Bedminster Union Workhouse and Victorian Social Attitudes on Epilepsy: A Case study of the Life and Death of Hannah Wiltshire

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Case Study Outline

This study offers a factual account of the life and death of the vulnerable poor living in rural England during the mid-nineteenth century. The narrative that unfolds is an attempt to demonstrate how, without adequate transparent social and medical support, a devoted family unit can rapidly fall apart. Despite class based medical discrimination towards the treatment of epileptics in Victorian England, Ann Howe and her supporters succeeded in provoking a legal obligation for accountability from the Guardians of the Bedminster Union Workhouse. Exploring original archived material, secondary sources, family history data and field visits, the account attempts to reveal how a woman who was probably illiterate, and the daughter of impoverished farm labourers, embarked upon a campaign for justice.

General Historical Background

During the year of 1855 rumours of murder and cover up were circulating in the small north Somerset village of Walton-in-Gordano. The allegations originated from the historic institution known as Bedminster Union Workhouse and the suspected man-slaughter of a 22 year old female inmate named Hannah Wiltshire. Hannah Wiltshire's death caused local public outrage at the time as well as a perception of a cover up at the inquest court. Media controversy also led to accusations that workhouse guardians concealed the true extent of neglect at Bedminster Union Workhouse.

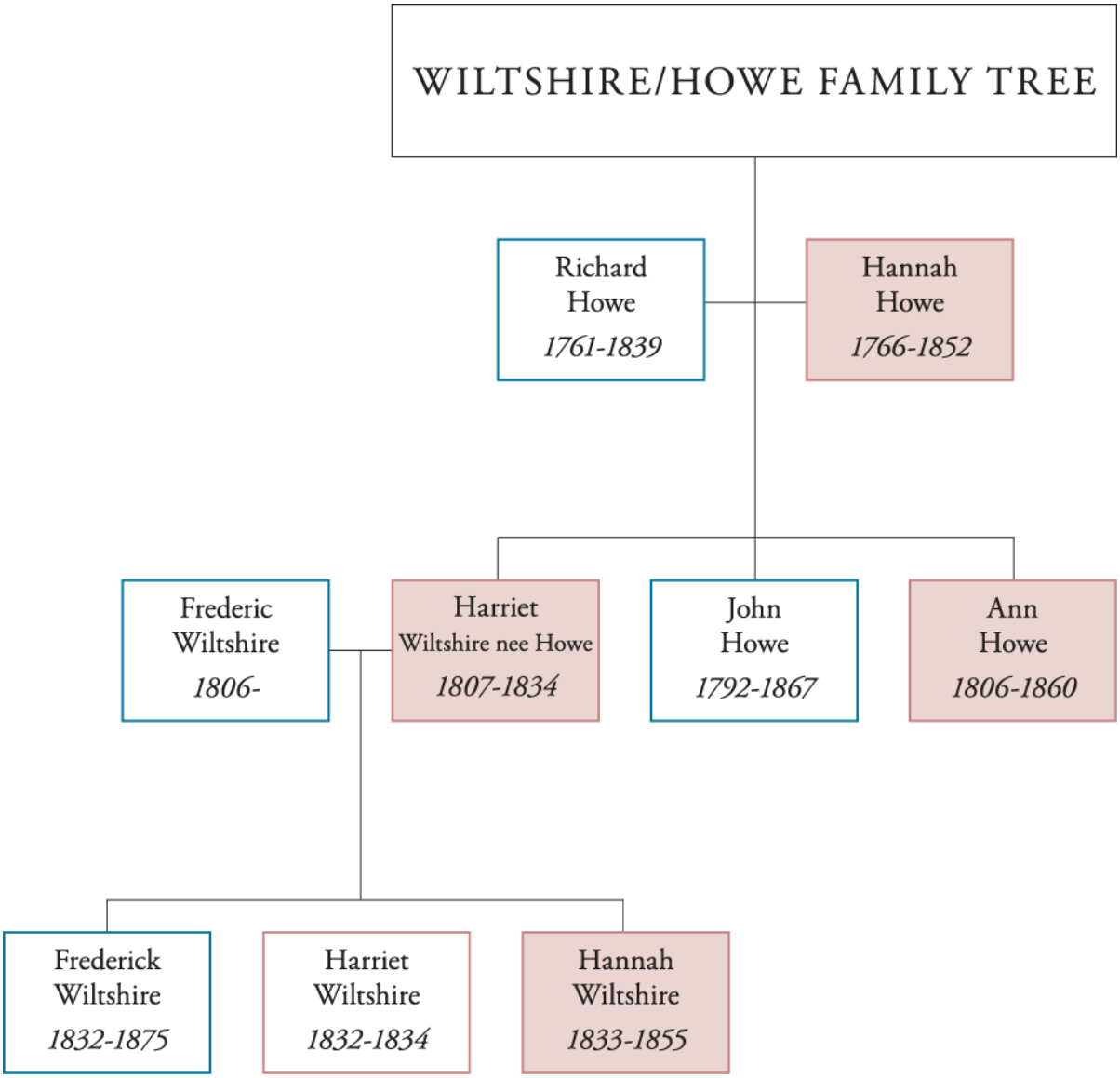
Using historical records and extensive analysis of archived material, an attempt has been made to piece together an account of the life and death of Hannah Wiltshire, a pauper who lived near Bristol. The inquest documents no longer exist (Somerset Records Office, 2015), but detailed reporting on the day of the inquest by regional newspaper reporters provided a valuable secondary source of material.

Key dates:

Birth of Hannah Wiltshire	1833
Death of Hannah Wiltshire's mother	1834
Death of Hannah Howe, Hannah Wiltshire's grandmother	1852
Hannah enters the workhouse	circa May 1854
Hannah assaulted	5th May 1855
Hannah dies	7th May 1855
Hannah buried (recorded as 'Anna')	10th May 1855
Inquest held	11th October 1855
Inquiry held	13th November 1855

Wiltshire/Howe Family Tree

Figure 1



Introduction

Hannah Wiltshire had a difficult start in life. In December 1834, when Hannah was about 16 months old, her mother and sister died. This was followed by separation from her father and brother. In addition Hannah suffered from a form of epilepsy,[1] although it is not clear when her condition first emerged. For a while after the death of her mother, her grandmother Hannah Howe was able to care for young Hannah. However, her grandmother subsequently died in 1852, aged 88 years, when Hannah was around 19 years of age. The grandmother's burial is recorded, in the *Church Book of Burials* held in the small church of St Paul's, Walton-in-Gordano, as being on the 27th June, 1852.

Following her grandmother's death Ann Howe, Hannah's aunt, took over the responsibility for Hannah's care. Evidently caring for Hannah was to prove too much for Ann Howe who herself was by now a pauper and receiving poor relief at home from the parish, known as 'being on the parish'. As a consequence Hannah was placed in the care of Bedminster Union Workhouse in May 1854. Within a few months of entering the workhouse and at the age of just 22 years, Hannah died a violent, neglected death after an altercation in the workhouse dining room with the woman in charge of the dining room, Mrs Cavil.

Family History

(See *Figure 1*)

It is useful at this point to reflect on Hannah's family history and social background to establish how Hannah's life circumstances evolved. Record searches have revealed that Hannah's parents, Frederic and Harriet Wiltshire nee Howe, were married on the 26 July, 1830 in Bristol, Gloucestershire. The Wiltshire family resided in the village of Frampton Cotterell, Gloucestershire following their marriage. Reviews of the parish records of St. Peter's church, Frampton Cotterell, together with extensive searches of archived records uncovered that this was their home and the place of work for Frederic Wiltshire. On the 1st July, 1833 Hannah was baptised at St Peter's church, Frampton Cotterell. According to the records Hannah was the third child of Frederic and Harriet. Two other children were recorded in the parish baptism records; Frederick, who was baptised at St Peter's church on 22nd April, 1832 and a sister, possibly a twin, named Harriet, who died aged 2 years 10

[1] The Epilepsy Foundation of America, the World Health Organisation, and the National Institute of Neurological Disorders and Stroke in Britain all describe epilepsy as a chronic seizure disorder in which a surge of electrical activity in the brain causes recurrent seizures that compromise a variety of mental and physical functions.

months. The records confirm infant Harriet Wiltshire was buried on the 4th December, 1834 at St Peter's church on the same burial date as her mother Harriet Wiltshire, aged just 27 years. There are no records to say how mother and child died at the same time, but it is probable their death would have been due to an infectious disease. Her surviving daughter, Hannah who was aged approximately 16 months, was sent to live with her grandmother Hannah Howe, in Walton-in-Gordano located in North Somerset, some 20 miles to the south of Frampton Cotterall, South Gloucestershire. The first concise national census of 6th June 1841 is the first record of Hannah living with her maternal grandmother.

The elder surviving sibling, Frederick, appears in two census entries; the 1841 census recorded as aged 9 years, living with a couple named John and Mary Skuse who were both aged 45 and, perhaps childless as no other children were recorded as living with them in Frampton Cotterell. Frederick was found again in the 1861 census, now aged 29 and still living with the Skuse couple. At the same time his father Frederic is recorded as living in a separate household in Frampton Cotterell, working as a master Hatter. (Frampton Cotterell was famous at this time for its factory making large felt hats that were exported to the colonies).

As mentioned, the census records for 1841 revealed that Hannah was living with her maternal grandmother in Walton-in-Gordano, a small Somerset village 8 miles to the south-west of Bristol. The enumerator who recorded the census shows the whole family as being agricultural labourers. Hannah's age was actually 7 years but the 1841 census rounded down ages to the nearest 5 for younger people as shown below:

<u>1841 census</u>:

Hanah Howe	*76*	*Ag. lab*[2]	*' y' (born in Somerset)*
John Howe	*50*	*Ag lab*	*'y'*
Ann Howe	*35*	*Ag lab*	*'y'*
Hanah Wiltshire	*5*		*'n' (not born in Somerset)*

(The National Archives)

The 1841 census did not record where a person was born, but merely whether born in the same county or not. The census of 1841 states that Hannah was born outside of the county (*n*), and, as subsequent research has uncovered, Hannah was born in Gloucestershire. John

[2] 'Ag. lab' abbreviation for agricultural labour commonly used in 1841 census

Howe, aged 50 was Hannah Howe's son. He is recorded in St Paul's church, Walton-in-Gordano Burial Book as having died in the workhouse infirmary and buried on 18th February, aged 83 years in the churchyard. (*Book of Burials*).

According to an article by Tebbutt (2014, p.28) Hannah Wiltshire was an orphan, yet, no details about Hannah's early life had apparently been researched by Tebbutt. However, and contrary to Tebbutt, it can now be substantiated that Hannah was not actually an orphan. Census searches on the family categorically disclose that Hannah's father was in fact still alive in 1861 and working in Frampton Cotterell. Hannah was actually merely being cared for by her grandmother which was, and still is, a common practice employed by families to care for children during a family crisis and times of hardship.

The census of 1851 validates the Howe family to still be living in Walton-in-Gordano and correctly records Hannah's details as being age 17 years with no employment. By this time her grandmother, Hannah Howe, was now aged 85. The census records she is a widow with annuitant, meaning she was in receipt of a pension of some sort. Ann Howe, Hannah Howe's daughter, now aged 42, was still living at home and has no occupation recorded.

<u>1851 census</u>:

Hannah Howe	*Widow*	*85*	*Annuitant*	*Iron Acton Gloucestershire*
Ann Howe	*Daur*	*42*		*Walton Somerset*
Hannah Wiltshire	*Gran Daur*	*17*		*Frampton Coteral Glous*

(Find my Past, 2015)

During the subsequent inquest that was held following Hannah's death, the attending magistrate, Sir Arthur Elton, who could have known Hannah said "After a fit she would be able to go to Clevedon or to her work; sometimes she would be well in 10 minutes." From this note reported in the regional newspapers it would appear that Hannah was actually employed in some way. Although the census did not record her occupation, her work during this period in time would have almost certainly been as a domestic servant, or in some form of farm work.

The Howe family was unquestionably very poor and living in such poverty that it did not take much for the family to have to depend on charity or parish relief. In this case it would

appear the death of the grandmother Hannah Howe in 1852, and the consequential loss of her pension and tied cottage[3] was most likely the catalyst that caused the family breakdown, and inevitably for Hannah, suffering from epilepsy, to be placed in Bedminster Union Workhouse where Hannah was to die.

Following Hannah's death her aunt Ann Howe was so anxious about rumours she had heard concerning the circumstances of the death of her niece that she asked a gentleman friend to anonymously write the following letter to Mr Burges-Fry, coroner for North Somerset, dated the 30th September, 1855.

An extract reads:

> *"On the 8th May a quarrel was between her and a Mrs Cavil, when she struck her down over three benches. She was taken up and put to bed; the next morning she was found dead. I have ben (sic) to the guardians, who*
>
> *Mary Jane Tyler of Clevedon and Mary Summeril of Nailsea, that were eye-witnesses of the shameful treatment. They did not have a doctor to her. I cannot rest day or night about it. They want to say she died in a fit. They send to me on the Monday to say she was dead, and was going to be brought to be buried next day. But instead of bringing her next day they came on Thursday, and it is generally believed that she is not in the coffin. I hope, sir that you, in your kindness, will see into it, as I have been persuaded by several gentlemen to write to you."* (*The Bristol Mercury*, 1855). (*Devizes and Wiltshire Gazette*, 1855).

Clearly Ann Howe was very distressed that she had not been given the chance to view her niece's body before she was buried and was not even convinced that Hannah's body was actually in the coffin. Ann's letter also demonstrates that she was extremely uneasy about the circumstances of Hannah's death because she had not been given a full and transparent explanation of how her niece died. After reading the above letter and several other anonymous letters that were sent to the county coroner, Mr Burgess-Fry agreed to hold an inquest on the 11th October, 1855 in the village schoolhouse. The schoolhouse is situated next to St Paul's church, Walton-in-Gordano, Somerset.

It was decided that Hannah Wiltshire's coffin was to be opened for inspection with the jury and those who knew her to be present. The coffin was exhumed in Walton-in-Gordano

[3] A tied cottage is a dwelling owned by an employer that is rented to the employee. If the employee leaves their job they may have to leave. In this way the employee is tied to their employer. In this case the landlord turned the family out after the grandmother died.

churchyard on the day of the inquest. It was reported that when the coffin was opened the female body inside was recognisable by those that had known her as the deceased Hannah Wiltshire. The local surgeon who carried out the autopsy stated that although her skull had not been fractured there was a sign of a bleed under her skull. Surprisingly the workhouse doctor, Mr Massey, was not required to be present at the inquest.

The Inquest

The inquest papers no longer exist because the sitting coroner for North Somerset in 1935 ordered that all inquest documents attributed to the last 100 years be destroyed. Fortunately a very detailed account of the inquest was published at the time in several regional newspapers and it is from these sources that the story of Hannah's death has been reconstructed.

The regional coroner, Mr Burges-Fry was to oversee the inquest. The jury consisted of sixteen men, including the village curate, Rev John Colston as foreman, and Sir Arthur Elton the local magistrate who was sitting in. Witnesses at the inquest were; Eliza Barge, a nurse at the workhouse; Sexa Marshall, assistant nurse for the aged and infirm inmates; Ann Howe, the aunt; Martin Noble Shipton, a local surgeon from Clevedon, and Mary Jane Tyler, an inmate. Surprisingly the persons accountable for the management of the workhouse were not called to be present.

Sexa Marshall, the assistant nurse, was first to give evidence. According to the newspaper reports she recalled that after the fight she had taken Hannah Wiltshire to a room and put her to bed. She asked a bedridden woman, by the name of [Mrs] Hunt, to let her know if Hannah's condition changed. Two days later Hannah was found dead. Sexa Marshall also said that she was responsible for placing the deceased in the coffin and she could confirm the body in the coffin was that of Hannah Wiltshire.

The fight was also described by Mary Jane Tyler, an inmate in the workhouse, who stayed on the same ward as Hannah Wiltshire. From reading reports in *The Bristol Mercury*, apparently Hannah was in a fight with Mary Ann Cavil who had charge of the dining hall. The dispute was over Hannah wanting to warm some water on the fire and Mrs Cavil would not allow it. Hannah picked up a poker to hit Mrs Cavil but was stopped by Mrs Cavil's sister-in-law, Mrs Smith. Mrs Cavil's baby was taken away from her and the two women started to fight and pull each other's hair. During the struggle, the pair fell onto the floor with some force. Eventually, Mrs Cavil hit Hannah on her right ear three times which made her start to fit.

"After Hannah was struck about the right side of the head three times she fell onto the floor in an epileptic fit". (*The Bristol Mercury*, 1855). Today it is known that blows to the head can cause and aggravate fits, but in 1855 medical knowledge was very limited. The onlytreatment for epilepsy at this time was mustard plasters, blistering,[4] some crude medicines and, importantly for the Victorians, social isolation.

The foreman of the jury, Rev John Colston, the local curate, who must have known Hannah, commented during the inquest that Hannah "had been in the workhouse for twelve months; she was placed there because she had fits; she had fits generally once a week; sometimes they would last a quarter of an hour and sometimes ten minutes, and sometimes after them she was not quite right in her mind". He went on to add that "Sometimes the deceased would have three or four fits in a day; she always fell down suddenly in them and would sometimes recover in five minutes; the doctor of the union was Mr Massey; he was not sent for". *(The Bristol Mercury*, 1855).

Witness Mary Jane Tyler, also gave evidence of what she had seen. "Mrs Cavil struck her three blows under the right ear, and then got up; deceased then had a fit and got up, and attempted to put her hands into the fire, but was prevented; she then again lay down in the fits, and Mrs Smith went and got some water and bathed her temples with it, and then Sexa Marshall [the nurse] and other persons took her into the Infirmary and put her to bed; on the following Monday morning I saw deceased lying dead in the Infirmary; the doctor[Mr Massey] was at the union on Saturday, and might, perhaps have seen her, but I do not think that he was there on the Sunday, or that he saw her afterwards; neither the master nor the matron of the house was present at the time, but hearing the alarm they inquired about it afterwards". (*The Bristol Mercury*, 1855).

Sexa Marshall stated she was the Union's assistant nurse. She was the person who found Hannah dead on the Monday morning *"*In the first week in May; she was not found dead in bed; I am the assistant nurse, and deceased was brought to the Infirmary on the previous Saturday afternoon; the doctor was not sent for, but he came; she was lying down on the floor when he came; he asked who it was, and I said it was Hannah Wiltshire in a fit; he said, "She will rouse again by and by, I dare say;" he did not give her anything, or examine her, as she very often had fits; no one told the doctor, in my presence, that there had been a row". Sexa Marshall further gave evidence that "I immediately had her taken into the Infirmary, where I looked after her till her death; stayed in the Infirmary till between twelve and one o'clock on the Sunday night, and then I lay down in the next room; at between five and six o'clock the next morning I went again into the room, and found her dying; she did not speak

[4] A mustard plaster is a poultice of mustard seed powder applied to stimulate heat. Red hot pokers were used to burn the skin: 'To burn out the illness'.

before she died after Sunday morning, when she appeared delirious; she had fits all the time she was in the Infirmary; don't think she was free from them for five minutes; Mr Massey, the surgeon, was in the Infirmary on the Sunday, but I was not in the room with him; saw after her death a mark on her neck, but it was not a very large one; did not tell the master or matron about the fight; did not think that she had had any hurt."

According to the journalist covering the inquest for *The Bristol Mercury*, the coroner and the jury were very interested to discover what, if any, medical treatment had been given to Hannah so they could determine the general level of care given to sick inmates. The extent of her epilepsy was also discussed. The reporter goes on to write that "Sir Arthur Elton, the local magistrate, asked about precisely what medical treatment Hannah was given as he was anxious to know". The witness said she gave the deceased sips of tea, she did not believe the deceased could swallow; no mustard plasters or blisters were ordered, the matron saw her on Thursday, when she was in the fits, and after her death also.

The nurse, Eliza Barge said that "on former occasion, when deceased had fits for nine days, the doctor ordered her blisters, and had her hair cut off; he gave not such orders on the present occasion: I was present when the doctor saw the deceased on the Sunday; he pulled back the sheet, felt her pulse, and said she was not roused up yet, but did not order any medicines, blisters, or mustard plasters." (*The Bristol Mercury*, 1855).

The Coroner asked Mr Shipton, the local Clevedon surgeon, to confirm what treatment he would have administered had he attended Hannah Wiltshire. Mr Shipton replied that he preferred not to have to answer the question, but when pressed by a juror he did respond by stating,

> "I will observe that there must have been great blame somewhere in not calling the medical officers attention specially to the case".

The jurors took only fifteen minutes to return the following verdict:

> *"That the deceased's death was caused by apoplexy, but that sufficient care was not taken by the authorities of the Bedminster Union Workhouse to separate the deceased from the other inmates of the establishment, knowing, as they did, the very peculiar liabilities of the deceased to fit, upon being thwarted. The jury are also of the opinion of the peculiar circumstances under which the deceased on this occasion, came by her death".*

The newspaper reports at the time concluded with the final words from the jury,

"This verdict was dissented from by one or two jurors, who were for one of "Manslaughter"".

Previous medical treatment for her fitting would not have helped Hannah in any way. Perhaps the doctor knew this, but it would appear to others at the inquest that they did believe treatments such as mustard plasters could alleviate epilepsy. Nevertheless the duty doctor at the workhouse, Mr Massey, did have a duty to treat and care for Hannah by employing the methods of treatment at the time.

Victorian Attitudes on Epilepsy

During this period there was a substantial push to build lunatic asylums across the country where the disadvantaged classes who suffered with epilepsy could be sent.[5] The condition was believed to be a social stigma and the social characteristics of the patient often determined medical diagnosis.

Refford (2010), in his book 'Degenerates, Lunatics, and Idiots: Social Perception and Epileptology in Modern Britain', argues that the "social assumptions of Victorians shaped class determined modes for clinical treatment of suffering epileptics, individuals often dismissed as degenerates, lunatics, and idiots." Refford's research, taken from the pages of the *British Medical Journal*, elaborates on Victorian attitudes towards epilepsy, particularly among physicians and the social assumptions of middle class Victorians. Doctors had a basic understanding of what epilepsy was, but were unable to detach themselves from the social attitudes towards epilepsy that were common within British society. Perceptions of epilepsy among Victorian medical practitioners were formed by consideration of class and social status, a view that dramatically affected the treatment of the disease.

Sufferers of epilepsy were classified in Victorian times as being grouped with the poor, homosexuals, and alcoholics, this being a socially constructed view point. According to Refford (2010), "Epilepsy was characterized as a private misfortune among the wealthy, but as a dangerous character flaw among the labouring poor." For the economically and socially disadvantaged, the reality of epilepsy, with all its stigmas, reflected the lower class identity of public epileptics, whereas prosperous, private epileptics possessed the means to conceal the purported disgrace of epilepsy. Nineteenth-century British doctors, for instance, were reluctant to report epilepsy in respected families because it was thought

[5] During Victorian times the connotation of lunatic was a person who had episodes of mental illness with a hope of recovery. Idiot and imbecile referred to those who were permanently afflicted with some form of mental illness with no hope of improvement in their condition.

that seizures arose from the genitals. The poor were characterized as malingerers, violent criminals, pauper idiots, and habitual liars, while the well-born were described as merely melancholic, unfortunate, or at best, indisposed. "Eminent Victorians saw the working class epileptic as a burden on society, an element of a dangerous underclass that was uniquely susceptible to degeneracy, imbecility, criminality and insanity."

Despite negative assumptions about the illness the coroner, Mr Bruges-Fry, was very critical of Hannah's treatment in Bedminster workhouse. He stated that:

> "he could not help thinking that there had been negligence somewhere"…"The doctor had said that he was not surprised that Hannah was dead by Monday morning, now if so, how is it that he did not employ curative means as was done upon a former occasion and endeavour to restore her to health." He went on to tell the jurors that whatever verdict they might arrive at, "*a rigid inquiry would be instigated by the Poor Law Commissioners*".
>
> (*The Bristol Mercury*, 1855)

We do not know the reason for Hannah's fits before she lived in the workhouse, but a head injury in childhood may have been a contributing factor. Fisher (n.d.), has written that severe head trauma can be defined as "either loss of consciousness or amnesia for greater than a day or internal bleeding in or around the brain. Severe head trauma leads to epilepsy in about 15% of adults and about 30% of children. Post traumatic seizures may not appear for as long as 20 years after an accident. Laboratory studies suggest that this may be due to the long-term repair process after head injury."

Medical physicians also now maintain that a change in lifestyle can cause an increased risk of seizures in adults and children with epilepsy such as and, most importantly in this case, emotional stress, illness with infection, lack of sleep and pregnancy.

Following the reporting of the verdict at the inquest a public outcry ensued which resulted in numerous letters of complaint and dissatisfaction over the conduct of the inquest being sent to the Editor of *The Bristol Mercury* newspaper over the next month. Below is a sample of the most relevant letters including a letter from Sir Arthur Elton, the local magistrate, defending the verdict of the inquest and supporting the coroner's instructions for a public investigation by the workhouse guardians.

Letters to the Editor:

Just two weeks after the inquest was held the following letter was sent to *The Bristol Mercury*. The letter was written by the chairman of the Board of Guardians at Bedminster Workhouse, Rev Mirehouse, and forwarded to the editor by the workhouse clerk, Thomas Coles.

> Bedminster Union Case of Hannah Wiltshire, Deceased. *To the Editor of The Bristol Mercury*.
>
> > "Sir – I am directed by the Board of Guardians of the Bedminster Union to request your insertion of the accompanying letter to the vice-chairman and guardians, in reference to this case, in your next publication. I am, sir, your obedient servant, Easton-in-Gordano, near Bristol, 25th October, 1855. Thomas Coles, Clerk"
>
> "Dear Sirs – It was stated to me…the jury …had censured the authorities of the Union, without examining the master, the medical man, or any of the officers of the establishment. ...we ought to request the Poor Law Board to hold a public inquiry into all the facts of the case, and that if they declined to do so it was to the public on the one hand, and the Union officers on the other, that the Guardians should hold such inquiry themselves…The jury returned their verdict that the deceased's death was occasioned by apoplexy; that sufficient care was not taken by the authorities of the Bedminster union workhouse to separate the deceased from the other inmates of the establishment: that sufficient care was not taken to inform the medical officer of the peculiar circumstances under which the deceased on this occasion came to her death….The first part of the verdict records that the death of the pauper was by apoplexy, thereby causing no reflection on any human being. Secondly, that the workhouse authorities should have separated the deceased from the other inmates. … It is impossible for a Master of a Union to separate each pauper that may be subject to fits from the other paupers; it would require a house far larger than the one we possess to do anything of the kind. …It is manifest that a pauper under such circumstances, if unfit to mix with other paupers in health, could not be sent to the infirmary ward to mix with paupers who were ill and unable to compete with a quarrelsome excited pauper."
>
> Yours faithfully [Rev] Henry Mirehouse. [Chairman of Bedminster Union Workhouse Board of Governers]

The Rev Mirehouse was chairman of the board of governors at Bedminster workhouse. He was driven to write the above letter to defend the management regime at the workhouse and to give an answer to the criticisms. Rev Mirehouse states that epileptics are given the freedom to mix with the other paupers because the premises were are not large enough to segregate the paupers that have fits. He reiterates that the verdict was one of death by apoplexy and was not caused by the fight, therefore, the workhouse guardians could not be held responsible.

A few days later on the 3rd November, 1855 a letter was published in *The Bristol Mercury* from the foreman of the jury, John Coulson, the curate of Walton-in-Gordano, who wrote complaining of the treatment of two witnesses by the guardians:

> "Sir - …Two other witnesses appeared before us; they had no carriage to convey them, even the shoes which they petitioned for to aid them to their weary walk of ten miles were denied them. Their evidence, which was singularly clear and well stated, regarded only the uncounted between the two women. The proof of apparent neglect we gather from the favoured ones of the master and the matron. And let it not appear strange that I say "favoured ones". Listen to this, Mr Editor. The inquest terminated at a late hour in the afternoon. The night was wild and dark and threatening. The Cobourg [carriage] conveyed back the two nurses to the union, whilst the two poor barely-shod paupers (one of them with a baby in her arms) who had come forward at the solicitation of an aunt of the deceased, herself a pauper, were left to find their way back over the weary ten miles as best they could. The kindness of a neighbouring magistrate, however, conveyed them home in a fly. "That the authorities of the union were to blame for not having taken more care of the deceased … that was no ordinary fit, but one produced by a violent encounter with another pauper". I will only add, that if the terms of their verdict is dissatisfy the Rev Chairman, [Mirehouse of Bedminster workhouse] his astonishment would indeed be profound did he know the "finding" originally proposed by the great majority of the jurors".
>
> I remain, Sir, your obedient servant. John Edmond Coulson, Forman of the Jury. November 1st, 1855.

This letter also offers a scathing attack on Rev Mirehouses's letter to the newspaper. It can be assumed that the local curate, John Coulson, was friendly with the local magistrate, Sir Arthur Elton, and in writing the letter he is praising his friend for his assistance to the witnesses who were not the "favoured ones". He is accusing the guardians of the workhouse and Rev Mirehouse of attempting to hinder witness evidence at the

inquest. The foreman of the inquest also reminds Rev Mirehouse that the verdict could have, or should have, been one of manslaughter.

The local magistrate, Sir Arthur Elton, who attended the inquest, wrote the following letter to *The Bristol Mercury* (3 Nov. 1855), harshly criticising the guardians and Rev Mirehouse for not holding an inquest until forced to by the adverse publicity instigated by the Hannah's aunt, Ann Howe.

BEDMINSTER UNION
CASE OF HANNAH WILTSIRE
To the Editor of the Bristol Mercury

"Sir- The publication of a letter from the Rev Mr Mirehouse to the guardians of the above union, in your paper last Saturday, compels me to take a step which otherwise I should have been very glad to avoid, namely, to publish, …the reasons why I together with my brother magistrates…who are of the same mind as myself, differ from the view Mr Mirehouse takes of the circumstances attending the death of Hannah Wiltshire…held at Walton-on-Gordano on the 11th instant.

As the case now stands before the public, it would that Hannah Wiltshire, an epileptic patient of weak mind,[6] is thrown and struck, more than once, under the ear by a woman named Cavil, who would seem to have had charge of the dining-hall on the day in question, namely 5th of May last. Immediately following the fall and blows, Hannah Wiltshire is seized with fits and carried to the infirmary, where she remains suffering a "rapid secession of fits" until her death on Monday morning the 7th May. …from Saturday afternoon until Monday morning – no medical treatment was administered to her, and for some hours previous to her decease she was left in the charge of a paralytic pauper. Such would appear to be the correct version of the circumstances attending Hannah Wiltshire's death.

…Although the death of Hannah Wiltshire resulted from fits which immediately followed violent treatment at the hands of one of the paupers, no inquest is held, and none would have held unless the complaints of the aunt of deceased had not very properly induced the coroner to make inquiries …and duly order the body to be exhumed.

If these statements be incorrect then for the credit of the authorities of the union, from the least to the greatest, as well as for the satisfaction of the public to them be disproved. A technical criticism of the *verdict* at the inquest cannot,…cancel the

[6] A weak minded person may be easily swayed by emotional manipulation tactics as they do not possess an adequate ability to judge the quality of an assertion. (meriam-webster.com)

serious imputations conveyed in the *evidence* taken on oath …and made public to the newspapers.

…I should still consider that the board of guardians ought to have instigated an inquiry into the circumstances attending the death of Hannah Wiltshire as soon as the evidence at the inquest was made public; and I cannot yet bring myself to believe that the board of guardians, and the various authorities directly or indirectly implemented in this transaction intend to take no steps to remove the painful impression which that evidence must have left upon the minds of all who take any interest in the welfare of union-workhouses."

I am sir, your very obediently Arthur H Elton, Oct.30.1855

Below Elton's letter was printed the following announcement:

> In order to bring this matter to a practical issue, the following notice of a resolution to be moved on the 17th November ….entered in the notice book:- "That the master and matron of the workhouse, the medical officer, and the nurses of the infirmary directed to attend the board of guardians, and give information touching certain circumstances connected with the decease of Hannah Wiltshire, on the 7th May last, which transpired at the coroner's inquest held on her body at Walton-in-Gordano on the 11th instant"

The announcement was issued only due to public pressure, jurors' assertions, adverse newspaper publicity and a compelling argument from the magistrate, Sir Arthur Elton. As the public announcement above indicates, the guardians had finally agreed to hold an inquiry on the 17th November, 1855. But then again, and highly significantly, the notice above omitted to disclose that the inquiry was to be held in private and not in public as had been directed by the coroner and as advised by others. The workhouse minute book has recorded the details of how the internal inquiry was to be held. Sir Arthur Elton was once again trying to force the issue for a public enquiry.

Taken from the Bedminster Workhouse Minute Book No.10, (1855)

> "On Sir Arthur Elton's Motion being called, the Chairman recommended that such Motion be postponed with the Medical Office, Master, and Matron be called into the room and asked if they had any communication that they wished to make relative to the imputations and reflections that appeared in the Newspapers regarding their conduct with reference to Hannah Wiltshire, deceased. The recommendation as adopted – strangers order to withdraw, and

each of the officers together with two nurses having been called into the room, and having stated what took place as far as they know.

Sir Arthur Elton withdrew his Motion."

The Rev Mirehouse had put a vote to the Board as to whether the evidence from the managers and others employed at the workhouse, who were witnesses, should be held in secret. As a consequence, Sir Arthur Elton's call for a motion for transparency was defeated. 'Strangers' were removed and no mention of what was said in the room appeared in the minute book or again in the newspapers.

Following the circumstances of the internal inquiry held at Bedminster Workhouse a final letter was sent anonymously to the newspaper complaining about the lack of transparency with the internal inquiry being held in private by the guardians of Bedminster workhouse, suggesting that it went against the direction of the coroner, Mr Burges-Fry.

Hannah Wiltshire's Case. To the Editor of *The Bristol Mercury.*

"Sir – I was greatly surprised at finding the whole matter brought to a compromise, at the suggestion of the chairman of the Board, the Rev H. Mirehouse, at a meeting of the Bedminster Board on Tuesday week. …Now this compromise is tantamount to this – That the charges relating to and attendant upon the decease of the poor afflicted woman, though publicly made, which be regarded by the Board in a private light and …private investigation…treating the feelings of the public at large with indifference…"

I am, sir, D. Nov. 19th, 1855

In order to understand the nature of the conditions that existed for the provision of the sick in workhouses at this period, valuable sources of reference do exist in historical reports of workhouse inspections. Unfortunately, according to the National Archives web site, the accounts of Commissioners inspection visits to Bedminster workhouse circa 1855 no longer exist. However, a report published in *The British Medical Journal* (1867) gives a valuable insight into the living conditions at Bedminster Workhouse 12 years after the death of Hannah Wiltshire: A shortened transcript of the report reads as follows:

"The Workhouse is situated four miles from Bristol, and generally contains about three hundred inmates. On entering the building we first noticed the receiving-wards, which are small; but we were informed that they never contained many people at the same time. Passing on, we came to the kitchen…It was also small, but kept clean, and the soup that was being made seemed good. The infirmary is a detached building, and, in describing it, we shall give a detailed account of some of the wards. The first we visited was the lying-in ward, containing four beds in a space of 2400 cubic feet. The medical officer informed us that the patients here had always been healthy. Proceeding onwards, we came to a female sick ward, twenty feet four inches long, sixteen feet six inches broad, and ten feet high, ventilated by means of two windows each, only three feet square, both on the same side, and not opening to the top of the ward, which contained nine beds, thus allowing less than 380 cubic feet for each. The next ward …contained six beds, with 450 cubic feet per bed. One small scullery, and two water-closets attached to these two rooms, both dirty….Upstairs a badly ventilated convalescent room…attached another female sick-ward, twenty-nine feet six inches long, seventeen feet two inches broad, and nine feet 5 inches high, ventilated by four windows, each three feet square, It contained…thirteen patients, thus reducing the cubical space to less than three hundred and seventy feet for each…the atmosphere of the ward smelt anything but pleasant…extremely foul water-closet beyond, for the use of twenty-six patients. Can it be possible that such an arrangement has been…sanctioned by the poor-Law Board?...The male wards we found to be in nearly every respect of similar to the female one, except that here one of the wards was set apart for the use of imbeciles, whilst in the female wards, sick patients and imbeciles were missed indiscriminately together…There is no bath-room in the infirmary, neither is there any supply of hot water, except from one small boiler…only one basin in the ward…only two towels a week were supplied for each. …the sheets and linen…are changed only once a fortnight, and the washing for both the sick and healthy in done in the same building...which were extremely dirty. The nursing of the sick, over sixty in number, is superintended by a paid female nurse assisted by one pauper nurse in the female wards, and by three pauper nurses in the make wards. …Some of the pints of beer ordered for the patients…we found them to be a quarter of a pint short. To sum up: the wards were crowded and badly ventilated. The water-closets were extremely foul. The lavatories were small and dirty; and there was no bath-room attached to the infirmary"

This damming report, published in 1866 and written by independent inspectors, was produced 11 years after Bedminster Union Workhouse had been already sharply censured by the coroner for lack of duty and care obligations. Yet again the institution was condemned for not adequately providing sufficient care and, not protecting vulnerable female patients with mental disorders from antagonistic behavior provoked by other inmates or by themselves. The inspectors advocate that epileptic paupers should be segregated on separate wards.

During the latter half of 1855 further letters were written to the newspapers to complain about how badly the pauper witnesses had been treated by the guardians and more significantly justifying the urgent need to build a lunatic asylum in Bristol.

Admissions into Victorian asylums

The population of asylums increased significantly during the nineteenth century, possibly due to an increased intolerance of mental illness. The Poor Law and Lunacy Reform Act of 1853 promoted the asylum as the "institution of choice for patients afflicted with all forms of mental illness, including insane epileptics" (Simon, Langharne, 2003). The Act stipulated that the parish medical officer was to visit paupers four times a year. The medical officers would have to inform the guardians of the local workhouse if he thought that the pauper needed [treatment]. All that was required was the signature of a local magistrate and the medical officer.

The Medical Superintendent at the Royal Albert Asylum in Lancaster, Dr Telford-Smith, noted in 1899 that the only refuge for the majority of poorer epileptics [was], either the workhouse or the lunatic asylum. Admissions to asylums in early Victorian England were regarded as a social rather than a medical problem. Clearly, the asylum was a convenient repository for the 'deviant' epileptic. Living conditions for epileptics living in asylums after 1853 were deplorable even by nineteenth century standards. After the mid-nineteenth century, Poor Law Commissioners, reformers and physicians maintained that the segregation of epileptics from society was in the best interests for society. (Refford 2010).

Refford (2010), further states that a more humanitarian approach to the social problems of epilepsy did begin to transform attitudes towards the possible treatment and rehabilitation of epileptics. Privately sponsored reform movements and charitable epileptic hospitals, such as the National Hospital for the Paralyzed and Epileptic, were founded in London in 1860. During 1884 the philanthropist John Passmore Edwards financed the construction of

the first British epileptic home at Chalfont St Peter, Buckinghamshire which provided an important role in the provision of safety and care for epileptics.

The Minutes Books (1884, 1855) for Bedminster Workhouse divulge that Sir Arthur Elton, the local Magistrate for Clevedon and Walton-in-Gordano, was somewhat of a social champion for the region and his letters are referred to on many occasions. He is often recorded as writing letters to the Board of Guardians requesting that they look again at various requests associated for 'out poor relief', presumably after being contacted by needy individuals in the community.

Sir Arthur Hallam Elton, (1818-1883), who was the 7th Baronet, was extremely active as a financial and social benefactor in the local community. He inherited his father's title and the manor house, Clevedon Court in Somerset, (now owned by the National Trust), and was a prolific writer of letters, a social activist and a Liberal party politician. After being appointed High Sheriff of Somerset in 1857 he was also elected as Member of Parliament for Bath at the 1857 general election. However, within two years of taking his seat in the House of Commons he stood down in the 1859 general election due to his opposition to the Crimean War.

After resigning his seat he dedicated the rest of his life to improving the town of Clevedon where he held the position of local magistrate. His notable achievements were; building an orphanage, named Hallum Hall (later to become St. Edith's children's home until closing in 1974); funding the building of a new cottage hospital, which is still used today by the National Health Service; starting up a lending library and granting land to be used as allotments to improve the nutrition of the town's disadvantaged inhabitants. It is understandable why Sir Arthur Elton was asked by the coroner to sit in on the inquest as he would have local knowledge of the living conditions of the poor families in the area.

Conclusion

This study is about a family, who although poor, understood that they needed to stand up for their rights, and also how, and by what means to draw attention to a suspicious death in order that justice could be seen to be done. Ann Howe wanted to bring those to blame for the death of her niece to trial, with the possibility of them being on a charge of manslaughter. Although ultimately not successful in provoking a trial or a public enquiry, the case did instigate a coroner's inquest and ultimately a private investigation by the

governors' of the Bedminster Union Workhouse. The case of Hannah Wiltshire also demonstrates disquiet in the community regarding the treatment of epileptic paupers. Ann Howe, instigated a letter writing campaign. Tirades of complaints were sent to *The Bristol Mercury* newspaper, many of them anonymously. This resulted in the coroner and foreman of the jury being forced not only to defend the summing up of the evidence, but also to express their great disquiet towards the workhouse management, thereby distancing themselves from accusations of a cover-up. Eventually letters were even sent to the press demanding that the accused were innocent of the claims. Many letters of complaint were also published in the press over the shoddy treatment of the witnesses and also giving great sympathy towards "the poor creature" Hannah.

Hannah Wiltshire was a victim of two family deaths; that of her mother and then of her grandmother. She was also a victim of a social care system that failed in its duty of care and ignored her illness, even by the standards of the time. The system was at best discriminating and at worse inhuman.

After the death of the grandmother the family unit unquestionably collapsed. The grandmother was the matriarch of the family, a strong woman, widowed before 1841, still working at 80 and living until 1852. It soon became evident that Ann Howe could no longer afford to stay living in the family home, and they were probably evicted by the landlord. At the inquest Anne Howe stated "I was turned out of my house". Her income had certainly been affected with the loss of her mother's pension. It would appear that Ann Howe had no choice but to declare herself a pauper and to consign her sick niece into the workhouse, or was ordered to.

We have to be cautious not to place present day ethics of gender equality and social discrimination awareness onto the conclusion of the inquest of 1855. However, at least two of the jurors did vote for a charge of manslaughter to be passed as the verdict and the conclusion of 'death by apoplexy' was considered contemptuous by some. What was extraordinary to many at the time was the revelation that the doctor and governors of the Union Workhouse were not present at the inquest. The coroner did promise that "a rigid inquiry would be instigated by the Poor Law Commissioners"**.** But the result was that the direction by the coroner was ultimately held in private, a decision that was heavily criticised in the newspapers.

There was no effective treatment available for epileptics in 1855, and the medical profession supported the prevailing attitude that socially disadvantaged epileptics should be placed in institutions, away from society. The case of Hannah Wiltshire strengthen the argument for building a lunatic asylum in Bristol so that poor epileptic suffers would at least

be in a place of safety, away from other inmates. The exposure of this case began a public shift of attitude towards the treatment of epileptic paupers and heightened suspicion of the management practises inside England's workhouses.

The case of Hannah Wiltshire also illustrates many of the significant discriminatory failings of Victorian society, mainly those of stigma and social class discrimination. The inquest exposed many fundamental issues: That key people were not answerable to an inquest court; that the treatment of epileptic's was class based and that institutions were not sufficiently transparent and accountable to the public. Indeed the very people they were set-up to protect were being left in danger.

Evaluating the evidence over how epileptics were viewed by the Victorian medical profession, and considering (with the benefit of hindsight) the more effective outcomes of modern medical approaches, it is fair to say that Hannah may very well have lived a longer and happier life if she had been allowed to stay at home with her aunt, Ann Howe, in the local community that she knew and trusted, and among local residents who accepted her condition without social prejudice.

Sometimes families today still have to struggle to expose suspected cover-ups of abuse, neglect and death in our institutions. This case explains how a disadvantaged, under privileged family during the mid-nineteenth century had success by lobbying officials and people of prominence in the community.

When confronting miss-management and neglect by our state and private institutions, some families still often have to instigate, with the support of high profile people and media interest, an awareness raising campaign in order for a public inquiry to be held. Many would argue that a lack of transparency and accountability in the institutions of our care and welfare system is still endemic in our society to this day.

Records of the family burials as recorded in St. Paul's parish church burial book, Walton-in-Gordano, North Somerset.

1839	Richard Howe	Walton 1st Feb	aged 78
1852	Hannah Howe	June 27	aged 88
1855	Anna Wiltshire	May 10th	aged 22 (Note: Miss-spelling of Hannah's name)
1860	Anne How	11 December	age 56 years
1867	John Howe	18th Feb	aged 83

(As recorded in *Book of Burials*)

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With special thanks to the Church wardens of St Peter's Church, Frampton Cottrell and St Paul's Church, Walton-in-Gordano for allowing access to the church record books.