-five, his father was a local Managing Director and owner of a large cannery, casing imported fruits. On admission, Shaun was given one of the two single side-rooms in the main observation ward, not because he was a private patient, but due essentially to his manic, religious behaviour. He was too often rushing excitingly in every direction, and verbally gushing out either expletives wanting to gain someone's attention or, too often, on his way to make unnecessary urgent purchases at the hospital shop.

One of his last manic actions, before being sectioned, was to sign half-a-dozen large personal cheques, including the purchase of a new car (he couldn't drive) and to give a donation of £500, in a Saturday afternoon collecting box, to a passing by amazed representative of a national charity.

I had, on a number of occasions, been led by Shaun to his room, where several well thumbed books on comparative religion and sheaves of hand written notes were used to lecture anyone, on a pet religious theory of his. But, of most concern, was the regularity with which he upset other patients in his manic behaviour, often interfering with men who wished to be left alone, at least by Shaun. He frequently changed his clothes. It was a wonder he retained any layers of skin, so often did he wash himself in the kitchen and bathroom sinks, or by soaking in numerous hot baths.

On the surface, harmless, and of a kind gentle disposition but, sadly, an enormous risk both to himself and to others during his manic phases. And worse, in his low cycles of depression, he was a self-mutilator and had attempted suicide on at least half a dozen occasions. Shaun was heavily dosed with Lithium Carbonate, which helped to reduce his energy output — the serum-level in his blood had to be checked regularly or else it led to toxicity, and even more confusion. He was another patient I came to know well during his stay on the Admission ward. Like Irish, Sean would recover from this acute episode, and be discharged back home.

Domestic

After several weeks of house and flat searching I remained unlucky, and was travelling by bicycle from Chichester to Lancing on days off in order to visit my wife Sara and the children. But eventually, luck dawned, and a sympathetic local Farm Manager, married to a nurse on The Edward James Estate out at Singleton, North of Chichester, offered to rent us a small tithe-cottage at the hamlet of Chilgrove, called Hoggs Back; a much neglected small two-bedroomed building with a large lightning gutted-tree outside its broken front gate. It proved unsuitable on internal examination but, a second offer by the same gentleman turned up trumps.

One of two *Stonerock Cottages,* it answered our prayer. Small two-bedroomed with a solid-fuel kitchen-burner, the internal structure recently renovated and a covered cesspit at the rear of the cottage; itself in front of a small wood inhabited by deer, pheasants and other wildlife; all for the princely sum of £2.50 per week plus running costs. It was also *very* isolated, and reached by a long unlit unpaved earthen lane, between a network of fields, and woodland, up from the Main Road which passed through Chilgrove. At the beginning, it was relative heaven; and I had my bicycle.

And so, just before Christmas 1967, we descended off a once-a-day, single-decker bus, my wife and I, holding a pushchair with infant Kit within, and young Paul, his two-years older big brother, who stumbled along holding the chair's metal arm. It was in a cold dark mid-winter afternoon with only a small hand torch to search out our new abode. Due to the fact that the cottage was unfurnished, and would remain so until the early new year of 1968, we made a quick visit, then caught the last return bus back to Chichester.

Sara and the children returned to my in-laws at Lancing, and I to the hospital and to duty, on Christmas Day.

Blind Spot

Adam Mitre, aged forty-eight-years, had been admitted to the admission ward a day before, direct from the Chichester Magistrates Court. He was a broad bull of a man, six foot four inches tall, heavy thick set shoulders with well developed muscles, 'Ugly though,' I thought, not unkindly, merely matter-of-fact, as I passed him.

Mr Mitre sat up fully dressed on his bed, both hands clasped to his stomach, an opened magazine face down on the bedding in front of him.

'Nurse! Nurse!', he looked straight at me. 'Can I see you for a moment please?' His voice was strained and demanding.

'Yes, Mr Mitre. What can I do for you?'

'Could you get a doctor, please, I'm in pain. It's me insides. They 'urt somefing dreadful,'. He clasped his trunk tightly, as if to retain certain organs within, attempting to escape his form.

'How long have you had these pains?' I enquired. I might be only a first year student; but it was an obvious question.

'Oh, erm, sometime now. They come and go you know ...'

'All right, Mr Mitre, I'll have a word with the Charge for you.' I walked off to see Bob, who was busy seeing someone's relatives in company of a visiting Nursing Officer.

I had to knock loudly to interrupt the talking behind the closed office door. It stopped, and Bob opened the door.

'Yes, Barry. Anything wrong?', he guessed straight-away from the look on my face.

'Sorry, Bob. Just in case, I thought I'd better come and see you. It's about Mr Mitre. He's says he has severe pain, stomach, I think. And, as Tom is off the ward, I thought I'd better come and see you. Just in case...'

'Quite right! Barry.'

'I'll be out in about three minutes and I'll talk to you about our Mr Mitre.', and Bob, of necessity, returned to wind up the heated conversation in his office.

A few minutes later, Charge Bob met me by Mr Mitre's bedside. I drew the green bed-curtain around the bed, to give some privacy from the growing audience of other ward patients.

'Wotsa matter wiv 'im?' lisped young Ted, himself a recent new d.a. admission.

'That's what *we* are going to find out, I hope.', as I closed the curtain behind me.

'Right, Mr Mitre,' Bob in sympathy. 'Where does it hurt?'

'Here!' Mr Mitre pointed to his lower abdomen, and looked up into Bob's face as he reached forward and lightly touched the spot with his right hand.

'There?'

'Ouch. Yes, that's it. Its been coming and going for some months now.'

'Hmm,' mused Bob, and lowered his voice to a whisper so that only Mr Mitre and I could overhear hear his question.

'Mr Mitre. It's on a Court Report asking for your remand. That *you* have been complaining of *not* being well for sometime but, *you* did not specify to the probation or police officers of a pain in your abdomen... in fact,' Bob paused, in posed question rather than remark.

'One of the reasons you are in our hospital, and not in Lewes Prison on remand, is because of your clinical depression and *not* feeling well.'

There was a momentary silence while Mr Mitre framed his reply.

'Well, erm, you know about my case then. I'm not admitting to anything. I love my wife, and daughters. Ask 'em, any time?'

And, in afterthought, 'This pain is still real you know.' He clenched his stomach. 'Even if the police and probation think I'm only trying to get sympathy.'

Bob paused, and indicated I could draw back the curtains.

'I will ask our doctor to have a look at you on his next ward visit.'

'When's that?' Mr Mitre challenged, vindictively; doubting that anyone would come onto the ward to examine him.

'About one hour's time actually, Mr Mitre.'

Charge Bob walked back towards the office, beckoning me to follow.

The curiosity of the other patients abated and left the vicinity of Mr Mitre, who had returned to the magazine he had been reading.

At the office Bob launched into an explanation, after closing the door behind us.

'I'll be as quick as I can Barry as I want you back on the ward. I'm sorry I haven't told you anything about our passing through resident.'

'Oh?' I looked puzzled by his turn of phrase and lack of patient reference.

'Mr Mitre is an unusual patient for this ward. He has apparently been committing incest with all four of his daughters for over ten years. Several weeks ago his eldest girl broke down, more out of consideration for her

youngest sister who is only twelve now, than her own damaged feelings; and those of her other two sisters.'

'Christ' I spluttered, wondering, what next....

'And', Bob continued, 'since being taken into custody he has complained of one thing and another so that, as I read it anyway, no one is inclined to believe his pleas of occasional pain. A question of crying wolf I guess.'

'And what do you think, Bob?' I enquired, not sure what to make of this set of information.

'Well, Dr. Crampton will be here shortly to take a look at Mr Mitre. Remember, Barry,', he added sagely with a nod of his head, 'we are *not* a Court but a hospital, and should behave like it. Hmm! He's not on a Section, he knew what he was doing in his incest during all those years. We don't, yet, know the forensic psychiatrist in liaison between Mr Mitre and the court, though we know the mental welfare officer who brought him in. I suspect it won't be long before he's transferred out of here.'

True to Bob's word, Mr Mitre was shortly afterward escorted up to the ward clinic room where duty doctor Dr. Crampton gave him a full examination.

'Well I don't know if he is pretending or not, as the officers say in their report, but I think you'll agree, Bob, we ought to get an x-ray at least?' Dr. Crampton concluded, as Mr Mitre was directed back to the ward in my company.

Several days later it was confirmed; Mr Mitre had a duodenal ulcer and two days later received medical treatment at the West Sussex County Hospital, in Broyle Road. Ten weeks or so on, and an item in the *Evening Argus* reported his conviction for multiple incest, and his removal to Lewes Prison to serve out a custodial sentence.

We concluded that his ulcer was a 'blind spot' for earlier examiners who understandably, if not in justification in view of the enormity of his offences, believed he was telling one lie after another to escape the inevitable track of justice underway since his daughters' accusation.

The Blanket

Breakfasts over, beds completed, medicines new orders boxed, patients were 'out' to their respective treatments at Occupation or Industrial Therapy, Social Therapy, or to the Dentist, and only two patients left on the ward, Jim Howes and Fred Jackson.

I was in conversation with Jim, a depressed patient who had stayed back from IT, to see the Duty Doctor to ask for Electro Convulsive Therapy, which

he had had some months previous. The ward staff did not feel that he needed ECT but Jim insisted he wanted to see the doctor and persuade him otherwise. He was looking for a shortcut, rather than commence *talking* out numerous problems, which had led to his recent overdose of prescribed drugs. He was about ready now.

I was engrossed, with Jim, in a corner by the billiard room entrance.

'Can I see you for a moment?' Bob said to me and, aside, politely remarked to Jim that 'Barry will be off the ward for a few minutes but he'll be back to you afterwards.'

I excused myself, and left the Day Room to join the Charge in the ward-corridor.

'Barry. Office rang. They have a bit of a flap on up on Bramber Two. Would you go up and give them a hand. It'll be good experience for you?'

In some haste, I strode up the main hospital corridor and ascended the concrete stairs up to the locked ward of Bramber Two. As I inserted the jig-saw key in the lock, I could not avoid hearing shouting and singular threats from somebody. And, just as I opened the door, another nurse, also called upon to assist as back-up, caught up behind me. Panting, it was Mauritian Jack, our third-year student.

We entered the ward together, and I locked the door behind me. Normally, in the day time, this ward was left unlocked, as with most wards in the hospital.

Jack and I marched into the Dining-Room area, where the noise was coming from, and there was Dick the Ward Charge talking, or trying to talk, to a man dressed in pyjamas and brandishing a knife, screaming out... 'I will, I will, I'll kill myself, don't you DARE stop me, or else.'. Distress blazed in the patient's eyes, who was unknown to me, but apparently well-known to Jack who echoed, 'Hi Dick.' to the Charge nurse. To the distressed patient, he cautiously added at a whisper... 'Hello Vic, can we help?'

'Vic's rather upset, as you can see?' the Charge Nurse quietly said to Jack and I, across Vic's vision. 'But he's not ready yet to tell us what's upsetting him. Are you Vic?'

I noticed several other patients, sat quietly over by the television watching the ward's drama. -They were used to ward incidents of one sort or another. Charge Dick looked across to Jack and I, and asked, 'Could one of you fetch a blanket off a bed in the ward dorm for me, and fetch it here.'

Jack moved to the side of the Charge, and I, most curious, turned round and walked back through the short ward corridor, down into the dormitory. I took the first blanket I could see off one of the beds and returned to the ward dayroom.

I was bewildered. What did he want a blanket for, the patient?

Vic, in a then frozen posture, had a raised knife, and at that moment appeared not responsive to soft re-assuring words, but at least his shouting stopped. He too was wondering, as I was, what happens now?

'Thanks.', Charge replied as he took the blanket from me and, folding it in half lengthways, then asked of me, 'right, lad, take the other end.' I thought, we are going to fold-it-up, (whatever for?). No, he had something else in mind.

'Stand back a moment please, Jack.' Dick, to our colleague, and Vic, who was frozen now in a sculpture, both still puzzled as I was, looked on; the kitchen knife still a threat; speechless during this activity...

'Right lad, now walk around Vic, that way round please,' gesticulating as he proceeded to walk in the opposite direction, around the distressed patient, Vic holding his *felo-de-Se* weapon aloft.

The blanket went taut and, as we moved on circling Vic, it became obvious what Charge wanted and within two-seconds the blanket was effectively bound tightly around the distressed patient; and he was disarmed. Charge deftly removed the knife from Vic's perpendicular, up-stretched arm and clasped hand, just outside the blanket's perimeter.

Jack and I moved in, but there was no need. Instead of more aggressive movements, Vic collapsed in tears: 'All right Vic ole' son.' Charge Dick tenderly put an arm around him and, together, they started for the ward office. Turning for a moment, he remarked to Jack and I, 'Thanks lads, could one of you stay a while until my Staff Nurse arrives back from the Pharmacy.' Jack remained and I returned to Charge Bob, patient Jim, and the Admission Ward.

Back on my ward, and after relating the event to Bob, he recalled ; 'Ah, yes; that would be Dick; one of our old school of Charge Nurse Attendants.' He then added, 'The *Blanket Method* is very effective in certain situations. It's safe, and avoids heavier methods when talking-down isn't working, but still possible for innovation and non-restraint in defusing your situation.'

Bob continued, clearly thinking of past years, 'Not so long ago, we had few drugs to work with, and more patients could be acting out with few resources to deal with any explosive situation. Remember, *At All Times*, you never, ever

use *any* restraint which can harm the patient. If *you* cannot handle the situation, leave it, and either do what you can *or,* go for more effective help. We no longer have a Heavy Group of staff to call upon.'

'Blow ups are few. Most are confused, frightened people, who lose control. Wilful violence is rare, but does happen. Remember, a patient's rights ought to be protected, and *not* have a violent as well as a psychiatric label to follow them on after discharge, if you can help it. A Heavy Group, sometime existed pre-war. This was a number of well built hospital staff, called upon if a nasty situation needed defusing. Since our modern drugs, few patients display such a range of florid symptoms, hence staff being called on from other wards with staff shortages...'

Jack and I, no-way being 'a heavy mob.'

This was the first, and *only,* time I ever saw this *Blanket Method* for arresting a potential violent situation. But, the safeness of this action, combined with the personality of the member of staff was just right. Vic recovered and was discharged several weeks later.

Pad

Eleven years before, in 1956, I had been a member of HM Forces embarking as a squaddie in *Operation Grapple* [45] for the H bomb tests off Christmas Island, one of the Line Islands. I was a thin immature institutionalised youngster, doing his duty for Queen & Country; a member of a Sappers' stores group. We were assisting in loading a small battered troopship, *The Charlton Sta*r. Nearby, we had the immense company of the giant liner *Queen Elizabeth* (not as our escort, no honestly) at Southampton Docks.

Sent down, into the bowels of our elderly, smelly vessel, several of us stumbled into a minute dark, odd-smelling black rubber padded room — walls floor and thick door all well padded. A ship's crew member informed us it was a room for crew who went *off their heads* by excessive drink, or whatever, and who became insane. Surely, all ships did not enjoy this facility. I thought of Bogart as the insane Captain Queeg in the 1954 film of Herman Wouk's naval novel, *The Caine Mutiny.* A lone episode, as part of an Royal Engineers stores troop, this incident soon forgotten — but brain stored in the trunk of my mind.

A few weeks after the incident, involving the blanket up on Bramber Two ward, one of our new patients, a rather burly gentleman, went berserk; and could not be managed on the admission ward — I was not aware of all the

details, but I was asked to assist his temporary transfer. The patient was subdued, after an injection, placed in a wheelchair, and taken up the corridor to one of the pads on Eastergate One ward, at the other end of the hospital. It was an emergency treatment, *already* on the way out in the hospital but, as we entered the dark, green-dyed, cork padded side-room in 1967, I was instantly reminded of that prison-like cell in the 1956 troopship's belly.

The full extent of new post-war controlling drugs was still underway, to pave the way for Community psychiatry. *No* member of staff, past or present, in *our* hospital's records of seventy years, remembered use of the extra-long sleeved strait-waistcoat or, better known, strait-Jacket in Graylingwell. In the United States and in Europe this straight-Jacket, I understood, was still used, I was informed, in some State hospitals but, not thankfully in the United Kingdom.

Years later, my mother gave me an anecdote of my father, an Australian Vaudeville artiste and Stage designer, of whom I have no personal memories of at all. Anyway, she said he had worked very closely with American Vaudeville (burlesque) comedians Olsen & Johnson for some 13 years or so in the States. Came the 1929 Wall Street crash and subsequent Depression, and the movie Talkies in America, he came over to work in showbiz in London in the 1930s, then met my mother and married her in Jan 5th 1935. He would be in the theatre foyer, as customers arrived, and be seen tied-up in a straight-jacket in the foyer. Shortly afterwards, he would be seen as a straight man on stage with the comedy pair, and in his own acts, whatever they were. Then, as the show concluded, he would again be seen, still apparently bound in the straight-jacket, by exiting theatre goers as they passed through the foyer and out onto the street.

Critics, in the 1960s, were already referring to powerful new tranquillizing drugs (merits and demerits) as chemical strait jackets but, sadly, seemed to miss the point, either or what legitimate alternative treatments were available; viable, when a person was very 'ill' and, talking down unhelpful, to control *in extremis* disturbed behaviour towards themselves, and towards others. These new drugs, despite cumulative side-effects, in the main really did arrest many of the causes of disturbed symptoms, and allowed acute and chronic patients more 'freedom' from adverse *biological* chains. And more people discharged from the long-stay hospital back into The Community.

Routine

Christmas 1967 arrived, and I was on duty throughout the holiday week of Christmas and New Year festivities. On Amberley, most patients were quite vocal, including the depressed, and mobile. A number were well enough to go home to relatives or friends, but for those who remained, within their clinical boundaries, all appeared to enjoy themselves.

Staff, and the better patients, were brilliant in putting up and making up Christmas decorations; being no exception, because it was a psychiatric and not a general hospital. The huge Christmas fare and wonderful *bonhomie* of all institution staff and patients was rewarding for me to witness as a first year student nurse.

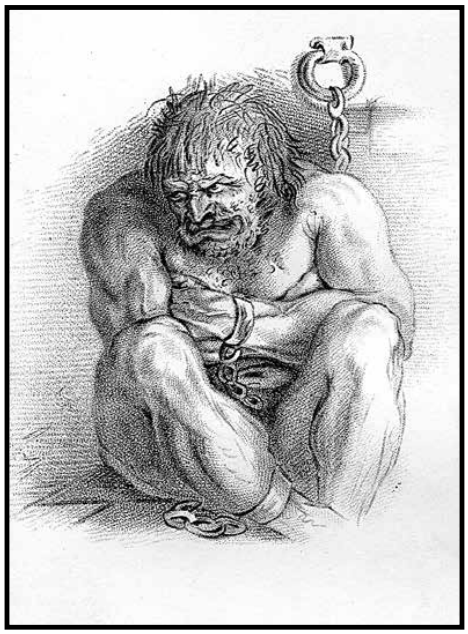
Of special interest on Christmas Day, was a visit of the Chichester Mayor and his followers, accompanied by Senior medical and nursing staff. The corporate visit was brief, after all they had all the occupied wards to visit, but it was pleasant.

I was already identifying myself, with the patients and staff, as *us* when meeting outside visitors. A children's choir, from a local church group, accompanied the notables. It was their honest acceptance; no signs whatever of stigma or fear of the children, and their escorts, as they sung their Christmas carols to our gathering on the admission ward.

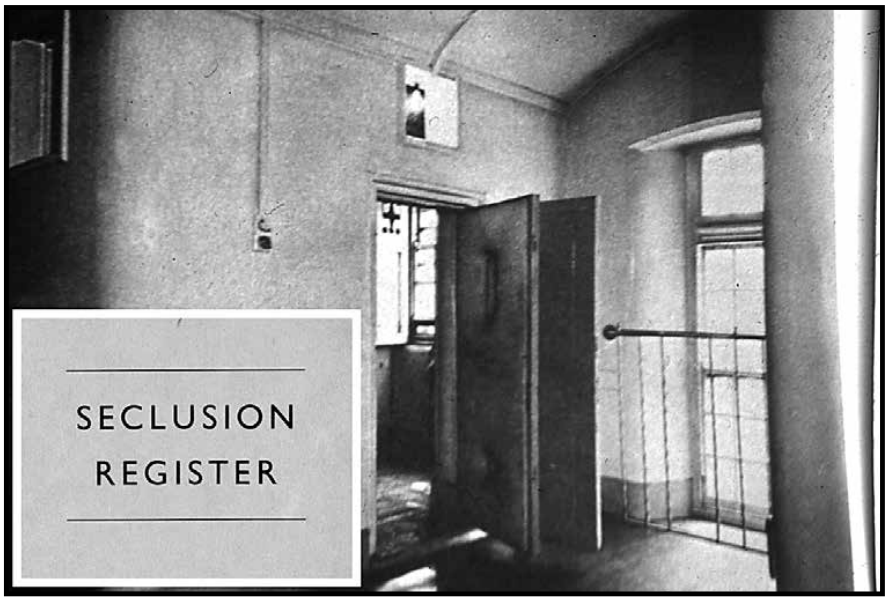
And there were the ward office parties across the hospital. At breaktime Bob sent me off for a half-hour tour of the wards; but not to accept drink: 'Because you are still on duty.' But, the odd sherry was accepted with the offered sausage rolls and ward fare. There was no untoward event to mar the Christmas festivities though it was quite exhausting at the finish.

Drug rounds, meal time distributions, medicine collections, new admissions, TTO. distributions, occasional incidents, callouts to other wards, and especially, patients being discharged home, for good. And, hospital schooldays once per week, every week (except Christmas). And beds to make up; ECT. sessions, talks with relatives, and lots, lots of overtime on offer. All soon became routine to me on the Admission Ward. And, it was a cold wet mid-winter day on February 11th 1968 when I finished my Amberley One duties and briefed by the Nursing Office for my next ward block, called *Chilgrove One* Ward.

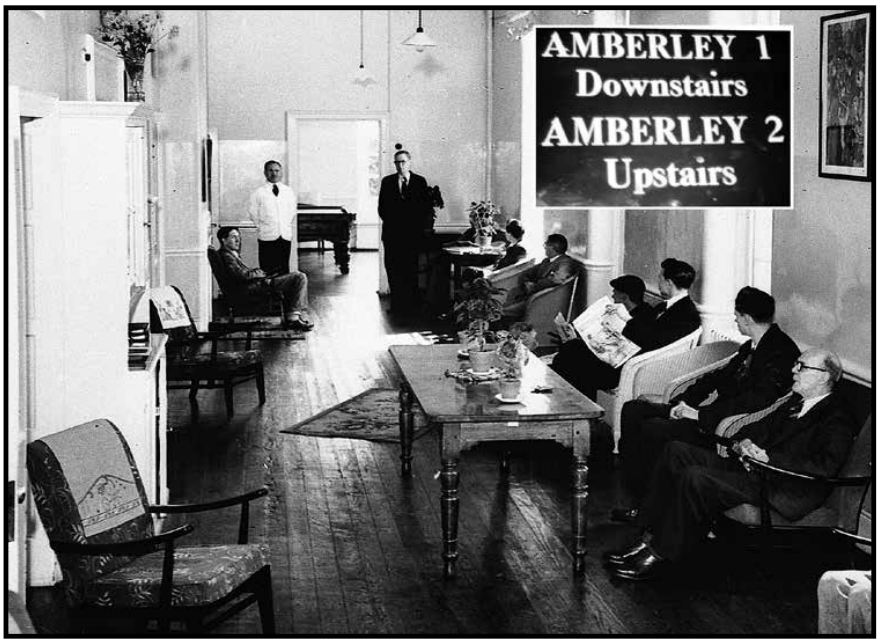
Time to move.



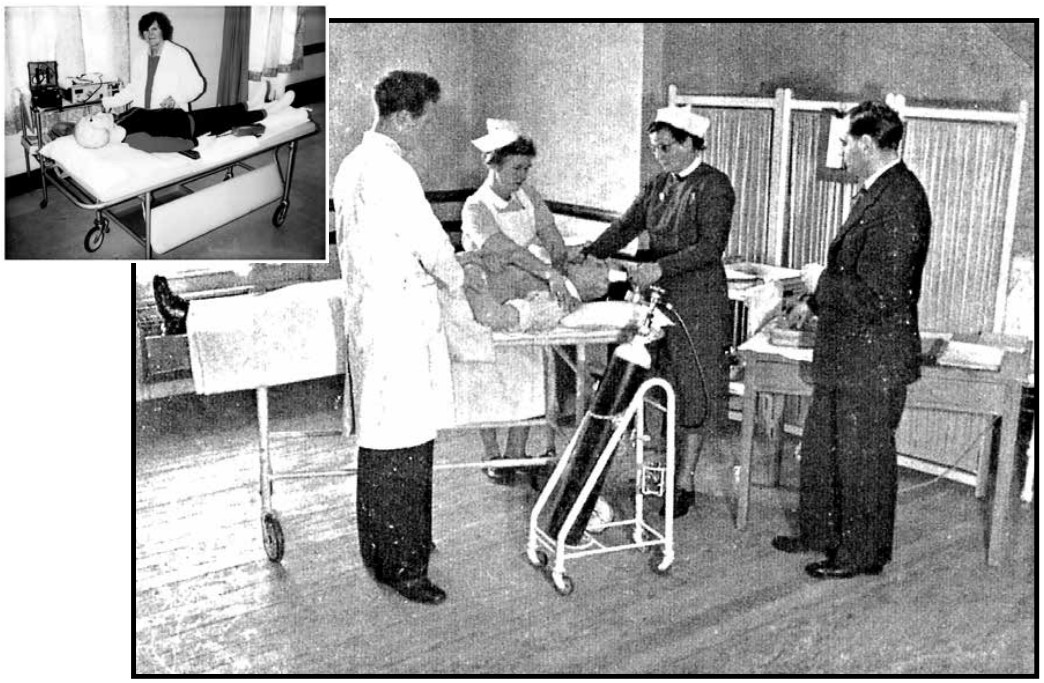
Left, Published mid-19th century drawing of a chained sufferer in Madness. A human being in absolute despair and resignation, seen 'in solitary confinement' - a*s envisaged in 18th century* : caption read 'You see him in his cell regardless of everything, with a death-like settled gloom upon his countenance. ' (Source. The Anatomy And Philosophy of Expression. By Sir Charles Bell.(1806), Publ. Bell London 1877 ed. see pp 160-1). **Right**, a contemporary print of a late 19thc. linen strait waistcoat. Fortunately such treatment in 20th century U.K. Britain, with due compassion and better resources, such restraint, given as a duty of care in a hospital long redundant — but, perhaps not so in other countries.



Single room 'Pads' were a fixture in all asylums to control and contain episodes of violence and self-mutilation when talking-down or other pacific means was ineffective. In Graylingwell Hospital and UK they were closed down in the late 1960s.



Amberley One admission (reception) ward, in early 1960s. Staff standing. **Left** Nurse Mr.J. Morris. **Right** (in civvies) Deputy Chief Male Nurse Henry George Clinch, a WW1 veteran, who qualified 21st May 1924. Dr H.A.Kidd was his Examining Superintendent.



1958. ECT existed in WW1 as faradism: 1934, Meduna introduced Electro Shock Therapy, unsafe, until post-war Electro Convulsive Treatment — with Scoline. It did not cure Schizophrenia but, in low doses for short courses, was effective for clinical depression. But, heavy doses and prolonged courses — abuse! (Main picture from Park Prewitt Hospital, Hampshire, Exhibition Brochure, 29th April 1958.) **Inset**: Brenda Wild, RMN, Graylingwell ECT Suite, 1997.