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*A Sociological Investigation of Infant Overlaying Death*

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*A thesis presented for the degree of Doctor of Philosophy at the University of Edinburgh 2012*



***Declaration***

*This thesis 'A Sociological Investigation of Infant Overlaying' has been composed by me, is my own work and has not been submitted for any other degree or professional qualification.*

***Sheree Sartain***

A handwritten signature in black ink, consisting of several overlapping loops and a long horizontal stroke at the bottom.

***1 June 2012***





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**Abstract: A Sociological Investigation of Infant Overlaying Death**

Overlaying was a common nineteenth century explanation of sudden infant death while bed-sharing. This thesis shows that in many cases the term overlaying was a misnomer, and instead it identifies infant overlaying death as a socio-structural historical event that can best be understood within a sociological and social constructionist framework. It expands on the work of Giddens, Elias and Archer to develop a theoretical perspective that incorporates ideas about structuration, sequestration, figuration and reflexivity. It also deploys concepts such as motherhood, infancy, infant care, the family and intimacy to explore and analyse its research materials and develops two further explanatory concepts; reflexive motherhood and the sequestration of infancy.

The thesis uses ideas around discourse as socio-structural conditions of action in order to expand current understanding of overlaying death, and it explores and analyses public representations of overlaying during the nineteenth and early twentieth centuries to detail the discourse of overlaying. It goes on to identify cases of overlaying in Somers Town, St Pancras, c1900; and it shows the influence of social conditions in regard to the way such deaths were interpreted.

It then examines other cases of sudden infant death in bed through the case notes of pathologist Dr Ludwig Freyberger, and analyses these in terms of the domestic setting and the body. It goes on to detail and analyse a dispute between Coroner John Troutbeck, Dr Freyberger and the GPs of south west London to show the ways in which the overlaying discourse was deployed to support the claims and positions of those involved. Overlaying subsequently became detached from the domestic context in which it was embedded and used to support discourses around infant mortality, maternal 'ignorance', medicine, national efficiency and temperance.

The thesis provides a historiography of infant overlaying death and concludes that overlaying was constructed as social category of death through the actions of individuals in extensive networks of interdependence in relation to socio-structural conditions.





## **Chapter One: Structuration and Overlaying: Domestic Figuration, the Event and its Structural Hermeneutics**

### **Introduction**

In 1900, a reader picking up a copy of the London St Pancras Guardian would have seen, between reports of the 'monster excursion' for 'slum children' (STPG 24/8/1900) and news of Mary Hatton's immoral earnings (STPG 18/5/1900), a report of the inquest held into the death of 6 week old Richard Gould, the son of a caretaker who was found dead in bed with his parents and a sibling (STPG 25/5/1900). Each week reports of the many sudden deaths that occurred in the parish appeared in between local news such as the minutes of vestry meetings, criminal cases in the magistrates' courts, and the other day-to-day life and death of the parish. Inquest cases were routinely reported as part of this weekly fare and among the deaths the coroner investigated each week were those of infants found dead in bed. Such reports were regular and frequent and formed as much a part of daily life as did the reports of petty crime and local politics. Sometimes the infant deaths were reported as being due to natural causes, with diseases such as pneumonia and bronchitis providing an explanation. On other occasions the deaths were attributed to accidental suffocation by overlaying and explained in terms of the mother overlaying her infant and causing its death. The way in which such sudden infant deaths in bed were interpreted as infant overlaying during the nineteenth and early twentieth centuries is the subject of this thesis.

This chapter describes the importance of nineteenth century infant overlaying death as a topic of sociological investigation. Against a background of nineteenth century social change, overlaying deaths were reported in increasing numbers with little or no supporting pathology to justify the claims of doctors, pathologist, coroners and others that mothers had wilfully or neglectfully overlain their infants and so caused their death. The lack of definitive pathology in such cases suggests that the attribution of overlaying as a cause of death relied more on the social context of the death than on medical scientific knowledge. As such, the tools of sociology provide a useful means of interrogating the material detailed in this thesis.

Infant overlaying death occurred within the home and within the intimate relationship between a mother and infant. In this sense overlaying was a private concern, but it was also constructed as a public issue against a background of high infant mortality during the nineteenth century. Through the event of overlaying, the private relationship between mother and infant became exposed to public, medical, legal and moral scrutiny. Such deaths, organised by the routine and regular attribution of wilful or neglectful overlaying as

explanation, increased during the nineteenth century only to decline in the early part of twentieth century. As such these deaths offer an opportunity to explore a social phenomenon that is not explicable by reference to individual cases or to medical pathology alone. This thesis therefore builds on the traditional tasks of sociology by investigating the routines of people's lives and deaths to provide social explanations for their social regularity.

Infant overlaying death also augmented fears about moral decline and challenged what were at the time changing ideas about the responsibilities of infant care and what it meant to be a mother. As a consequence, an investigation of infant overlaying death also addresses a subject that is on the edge of defiance, infanticide and the killing of a child by its mother. Such deaths occurred in opposition to a supposed natural order that decries the killing of children (especially of infants by mothers) and describes them as unnatural and pathological.

Other issues are also raised by an exploration of overlaying and these relate to the ways of being and doing undertaken by people in the management of their day-to-day lives. In this sense, overlaying provides a focus for exploring practices around motherhood, infant care, the family, law, medicine and pathology. Around these social practices, investigation of overlaying death also reveals broader sociological themes such as the meaning of intimacy and its consequence for bed-sharing, the restructuring of the family and household space, the management of childbirth and infant death, the study of pathology and much more. And while these themes intersect in the context of sudden infant death in bed, interrogation of the material detailed in this thesis also casts light on them in terms of morality and a discourse of (non) normativity against a background of social change with gender, social class and power / knowledge providing analytical axes for exploring the topic. The discussion that follows in this chapter is provided as an exposition of the sociological thinking that underpins this thesis.

Despite the far reaching social consequences of infant overlaying death, its immediate context was the home and family with the domestic setting serving as the place where the majority of overlaying deaths occurred. This thesis explores the issue of infant overlaying death using what Elias (2000 [1994]) calls the 'domestic figuration', which is understood here as a nexus of action and structure connecting individuals with broader social structures. It will deploy documentary sources viewed and organised around ideas about reflexivity, discourse and biography. As individual women went about their daily tasks caring for their offspring, their lives were shaped by a range of overlapping, interacting, ongoing and singular influences. Some of these influences originated in the immediate context of the women's lives, others from further afield, both in terms of space and distance and in terms of

time. The influences that shaped the lives of women also occurred either through human action (intrinsic) or through other factors external to human action (extrinsic) but which were sometimes nonetheless interpreted in social terms. The consequences of intrinsic and extrinsic influences were brought to bear on individual women who may (not) have been directly aware of their impact or origins (Smith: 1988). The sociological problematic of this thesis therefore lies in describing and explaining the interrelationships between these so called 'overlaying' mothers as situated actors and broader social structures (Abrams: 1983; Elias: 2000 [1994]; Smith: 1988)

The relationship between social structure and human agency is widely recognised as a major theme of social theory (Abrams: 1983; Archer 2010 [1982]; Giddens: 1979, 1984; Parker: 2000, 2006; Smith: 1988; Stones: 2005) and can be understood as the problem of explaining social structure as both the context and outcome of human agency. The elaboration of the problem acknowledges the structural conditioning of human agency, while simultaneously recognising human agency as the origin of social structure and is sometimes referred to in terms of structuration. Other terms have also been used in sociological discussion of this problem, most of which relate to the issue in terms of whether this should be thought of as a dualism or something more complex. The significance placed on either human agency or socio-structural conditions is emphasised in relation to the focus or perspective of the theorist or researcher and their concerns. Some theorists have attempted to overcome this dualistic approach and promoted a theoretical perspective which re-constructs the relationship between agency and structure as a duality (Elias: 2000 [1994]; Giddens: 1979, 1984; Smith: 1988; Stones: 2005). More importantly, both perspectives face the problem of describing the interplay between the self and the social world in a way that is neither overly determinist nor voluntaristic and yet is capable of explaining both individual constraint and enablement and also social stability and change.

The theoretical exploration of the structuration problematic, despite its many forms, can therefore be organised into those who maintain a dualism of structure and agency (at least in analytical terms) and those who theorise the relationship as a duality of structure and agency. The former group, although perhaps referring to the issue confronting them as structuration, always discuss it in terms of structure and agency (or their synonyms), while the latter deal with the problem in terms of structuration. While the idea of structuration is widely accepted within sociology, structuration theory as its solution has received much criticism. Despite this, both perspectives have something to offer in analysis of the material presented in this thesis.

Structuration theory (Giddens: 1984; Stones: 2005) proposes a sociological

perspective which encompasses the duality of structure – where structure is understood as both the framework and outcome of social action – in a way that places structural hermeneutic diagnostics at the core of research. Although of course not necessarily referenced in terms of structuration theory, the problem of understanding the interplay between agency and structure has a rich intellectual heritage and forms a central theme within sociology (including by Mead: 1934; Simmel: 1972; Weber: 2001 [1930]). While some recent theorists (Archer: 2010 [1982]; Mouzelis: 1989; Giddens: 1979, 1984, Parker: 2000, 2006; Stones: 2005) have addressed structuration theory directly, others such as Elias (2000 [1994]) have approached the issue in terms of 'process sociology'. They have all, nonetheless, provided intellectual strategies for bringing together action and structure within an explanatory sociological framework. This introductory chapter will therefore explore theories relevant to structuration and process sociology as detailed by Elias, Giddens, Stones and Archer, especially in relation to the conceptual aspects of their work which can be used to formulate tools for the socio-structural exploration of infant overlaying death as an historical event.

In his work, The Civilising Process, Norbert Elias (2000 [1994]) sets out the role of sociology as a means of exploring underlying historical changes, their mechanics and their concrete mechanisms (Elias: (2000 [1994] xiii). Elias's work prefigures later interrogations of the relationship between agency and structure through the process of structuration (Archer [1982] 2010; Giddens: 1984; Mouzelis: 1989; Stones 2005). The figuration forms a central concept in Elias's process sociology. Figurations are comprised of personal and emotional bonds of interdependence which knit people together as agents within social networks (Elias: 1978: 137). Within figurations, change is characterised by a fluctuating balance of power which is a structural feature of all figurations (Elias: 1978; 131). Although not directly stated, the resources (material or otherwise) on which individuals draw are also an aspect of the various figurations in which they take part. Consequently the primary means of analysing figurations (and therefore society at large) is through exploration of the emergent chains of interdependence. The extensive character of figurations which renders them at the same time both bounded and boundless provides the means for exploring continuity and change as part of the ongoing and recursive processes of society.

Elias's work has a focus on social change, where change is used to refer to transformations that reflect in the social structure by both increasing or decreasing social differentiation and integration (Elias: 2000 [1994]: 450), and he suggests that analysis of change should form the basis of all sociological investigation. Elias's work can be drawn on to explore the change seen in, for example, the increased differentiation between mother and

infant as social agents and the increased integration of the infant into social processes resulting in socio-structural change. Elias's demand for grounded evidence is met within this thesis, where historical records are used to explore long-term social change as connections between personality structures and social structures and ensuing reformations (Elias: 2000 [1994]: 452). Although Elias maintains that change rather than stasis is a normal characteristic of society (Elias: 2000 [1994]: 457), he also makes clear the requirement of sociology to develop a concept of social change that can distinguish between those changes that relate to social structural transformation and those that do not, which suggests that, for Elias, change can occur without consequential structural transformation (Elias: 2000 [1994]: 450). This, paradoxically, limits the relationship between structure as the outcome and the context of action described in structuration theory, where change cannot occur without modification of its context or outcome. This therefore marks a clear distinction between Elias's process sociology and later structuration theory. For Elias, nonetheless, social change represents a dynamic aspect of the figuration. In one sense Elias 's theorising of The Civilising Process can be understood as referring obliquely to social change as occurring via people's movement through time and our anticipation of the future, not as the compulsion of drives but as action in the face of anticipation, future orientation and desired control of what is to come.

The process that Elias (2000 [1994]) describes represents both the 'growing up' of an individual through a process of what he terms psychogenesis, and the development of society and social structures through the process of sociogenesis (Elias: 2000 [1994]: xi), with both processes existing in an iterative relationship wherein 'personality' is inextricably tied to social structure. The relationship between social and 'psychological' components is seen in the habitus (a term Bourdieu later employed to a different purpose), which develops as a function of social interdependencies (Van Krieken: 1998: 60) and is characterised by the perpetual monitoring of self with hindsight and foresight, and which is taken on by the individual from the earliest part of childhood (Elias: 2000 [1994]: xi). The extent to which this is achieved represents the integration of the individual into extensive chains of action by conscious self-control or by habit. The civilising process for Elias refers to the development of technology, knowledge, ideas and customs (Elias: 2000 [1994]: 5) and the ways that these are passed from person to person across generations for as long as they remain functional or retain existential value (Elias: 2000 [1994]: 8). This is particularly useful in regard to ideas about motherhood and infant care in the period dealt with in this thesis, where customary practices gave way to new knowledge about physiology and pathology and the practice, context and outcome of mothering were consequently changed.

Elias argues for a process sociology that identifies the dynamic relationship between action and structure based on figurations as networks of interdependence (Mennell: 1992: 253). In this sense, process sociology can be understood as a means of overcoming the stasis introduced into theorisation of the social by, among other things the limitations of our spoken and written language, which reduces the movement or process features of what is being described to a static state, making the conceptual analysis of process difficult (Mennell: 1992: 253). This approach therefore calls for concepts that are better suited to the investigation of figurations as dynamic networks of interdependence (Mennell: 1992: 257). Motherhood, in this context, becomes mothering and the ongoing practices of mothering. This re-framing allows the practices of mothers to be explored as ongoing, context dependent and productive of socio-structural outcomes. The consequence of this is to show that perceiving infant deaths as overlaying around the construction of mothers as ignorant is not the only possible outcome, but one part in a range of possibilities. Instead, the process of meaning attribution can be unpacked to challenge dominant ideas about overlaying death and can be used to explore the meaning given by mothers and others to bed-sharing. The role given to hermeneutics in this thesis will be referred to in terms of the sense-making narratives employed by individuals to give meaning and legitimacy to their activities for their selves and others. Personal sense-making narratives, derived from what has gone before and adding to what follows, are the basis of order that emerges as an elementary point of intersection between psychogenesis and sociogenesis in Elias's theory. In turn this is also the basis of what has been described as structure through regularity (Mennell: 1992: 263), although this is not to claim that activities within figurations have any ulterior goal from which all functions can be explained (Mennell: 1992: 266). Order when used in this way refers not to the orderly conduct of individuals and society, but to the regularisation of society, whether orderly or not, and denotes a patterning of activities, behaviours and practices seen in roles and institutions.

In relation to the methodological approach taken in this thesis, what emerges (and must be overcome) is an impression of stasis; that time and therefore action are flattened to a single plane (that of the thesis), creating a sense that the events described have occurred in close space-time proximity. This occurs because the limited evidence related to overlaying and the small number of detailed accounts that are available are compiled together; and, despite careful attention to dates, as soon as events are ordered other than chronologically, for example by theme or geographic location, they appear as if without the separation of time (Certeau: 1992). This serves to undermine the notion of process that forms a central element of this thesis and is an issue that has been referred to by C. Wright Mills (1959). It is also a

feature of the way concepts such as motherhood or overlaying are constructed, conveying a rather static or fixed construction of an event or role when in fact they are both concepts referring to processes and there is nothing explicitly static or process reductive intended in the use of them. In fact, motherhood and overlaying both connote relationships with others (interdependencies) and as such refer to networks of ongoing interaction. Elias maintains that the explanation for any social question must be found in social relations and figurations rather than in any of its components in isolation (van Krieken: 1998:62). While he also allows for the possibility that in the long-term the transformation of both social and 'personality' structures can be lost from view of the individual (Elias [1994]: 2000: 450) as networks become more complex (Mennel: 1992: 260). The thesis draws these together within the research materials and makes them visible, despite the opacity of network relations to the individuals concerned. The overlaying death and the figurations in which it is comprised therefore provide the context for exploration of the changing role of mother and infant as socio-structural entities.

Moving on from Elias's substantive process sociology, Giddens offers a generalised and abstracted perspective in his theory of structuration (Giddens: 1979, 1984, 1991a), which has as its focus the ontological and philosophical rather than the substantive aspects of structuration. Giddens's (1991a: 204) stated aim in his formulation of structuration theory is to provide a conceptual scheme that allows understanding of how actors are both created by and are creators of social systems. The basis of Giddens's structuration theory is the premise that dualism (agency and structure) must be re-conceptualised as duality (agents in a recursive relationship with social structure) (Giddens: 1984: xxi). Giddens draws on a range of (sometimes opposing) theoretical positions to construct a theory that recognises structure as both the context and outcome of agents in action, but makes only limited reference to Elias in his exposition of structuration (Giddens: 1984). Giddens does, however, utilise the idea of psychological and sociological aspects of the individual existing in a recursive relationship as the basis society. Giddens's structuration theory offers a number of useful concepts for exploring infant overlaying, especially in regard to individuals and their knowledgeability, and to structure as a mechanism binding space-time (Giddens: 1984: 17). Giddens identifies social structure as the "rules and resources recursively implicated in social reproduction," which includes among other things normative elements and codes of signification (Giddens: 1984: xxxi). Structuring properties are the means through which space-time is bound within social systems; and institutions are those aspects with the greatest space-time extension (Giddens: 1984: 17). For the purpose of this thesis, an important aspect of Giddens's project is his incorporation of the 'linguistic turn' into the theorisation of



structure, giving weight to the role of language as a code of signification in construction of the social system. The role of language in the construction of infant overlaying death and the contested ground on which this is played out is a theme repeated throughout this thesis, with the evidence of mothers, medical professionals and others interrogated in detail to provide an account of the way meaning is attributed to unexpected infant death in bed.

Archer (2010 [1982]) has offered a vigorous critique of structuration theory and its rejection of dualism. Archer instead proposes a realist explanation of the interrelationship of structure and agency which recognises a discontinuity between initial reactions and their product. For Archer, this demands recourse to analytical dualism because, although action can be considered to be ceaseless, subsequent action occurs in a context which has been elaborated by prior action, thus making action dualistic and sequential (Archer: 2010 [1982]: 227).

There are several issues relevant to this thesis that emerge from Archer's (2010 [1982]) interrogation of Giddens's structuration theory. The first is Archer's real rather than analytical separation of the natural, practical and social spheres (Archer: 2007: 2), which places the social on a par with the natural and practical orders, so that within the framework she proposes there are times when resources are not 'entangled' with rules of signification and legitimation (Archer: 2010 [1982]: 232). The consequence of Archer's rejection of linguistic mediation between the self and the social world (Archer: 2007: 8) is to ignore that the use of natural or practical resources is shaped by socio-structural influences. It also ignores the fact that the differential malleability or mutability of structural properties is related to the who, when and where of their constitution rather than to some internal feature independent of human agency.

The second issue (and related to the first) is Archer's rejection of what she terms the 'linguistic fallacy' (Archer: 2000: 2). For Archer, there is a pre-discursive self which renders "our sense of selfhood independent of language" (Archer: 2000: 2). This gives practice primacy over language and rejects the "grammatical fiction" (Archer: 2000: 4) of the self that emerges from the linguistic turn in social theory. In this respect Archer has not precluded a discursive order, but instead rendered it a subset of the social order (Archer: 2000: 9), where the self is first learned through embodied practice and then expressed in language (Archer: 2000: 8). This subordination leaves social identity as a subset of personal identity (King: 2010: 257). But this is to ignore that the distinction between practice and language is an analytical one and that 'in life' practice and language are learned concurrently, with both incorporated simultaneously into the process. The other issue that must be noted is the claim that structuration theory fails to properly integrate temporality, leaving it unable to address

questions about when recursiveness or transformation will prevail (Archer: 2010 [1982]: 237). For Archer it cannot therefore provide a theoretical understanding of “structuring over time” (Archer: 2010 [1982]: 237). Structuring over time can, however, be interpreted to mean anything from the immediate horizon of action (Stones: 2005) to a period representing inter-generational time (Parker: 2006: 131). Emerging from Archer's critique is the useful question of whether or not analytical purchase can be had by exploring the primacy of a particular order – natural, practical or social - and whether one dominates at any given time or place or for any individual. For example, in the case of bed-sharing, do the natural, practical and social orders exhibit differing influence as a frame of action during the period detailed in this thesis, and can this be used as an explanation of the changes evidenced in relation to mothers bed-sharing with their infants?

Mouzelis (1989) extends the usefulness of duality beyond that suggested by Archer and has, as his main concern, the variability of relationships between agents and structures. While supporting a limited role for Giddens's idea of duality, he also claims that questions about agents and structures in highly differentiated social contexts (Mouzelis: 1989: 616) cannot be answered without recourse to subject / object dualism as an essential component of the analytical toolbox (Mouzelis: 1989: 613). Mouzelis identifies levels of the agent / structure relationship (practical, theoretical and strategic / monitoring), and suggests that, depending on proximity to structure, the agent is differently orientated (positioned) at each level and is therefore more (strategic) or less (practical) able to reproduce or transform structure. He asserts that the theoretical and strategic/monitoring orientations are distinct from the practical orientation that occurs in routine daily life and that there is a marked separation between subject and object at the theoretical and strategic levels (Mouzelis: 1989: 616). He also distinguishes between ‘lay’ agents as natural performative users of structure (Mouzelis: 1989: 617), experts who orientate themselves to structure at the theoretical or strategic level. It is through access and ability to deploy metalanguage that second order – secondary orientation - is achieved and for Mouzelis this can only be understood in terms of subject / object dualism rather than duality (Mouzelis: 1989: 617). But this is to omit metalanguage as a part of structure available to anyone with the means (position) to make use of it, and in this sense position themselves in regard to structure. In this sense, people shape and are shaped by structure and cannot be understood without recourse to duality. Unfortunately, Mouzelis's use of a distance metaphor shifts the analytical focus from the differently positioned agents with their variable ability to draw on structural rules and resource to the structure itself.

Mouzelis also discusses the relationship between agency and structure in terms of

social and system integration (Mouzelis: 1989: 621), thereby challenging Giddens's definition of social integration as interaction in conditions of co-presence and systems integration as interaction in conditions of non-co-presence stretching across time and space. Mouzelis outlines examples of co-presence where practical, theoretical and strategic / monitoring orientations are adopted and claims these have qualitative differences which require distinct analytical tools. He also suggests that the practical micro-processes of interaction have limited time space impact and that strategic / monitoring interactions have extensive consequences (Mouzelis: 1989: 621). This, however, does not acknowledge that it is not the structure that has changed but the individual in relationship to structure and other agents in different practice positions. It is not unthinkable that actions by individuals in the first category, by drawing on structure, set in motion extensive consequences while individuals in the second category do little to reproduce or transform structure beyond their day to day engagement as routine practice. The outcome of this for Mouzelis is that he rejects Giddens's structuration theory and claims that it cannot explain the relationship between agency and structure beyond the practical level of personal day-to-day interaction. He also proposes that at the strategic / monitoring level of orientation to rules and resources (Mouzelis: 1989: 622) explanation of the relationship between agency and structure can only be achieved by the use of subject / object dualism (Mouzelis: 1989: 624). This thesis goes on to explore qualitative differences in orientation between mothers in situations of co-presence and reciprocity in micro-contexts, on the one hand, and doctors, pathologists and coroners in strategic monitoring orientation to rules and resources, on the other and compares subsequent socio-structural outcomes.

In an effort to overcome some of the criticisms of Giddens's formulation of structuration theory, Stones (2005) has elaborated Giddens's theoretical framework to provide an outline of what he terms strong structuration. This has as its aim the support of Giddens's ontology-in-general with the empirical evidence of ontology-in-situ (Stones: 2005: 116). Strong structuration places its emphasis on the structural-hermeneutic core of the duality (Stones: 2005: 5). It is an attempt to move beyond Giddens's model of structuration which operates at the level of a general ontology about the nature of social entities over and above any specifically grounded example that might be found in particular social situations (Stones: 2005: 7). In this sense, it is Stones's intention to address criticisms of Giddens's theory by bridging the theoretical and substantive levels of structuration, bringing together ontology-in-general and ontology-in-situ to explore events and processes in specific times and places (Stones: 2005: 8). This thesis has at its core many detailed accounts of infant death which occurred at specific times and places which have been brought together in order

to explore the ways in which sudden and unexpected infant death in bed was constructed as overlaying or otherwise explained. And it does so by employing the “structural hermeneutic nexus [of] immanent moments of circumstance and agency, of medium and making [...] within networks of relevance” proposed by Stones (Stones: 2005: 6).

Constructed as a process model, strong structuration is comprised of four aspects described by Stones as the quadripartite nature of structuration (Stones: 2005: 9). These are: external structures as conditions of action; structures internal to the agent; active agency; and outcomes seen in terms of internal structures, external structures and events. The problem remains, however, in identifying the contribution of situated agents to wider social structures and the extent to which such structures can be shown to exert an influence on the individual (Stone: 2005: 10). This is exacerbated within historical sociology, where the interplay at the ontic level between social practice as the outcome of social structure over extended periods of time must be shown to occur in relationship to interactional patterns and the hermeneutics of their construction, as well as the internal structures of individual agents (Stones: 2005: 16). Despite this difficulty, strong structuration is characterised according to Stones by consistent relations between ontology-in-general and ontology-in-situ supported by empirical evidence (Stones: 2005: 116).

Stones takes ontological concepts such as knowledgeability (Stones: 2005: 80-81) and applies these at the ontic level to construct, for example, knowledgeability as “knowing, or lack of knowledge, of something or some things” and “more or less knowledge of that something or some things” (Stones: 2005: 81). Stones's work is, however, about working from the highly abstracted level outlined by Giddens and elaborating it to a point where it can be applied to the “agent-in-situ” (Stones: 2005: 8) in order to capture understanding of the agent-in-action. Stones addresses the issue in terms of directing ontological concepts toward a situated set of practices in order to bring them to the level of the ontic. The difficulty here identified by Stones lies in correlating the ontic level of conceptual framework with the empirical evidence in a meaningful way. With regard to historical sociology, the issue is further complicated by the requirement of a combination of structural diagnostics and hermeneutics, which for Parker (Parker: 2006: 126) places an unnecessary limit on the use of strong structuration as a methodological tool to empirical studies of “intermediate temporality of historical processes” (Stones: 2005: 81). The consequence of this is to restrict the usefulness of strong structuration as social theory while increasing its usefulness as an empirical research tool (Parker: 2006: 126). This issue aside, Stones is suggesting a method that raises in-situ questions about the hermeneutics of agents in combination with structural diagnostics (Stones: 2005: 117). In order to achieve this, methodological brackets informed

by the ontology of structuration as a guiding tool are used to analyse both the conduct and context of agents (Stones: 2005: 118), to make visible the intersection of agents and external structures as well as “the broader frames and dynamics of historical and social trajectories” (Stones: 2005: 118). Stones proposes the study of individuals in their relationships with social structural entities, leading to a mid-level theorising of agency and structure by placing the events of an individual's life within a broader historical or geographical context.

In his efforts to overcome what he sees as the totalising effect of Giddens's earlier formulation, Stones has also reduced the usefulness of strong structuration for exploring broad social structures persisting in the long-term (Parker: 2006: 126). Parker quite rightly states that social analysis must provide narratives about the emergence of the structures and processes being researched in the long, medium and short term (Parker: 2006: 131). The distinctiveness, however, of strong structuration lies in Stones's conceptual elaboration of internal structures (Parker: 2006: 129), which allows exploration of conjunctural constraints, probable sanctions, opportunities and (im)possibilities (Parker: 2006: 131). Although Parker acknowledges the sociological problematic of structuration, he disputes the need for structuration theory to employ the concept of duality to explain anything more than the emergent mature human being as the outcome of processes, forged by objective and subjective forces (Parker: 2006: 135) a view shared by Mouzelis (1989).

King (2010), however, identifies parallels in the theoretical concerns faced by Giddens and Archer and highlights that they have both moved away from their earlier concerns with ontological dualism to a position where priority is given to the autonomous self (King: 2010: 257-8) and the playing out of determinism and voluntarism. In Archer's work, this is seen with her focus on reflexivity (King: 2010: 256); and in Giddens's work, this is seen with his departure from structuration to exploration of the individual in conditions of modernity, as seen for example in his work on intimacy (Giddens: 1992). In respect of this thesis, the question must be asked whether Archer's analytical dualism or Giddens's methodological brackets offer substantive methodological help in the research process and whether either can answer the question of how infant overlaying death was constructed and drawn on in the processes of experiencing and dealing with actual instances of child death. Each position, in effect, isolates or reduces the focus of concern, and by doing so renders some details central and others peripheral. The selection of material detailed in this thesis has been made in order to overcome an over-reliance on one perspective on the issue by using multi-temporal and positional accounts of infant overlaying death. In this sense, the debate about duality or dualism has been bracketed. Ultimately the question is not whether dualism or duality are adequate concepts for exploring the relationship between

agency and structure, but at which points analytical dualism or duality serve to meet the concerns being given analytical attention. This echoes Abrams's (1983: 227) demand to 'unthink dualism' while simultaneously recognising the practical difficulties of doing so.

### **The individual, knowledgeability, sense-making narratives and reflexivity**

Giddens offers a model of knowledgeability that is particularly useful within the context of this thesis when considered in regard to infant overlaying death, for overlaying was considered a distinct and discernible category of death by those whose knowledge, views and opinions were given weight according to the distribution of status or power / knowledge. Knowledgeability refers to the internal 'structure' of an agent's knowing 'how to go on' in a particular situation. It includes practical understanding as well as the meaning attributed to action by oneself and others (Giddens: 1979: 64). In addition, knowledgeability in terms of Giddens's unconscious, practical conscious and discursive conscious provides a useful conceptual tool for exploring the differing ways in which individuals know how to go about their activities. By unconscious, Giddens means a pre-discursive form of knowing that has in some sense been forgotten but remains and is manifest or experienced as a kind of instinct or drive. The unconscious knowledge of individuals plays little part in this thesis and I make no call on it in my exploration of overlaying deaths. Practical and discursive consciousnesses, on the other hand, have significant contributions to make as part of the conceptual framework for explaining the changing ways in which overlaying death was constructed, in particular the re-categorisation of overlaying from a natural to a violent death.

Practical consciousness – the knowing 'how to' of a thing – and discursive consciousness – as the rational knowing of a thing – are forms of knowledge and understanding that can be used to explain the way in which mothering was transformed from the practical caring for infants to the practice of mothering and motherhood as a socially constituted reflexive category or role. Giddens (1984: xxix) suggests that practical consciousness should be incorporated into research work, and the 'how to' of infant care forms a central theme in this thesis. As women went about the business of caring for their infants in the cases detailed, it is apparent that many of their activities were portrayed as simply things that they 'do'. When the situation called for women to explain their actions, their explanations can, at times, seem hollow with little or no rationalisation of their actions. Of course this may be an artefact of the historical record or of the women's (in)ability to articulate their motivations, but (and I will go on to elaborate this claim) it can also be taken to suggest that mothering was not always undertaken in terms of a rationalised or discursive practice, and this reflects Giddens's distinction between what can be said and what is simply

done (Giddens: 1984: 7).

The question raised here is: can practical consciousness and discursive consciousness provide a sufficient conceptual mechanism for explaining the changing way in which women were described as taking care of their infants and conducting themselves in regard to (among other things) sleep practices and bed-sharing? If this is the case, the further question then arises, can the practices around infant care and bed-sharing be explained as transitions from practical to discursive knowledge, where infant care moved from something that was simply done to something that was thought about, spoken about and rationalised to oneself and others? Importantly, having undergone this transition, perhaps infant care should no longer be understood in any terms other than as discursive knowledge and practice. At times when women had no explanation for their actions and were pressed for this, their lack of discursive response was interpreted as a lack of care or ignorance. The understanding underpinning this concerned overlaying as an intended or unintended consequence of bed-sharing, with it being the intentions of the mother that were seen to constitute overlaying as an accidental death. Today, the absence of discursive knowledgeability and reflexive practice still leaves women as child bearers and mothers at risk of being attributed with sometimes pathological psychologies, for example, when they claim ignorance of pregnancy or an impending birth. A discursive knowledge (awareness) of pregnancy from its very earliest stage is now considered a responsibility of all women. To fail in this respect is to be inadequate in the role.

Stones (2005: 130) employs the concept of sense-making narrative as a way of exploring how individual agents engage with social structures. The sense-making narrative must therefore emerge from the internal structure of the individual as part of the interaction between general-dispositional and conjuncturally specific knowledge, although Stones (2005) does not state this explicitly. It also follows from this that there must be a degree of convergence or overlap between the sense-making narratives of different individuals in order for them to conduct relationships in a meaningful way. The distinction between sense-making narrative and discourse is, however, unclear except for the suggestion that sense-making can be understood as part of an internal process, while discourse in its broad meaning relates to both internal and external aspects of all that can be said, done or thought about something. In this thesis, for example, my own sense-making narratives are incorporated into the research process and are organised around knowledge of concrete events combined with categories such as motherhood, infant mortality, overlaying, nation and maternal culpability, drawn together in order to identify and explore particular people engaging in relevant particular practices at specific times and places.

In these situations, ideas are expressed by people through language and practice as an aspect of discourse. This is achieved through combining actions and practices within a framework that categorises particular practices together to provide both description and explanation of them. By juxtaposing these case studies and accounts of individual agents-in-action, I show that separate and unique events demonstrate patterns that cannot be explained from a perspective that remains focused within the specifics of the particular event or individual. This reflects theoretical transition from ontology-in-general to the ontic level or ontology-in-situ (Stones: 2005). Despite his optimism for strong structuration as a methodological tool, Stones recognises the practical problems that limit its use in historical sociology. Consequently he suggests that the most that can be achieved is to identify points of connection between “such broad trends and parameters and certain key aspects of the duality of structure and the quadripartite nature of the structuration cycle” (Stones: 2005: 127). In this respect, ideology can be employed to provide a sense of the general dispositions of particular groups of agents, as a starting point to look for “more detailed evidence as to the cultural schemas inhabiting particular actors” and also explore “how such aspects of their schemas are combined with other relevant cultural ideological and bodily dispositions and orientations” (Stones: 2005: 136). This points toward a method which is employed in interrogating the extended correspondence and other interaction between doctors in south west London, specifically pathologist Ludwig Freyberger and coroner John Troutbeck, where infant overlaying death provided the focus of an ongoing dispute about roles and authority, and the interpretation of overlaying as a death event.

Stones's approach raises the question, what can be taken as appropriate and sufficient evidence of the internal schemas of actors? That is, how can the reports and letters taken from archival sources be interrogated in away that provides useful information about the way the internal schemas of individuals are constituted? In addition and relatedly, there is a requirement to identify the discursive elements within a particular general-dispositional schema before claiming any causal significance for ideology in a particular context (Stones: 2005: 137). What this demands is an analysis of agents' conduct-in-situ that describes the interplay between the individual's general disposition and conjuncturally specific knowledge of external social structures (Stones: 2005: 138). This can, for example, be drawn from the reports made by doctors following a sudden infant death in bed and which they subsequently interpreted as overlaying. There is, inevitably, a gap between the discourse in analytical terms, and its manifestation at the point of situated action. Stones deals with this around the idea of incompatibility between new discourse and existing general-dispositions or the in-situ difficulties and the practicalities of situated action (Stones: 2005: 141), which can also



be seen in the disputes about the way sudden infant death in bed was defined and attributed. This approach therefore raises the problem of how it can be claimed that a particular discourse exists within the knowledgeability of an individual and is contributing to their general disposition. In this way, Stones's (2005) reworking of structuration theory as strong structuration points to the need for ways of addressing mid-level questions about the interaction between structure and agency and is taken up in exploration of the research materials.

Archer's exploration of the internal conversation and reflexivity (2000; 2007; 2010 [1982]) also offers theoretical purchase on the idea of sense-making narratives in terms of the subjective internal discussions that, for her, represent the most appropriate use of duality-of-structure as a conceptual tool. Reflexivity in this sense is the mental ability of actors to consider themselves in relation to their social context and is crucial in mediating what actors are concerned to achieve and the social enablements and constraints they confront in doing so (Archer: 2000: L2). Importantly, Archer (Archer: 2010 [1982]: L7) asks, is reflexivity a homogeneous practice for all people at all times, or does it show significant variations over history? This point is particularly useful in addressing my own research questions regarding motherhood as a reflexive and changing practice against a background of increased social reflexivity and pressure for individuals to become more reflexive as society moved from a traditional to modern order (Archer: 2007: 32). There are problems, however, with substituting first person meaning with third person interpretation (Archer: 2007: 77), and this is a difficulty in the exploration of meaning within a historical context. The reflexive internal conversation has been outlined by Archer as occurring in four distinct modes - communicative, autonomous, meta and fractured (Archer: 2007: 93) - with the communicative mode, unlike the others, serving a recursive function as well as being manifested externally in dialogue with others. Archer explains communicative reflexivity as sharing contextual continuity with 'similar and familiars', where people speak in the same way, share word meanings and draw on a common stock of references and experiences (Archer: 2007: 84). From this, can it be assumed that in conditions where traditional mothering practices dominate, that the communicative mode of reflexivity might also dominate? If this is the case, then asking questions about the internal conversations of mothers evidenced in this thesis could shed light on their understanding and the meanings they attributed to their care practices and the sudden death of their infants. These activities can show subjects considering themselves in light of their circumstances and in relation to society (Archer: 2007: 92) and may be represented by phrases such as I thought, thought to myself and thinking things over detailed in witness statements. Archer does not follow the

development model of psychogenesis offered by Elias, but instead suggests that changes in the social environment influence the mode of reflexivity that predominates at any one time but without being responsible for the human capacity to practice any particular mode (Archer: 2007: 314-5). Archer is equally clear in her claim that the types of internal conversation which prevail at any particular time, while dependent on various combinations of contexts and concerns, cannot be reduce to either (Archer: 2007: 315).

Giddens (1984) conceptualises structure as the rules and resources recursively implicated in social reproduction (Giddens: 1984: xxxi). Rules include normative elements and codes of signification and resources can be either authoritative or allocative. Institutional features of the social system have structural properties in the sense that relationships are stabilised across space and time (Giddens: 1984: xxxi). Giddens's use of structure is therefore intended to loosely denote the institutional features of a society (Giddens: 1984: 19). Rules can be understood as techniques or generalised procedures applied to the enactment of social processes (Giddens: 1984: 21). In this sense, agents are always rooted within a structural context and draw on their knowledge of this in their purposeful action (Stones: 2005: 170). Within Giddens's theorisation of structure, an analytical distinction is made between three types of structure: domination, signification and legitimation reflecting power, meaning and norms respectively (Giddens: 1979: 82). However, Giddens's definition of structure has led to the criticism (Archer: 2010 [1982]: 231; Stones: 2005: 18) that structuration theory fails to differentiate between those actions which replicate and those which transform society. In other words, it cannot tell us when actors are constrained and when they are enabled by social structure. How, then, does this definition of structure play out in relation to infant overlaying death in regard to the rules and resources relating to infant care, sleep arrangements in poor households and bed-sharing at a time when bed-sharing was both common yet bad practice? This could be interpreted as a transition in the rules governing mother infant bed-sharing, from Giddens's informal tacit to formalized discursive (Giddens: 1984: 22), as represented by demands to legislate against bed-sharing. Alternatively, and according to Giddens's interpretation of rules as both procedure and resource, the apparent contradiction could represent the playing out of authoritative resources used by coroners against the procedural rules governing the practice of mothers in relation to bed-sharing with their infants in a social context where neither had yet gained dominance.

Archer discusses structure in terms of constraints and enablements for the projects of human agency. Importantly, she identifies three structural orders (natural, practical and social) which operate in parallel to form 'natural reality' and to which she attributes

automatic causal powers (Archer: 2007: 7). The social order is comprised of both structural and cultural properties (Archer: 2007: 7) which, along with those of the other orders she discusses, serve as the pre-conditions of action. Archer's social order (which is neither subordinate to nor subordinating of the other orders) is conceived in terms of a social system that is 'causally efficacious' rather than reified (Parker: 2000: 71) and also without self-producing properties. Archer suggests that the conditioning properties of the social system allow for both social reproduction and transformation through the activities of reflexive human agents (Archer: 2007: 10). Archer's concept of reality orders allows infant care to be explored as an issue that was relocated during the nineteenth century from the natural to the social order, signifying the change from infant care as something done naturally by women as mothers to a reflexive practice that was accountable in terms of rationalised action.

Stones's (2005) concern with structure leads him to elaborate Giddens's idea of rules and resources so that it becomes useful at the level of the situated practices of individual agents and can be used in understanding the contexts they confront. But in doing so he also claims that strong structuration must draw on more conventional notions of structure (such as class or the family) to act as framing devices for situating the point of intersection between individuals and their biographies with the forces of history and social structure (Stones: 2005: 6). At the mid-level, Stones adopts the concept of position practice relations (Stones: 2005: 93), and sees this as extending beyond the reach of Giddens's socio-spatial presence to encompass the conditions of action faced by an individual through their network links with others. And these others of course also face their own infra-structures, interdependencies, reciprocities and relationality "stretched away in space and time" (Stones: 2005: 93). The use of network links and interdependencies (echoing the earlier Elias) has particular relevance in this thesis, where extended networks of interaction (whether or not they are visible to the individual) serve to constrain, enable, and connect the mothers, infants, doctors, pathologists, coroners and many others involved in the child deaths they are concerned with, through their own position practices and relations to one another.

The death of an infant in bed was an event viewed across the time-period dealt with in the thesis as comprised of both extrinsic and intrinsic factors. Extrinsically, the dead infant body was seen as subject to pathology, malformation, disease or act of God which resulted in a physiological condition not conducive to the continuance of life. This was a form of explanation that did not rely in the first instance on locating causality within socio-structural conditions of action. This was perceived as a natural death separated from social influences. Intrinsically, the death of an infant in bed was explained in terms of social action and structure. In this case the dead infant body had arrived at its condition because of the conduct

of others, whether by omission or commission, with the overlain body being one from which life had been expelled by another person or thing and, unable to breathe, the body died. Importantly, the explanation of overlaying death had strong intrinsic socio-structural features. The overlaying death was categorised and explained via an intrinsic framework of cause attribution largely without recourse to extrinsic features, because the overlaying death was categorised, described and explained in terms of human activity and meaning, and was therefore a socially constituted death event. In this sense, overlaying death was an event and an outcome, as a point in the cycle of structuration; but to this it should be added that an overlaying death was also part of a social process and as such was ongoingly conceived and understood.

Before it could exist as a socio-structural event, an overlaying death had to exist as a possibility on the horizon of socio-structural possibilities. That is, a death could not be described as overlaying until it was defined and explained as such. Indeed, in one sense, along with other bodily dispositions such as touching, suckling, resting and sleeping, this form of death has probably always existed as a possibility because of the bodily dispositions of mothers and infants during these activities. There is, however, a distinction to be made between the two expressions: the infant is dead and the infant has been overlaid. It is the transition between the first and second statements where the social construction of overlaying occurs. The first statement represents an acknowledgement of death, while the second represents a causal explanation of the death. In this way, the overlaying death provides a point of intersection for a network of socio-structural features – agents, structures, action and events; and because of this, the substantive, empirical investigation of overlaying death also provides an opportunity to explore the interrelation of these features of structuration.

This thesis will detail many cases of sudden infant death in bed, some of which were explained as overlaying, while some were attributed to natural causes. In some of the cases the mothers claimed or accepted the explanation of overlaying as a cause of death, while in others overlaying was refuted as an explanation. All of these cases were connected via a network of relationships and interactions that intersected at the point at which the prospect of an overlaying death existed as a possible event outcome. That is to say, they were not necessarily connected by the actual deaths of the individual infants involved, but by the idea of overlaying as it was applied or implied around each death. This is the discourse of overlaying as manifested through individual agents, practices and conditions. Overlaying was constructed as an event and outcome of a process wherein internal and external structures served as conditions of agency which in turn shaped further events, outcomes and

processes providing the context of further action. The complexity of the variables - structures combined with agency – involved in constructing overlaying as an event were such that it is not possible to describe every single one. However, through a methodological process of selecting, analysing and comparing multiple substantive instances of overlaying, it is possible to build an account and ontology of overlaying.

### **Analysis, content and parents as knowledgeable reflexive agents**

Hettie White claimed that she had overlaid her infant, Percy, and so caused his death. Percy's father, Mr White, also thought that Percy had been overlaid. However, Dr Parker GP, and Dr Ludwig Freyberger, pathologist together agreed that this was not the case and attributed Percy's death to natural causes. Coroner John Troutbeck, and the inquest jury accepted the explanation of death attributed by Freyberger and the death was recorded as due to natural causes. Other mothers also claimed overlaying as an explanation of their infants' deaths (Wheeler, Mussell), while in yet other cases the possibility of overlaying was refuted by them (Lyth, Jenny). In one case, Margery Bax had been found dead in bed with her mother and nurse although there had been a cot available in the room. The infant's father, Frederick Bax, said that they should have placed the infant in the cot to sleep but they had not because his in-laws had advised that it was better for the child to share its mother's bed for the first few weeks. In all of these cases, overlaying as an explanation of death existed as one possibility on the horizon of possible outcomes and formed part of the contextually specific knowledge of the mothers and other people involved as social agents.

Social agents analyse the circumstances of their lives (Archer: 2007: 22; Giddens: 1984: 191) Stones: 2005: 121) and therefore the knowledge of mothers (and others) as agents in the context of sudden infant death in bed must be taken fully into account in this thesis. Knowledge in this sense includes general dispositional knowledge (concerns, purpose, motives and desires) and contextually specific knowledge about how to carry out the work of interaction as it unfolds. This is a reflexive process which entails the individual's evaluation of their social situation in relation to their personal concerns and projects (Archer: 2007: 22). The mothers in these cases can be understood to have undertaken care of their infants in relation to concerns which may have extended beyond their immediate context and which included issues other than infant welfare. They would have been defined in relation to the context of their mothering, with their actions subsequently derived from reflexive deliberation. This reflects Archer's idea of practical projects developed in relation to objective circumstances (Archer: 2007: 17) and Stones's position practices (Stones: 2005: 93).

Pathologist Freyberger's records suggest that Hettie White had knowledge of overlaying as a possible death event and that this included knowledge about the risk of bed sharing and the positioning of bodies within the bed in order to reduce risk. For example, Hettie placed her infant on the pillow, not on her arm, and therefore away from her, thus suggesting concern about the infant and its sleep position. Hettie claimed to be a heavy sleeper and also that she had awoken to find her body partially covering the infant. She had felt pain in her arm, but she also stated that Percy's nose was not flattened. These details suggest that Hettie had knowledge of overlaying which included acting to mitigate its risk. It also suggests that Hettie recognised the possibility that she had caused Percy's death but did not fully subscribe to this explanation. She did, however, interpret the infant's death as her failure to act in accordance with contextually specific knowledge about infant welfare and the perceived risk of bed sharing.

In the case of Margery Bax, this is seen clearly when Margery's father explained his wife's actions (bed-sharing when a cot was available) in terms of views expressed by his in-laws, which indicates a point where their contextual knowledge was linked to the general dispositional frame of Mrs Bax's relationship with her parents. Once motivation, knowledgeability and rationalisation and reflexive monitoring (Stones: 2005: 24) are taken as points of reference, then Mrs Bax's action can be understood in terms of these dimensions organised around her concerns about her infant, her knowledge of overlaying, and her relationship to her parents. The possibility that the infant Margery could have been placed to sleep in a cot indicates that other factors took priority over the immediate concerns. One feature of the situation that might have had significant influence was the presence of the nurse sharing the bed with the mother and infant which suggests at least the nurse's acquiescence with the infant being placed in the bed, or at most her insistence that this should be the case. The presence of the cot and the actual sleeping arrangements in conjunction with Mr Bax's statement regarding the cot suggest that the issue of bed-sharing or otherwise had formed part of the deliberations of the parents (and nurse) in relation to the infant's welfare. This thesis goes on to detail many such cases of sudden infant death in bed recorded from a wide range of social positions, with the aim that alongside the micro-context of the mother and infant, mid and macro contexts are also presented so that overlaying is explored and analysed in relation to the lay, professional and nation-state perspectives of witnesses, juries, doctors, health care professionals, coroners and law makers.

The network of interdependencies demonstrated when looking in detail at an overlaying death extended to encompass other individuals and institutions connected to such a death through (among things) the discourse of overlaying and the event outcome and

process. In this way, Hettie White as a mother is located within a network of relationships, practices and actions. This includes her relationship to Parker and Freyberger and through them to institutions such as the British Medical Association (BMA) and the London County Council (LCC) and then further through influential media publications including the Lancet and The Times in which discussion of overlaying took place. Hettie and her deceased infant Percy were also situated within a network that linked them to the coroner, John Troutbeck, and so to the inquest process, which was in turn reported in the press as well as being recorded as part of government recording procedures including inquest verdicts and death registrations. The intimate details of the post-mortem were recorded by Freyberger in his records together with those of other infants who had died suddenly and unexpectedly in bed. Government records of infant death were categorised and the deaths of infants were recorded by cause as well as in number. At this point, the death of Percy White diverged from the death of other infants, such as George Foote in St Pancras, because Percy's death was classified as due to natural causes while George's was classified as the result of a violent death – overlaying.

Elsewhere, Dr Ludwig Freyberger was the subject of much activity and discussion by GPs in south West London, by members of the BMA, by coroner, John Troutbeck, by the LCC, the Lord Chancellor, Parliament, members of inquest juries, other coroners, and also correspondents to the Lancet. Throughout the conduct of these interactions, overlaying formed a central theme and issue. An unnamed infant whose death was recorded as occurring at 76 Speke Road on 2 January 1903 was described by Dr McManus as having been overlaid. Freyberger was requested by Troutbeck to perform a post-mortem examination, from which he concluded that the death had been due to natural causes. An inquest was held and the verdict recorded. But this death formed part of a complaint that McManus made about the work of Troutbeck as coroner and the involvement of Freyberger as pathologist. Consequently this overlaying death became the focus of disagreements between the local GPs and John Troutbeck, between the BMA and the LCC, also drawing in the Lord Chancellor, with legislation about the conduct of coroners subsequently becoming the focus of debate between legal counsel representing the LCC and the BMA. In this the conduct of LCC's accounting practices and the authority of the coroner and the LCC were challenged. In this way, the overlaying death in Speke Road was linked through the GP's action to socio-structural aspects and transformations of the judicio-legal system. Importantly, the Speke Road case was discussed throughout as an instance of overlaying, although it was officially recorded as a death by natural causes, with it being the right to interpret and attribute overlaying as a cause of death that formed the basis of the challenge made by

McManus and the BMA.

There are other structural outcomes that could have occurred as a consequence of an overlaying death and these too are connected with its intrinsic features. Among these are the post-mortem examination and the inquest. Although the post-mortem and the inquest are commonsensically connected, this link is not inextricable. The post-mortem is a medical process linked to the judicio-legal role of the inquest in identifying, describing and explaining social or physiological pathology, but it also exists as a formative aspect of medical knowledge. The post-mortem is at the same time a foundation of such knowledge and also a claim to know in the light of this. Both of these aspects are based on the interpretation of bodily signs, but also such interpretation of a death comes under the sign of power / knowledge.

The post-mortem is recognition that death is not yet fully explained and at the same time an indication that an explanation of such a death is required. The post-mortem is the process through which the immediate pathological cause of a death is made visible. Expert pathologists, through one aspect of their work, identify the pathological causes of a death and categorise them as either extrinsic or intrinsic in origin. In this sense pathology can be ordered in terms of events that have been caused by chance, by oneself, or by others; and the boundaries between these categories remain complex and porous, because knowledge, interpretation and morality change through time. The role of the pathologist and the post-mortem in constructing overlaying deaths is interesting because throughout the period dealt with in the thesis they remained ambiguous. This was a contested area where the pathology of overlaying was found to be elusive and the contextually and conjuncturally specific knowledge of the pathologist could be challenged. The knowledge of pathologists relating to overlaying death was not uniform and was characterised in particular by its dependence on noting an absence of bodily signs. Overlaying, then, was an outcome in the sense that it was an event, but it was also an outcome in the sense that it was represented in both internal and external structures (Elias's psychogenesis and sociogenesis). The moral categorisation of death can be seen in the inquest as another outcome of overlaying death. It is interesting to note that overlaying was not the only fatal event to occur through bodily disposition. There are many other possibilities, with the dropping of an infant offering a good comparator but at no point was there widespread moral panic about the dropping of infants by their mothers, which equally could have been done carelessly, wantonly, drunkenly, ignorantly, causing death either deliberately or accidentally.

What is the outer limit of an overlaying death as a social event and outcome? Can all of the factors that contribute to such an event be unravelled at the point at which the event is



said to have occurred? The terminology of structuration theory suggests that it is possible to delimit an event, but perhaps it is better to think in terms of the continuous unfolding of action (Elias's bounded and unbounded). Here events are points of significance that may lead to either structural change or reinforcement, even if this is only in terms of an increased or decreased possibility on a horizon of events. In either case, the ways in which sudden infant death in bed was interpreted and attributed as overlaying, and the consequences of this in terms of individuals in socio-structural contexts, provides the subject for the discussion that follows.

## **Conclusion**

This chapter has demonstrated that sociological investigation is needed to provide a socio-structural explanation of infant overlaying death as an historical event. As the reported number of overlaying deaths increased during the nineteenth century the consistent lack of definitive pathology identified at post-mortem suggests that the attribution of overlaying as a cause of death owed more to the social context of the death than to medical scientific knowledge, and as such the tools of sociology provide a useful means of interrogating the research materials detailed in this thesis. As well as describing the context and circumstances of the many overlaying deaths that follow, this thesis provides a useful insight into everyday activities around infant care, motherhood, childbirth, death, the post-mortem examination and inquest c1900, especially in relation to the way women as mothers organised and represented their role and how this was interpreted by others.

Throughout this thesis, the circumstances of many overlaying deaths are detailed and this casts light on the intimate detail of household life in Somers Town, St Pancras and also in south-west London c1900. In this way, ideas about intimacy and the organisation of household space and time especially in relation to the bed and bedroom are explored. Beyond this, the practices of doctors, pathologists, coroners and the inquest process are also investigated, to provide an understanding of the process as it was acted out in relation to sudden infant death in bed, constructing some sudden infant deaths in bed as overlaying and others as due to natural causes.

Behind this there looms the shadow of maternal infanticide, conceived as perhaps the most unnatural of murders and which challenges the everyday constructions of motherhood as both natural and caring. This suggests that motherhood is never based on an innate or natural role and that recourse should be made to sociology to provide social explanations of (non) normative 'unnatural' but irrevocably social behaviour.

This chapter has drawn on the work of a number of social theorists to provide

conceptual tools for an investigation of infant overlaying death. The work of Anthony Giddens (1979; 1984) through his theory of structuration provides a useful means of exploring the way that mothers enacted motherhood and infant care through their knowledgeable ability as agents using their practical and discursive knowledge. Importantly, Giddens places emphasis on the role of language and the 'linguistic turn' in developing understanding social life, and this is particularly important in my discussion of discourse as a form of knowledge. Archer (2000; 2007; 2010 [1982]), despite her rejection of the 'linguistic turn', provides a particularly useful conceptualisation of the 'internal conversation' and reflexivity as a means of elaborating Stones's (2005) 'sense-making narratives' offering one explanation of how individuals negotiate the constraints and enablements of the socio-structural features of society. Agents must also be understood as acting in relation to structures. Archer (2010 [1982]) suggests that there are orders of reality in addition to the social order that must be addressed to understand the behaviour of individuals, while Mouzelis (1989) suggests that there is a qualitative difference in orientation to socio-structural features. This is helpful in considering the relationship between mothers (in situations of co-presence) and doctors, pathologists and coroners (in strategic monitoring orientations to rule and resources). To this is added Elias's (2000 [1994]) idea of process sociology, using figurations and networks to explore the interdependencies between social agents, something which is particularly useful in understanding the interconnectedness of embedded agents in the acting out of their roles across space and time and also in recognising change over time. Used in combination, these ideas provide a tool-kit for exploring, conceptualising and providing a socio-structural explanation of infant overlaying death as an historical event.

The material described in this thesis is drawn from a range of sources and comprises a historiography of infant overlaying death. The material can be divided approximately into three categories: 1) those relating to individual infant deaths such as the post-mortem examination reports of the pathologist Dr Ludwig Freyberger, reports of inquests from the St Pancras Guardian and The Times and the Coroners' Registers of the period; 2) those providing contextual information such as the 1901 Census records, Charles Booth's poverty notebooks, reports of government commissions and the Reports of the Medical Officer of Health for St Pancras; 3) and those that detail the professional disputes between general practitioners, Dr Freyberger and coroner John Troutbeck, such as the Lancet and the British Medical Journal. These sources are used to provide information about the dates, times and circumstances of infant deaths, the pathology of the dead infant bodies, eyewitness testimony, family context, occupations, inquest verdicts, population densities, background

information on local events, crimes and politics, and the day-to-day and professional understanding of overlaying death gleaned from its discussion in official reports and the press. Underlying this compilation of detail is the assumption that something of the past can be understood from archival documentary sources in order to develop an analysis of events from afar in order to chart historical sociological change. The methodological problem is therefore the problem of building knowledge of action and socio-structural contexts at a past point in time (c1900) and also across an extended period of time (1837-1920). In addition to the methodological issues associated with employing historical documents (in particular representation and the authenticity of reported voices), the surviving archival sources are incomplete, either because they were never preserved or because they have subsequently been lost or destroyed. In order to overcome this problem, a range of sources has been used to provide depth to the topic.

To this point, the thesis has set out the theoretical framework that will be used to explore infant overlaying death as a socio-structural historic event. Chapter Two will go on to expand on the issue of infant overlaying as a sociological problem and explore in detail the sociological concepts that must be employed in understanding the way overlaying death was categorised. This chapter also explores current debate about overlaying and challenges any unproblematic acceptance of overlaying or its reinterpretation as sudden infant death syndrome (SIDS). In addition, it also examines many of the conceptual themes which can be used to explore overlaying death, such as motherhood, childhood, death, the family and intimacy and shows how overlaying as a category of death may have developed and increased within its broader social context.

Chapter three explores public representations of overlaying through the nineteenth century, charts medical, legal and broader social interest in overlaying and examines the way that women as (potential) overlaying mothers were portrayed as ignorant, neglectful and feckless. This chapter shows the way that the discourse of overlaying was deployed across a wide range of issues, such as infant mortality, national efficiency and temperance, and also demonstrates the lack of consensus (especially within medical discourse) about the overlaying diagnosis. It also explores the ways in which the discourse of overlaying was employed across a variety of contexts and that overlaying provided a conceptual container into which all manner of infant death could be placed.

The fourth chapter outlines cases of overlaying that occurred in Somers Town, London, between 1899 and 1902 and discusses the way that these were portrayed in public representations of overlaying. This chapter explores the role of geographic space and its utilization in the life and death of overlain infants in Somers Town and asks the question of

whether or not infant overlaying occurred as a consequence of overcrowded living conditions and poverty. This chapter shows that in Somers Town accidental death by overlaying was the routine verdict in such cases.

Chapter five analyses detailed records of the post-mortem and inquests of twenty-two new born infants from the case records of pathologist Dr Ludwig Freyberger. The inquests for these deaths were held by coroner John Troutbeck in Battersea, Lambeth and Wandsworth, south London, between 1908 and 1912. These records were selected because Freyberger himself had recorded that the infants had been found dead in bed. The case records provide detailed information about both the body of the deceased infant and the immediate situation of their death taken from the inquest evidence. This chapter details the way that the responses of mothers (and others) were presented in the judicial system and also that juries routinely returned verdicts of natural death in such cases. It also highlights the 'absence' of mothers from the proceedings but also, through the reporting of others, demonstrates the ways in which mothers acted to look after and safeguard their infants and shows that instead of the routine ignorance and neglect with which they were sometimes portrayed, many of these women acted to ensure the welfare of their infants.

Chapter six explores the long running dispute that occurred between the medical doctors of south west London, coroner John Troutbeck and his pathologist Dr Ludwig Freyberger, much of which was focused on the issue of overlaying and the role of GPs in the inquest process. This points up the ways in which disputes about medical knowledge, knowledge claims, status and national identity became crystallized around the issue of infant overlaying, while the overlain infants themselves were marginalized within the debate. This chapter demonstrates that overlaying became important in issues to which it was peripheral. The chapter also examines the ways the overlaying thesis was employed through the lens of one particular issue, demonstrating that overlaying had become a diagnosis which was detached from aspects of medicine and pathology in which it was supposed to be embedded.

Before moving on to the substantive research materials the next chapter will show how overlaying can be understood in terms of a sociological problem and provides detail of the key concepts and ideas required for this task



## **Chapter Two: The Sociological Problematic: Categorisation, Sequestration, Infant Mortality and Overlaying**

### **Introduction**

Each year in England and Wales a number of infant deaths are still attributed to overlaying. In 2007, the latest year for which records are currently available, the total number of neonatal infants (i.e. under 28 days) recorded as accidentally suffocated or strangled in bed was 3 (2 male and 1 female) (ONS: 2009b: 72)<sup>1</sup>. The category of overlaying offers a seemingly persistent explanation of infant death in bed that has been reported since the seventeenth century when these deaths were recorded in the 'Bills of Mortality' (Jordan: 1987: 90). From 1837 to 1885, overlaying deaths were reported annually by the Registrar General and the number of deaths in each year was low. In 1839, for example, the number of deaths reported was 32 (*The Times*: 31 December 1841: 3: C) and the highest recorded incidence in any one year was in 1871, when 277 deaths were reported (*The Times*: 18 October 1873: 7: E). Between 1880 and 1906, however, the number of infant deaths referred to as overlaying increased many times over and overlaying deaths were reported to have numbered in the thousands each year (Jones: 1894: 40).

In sociological terms, the death of an individual infant diagnosed as due to overlaying has to be explored within its wider social context and the linkages between the diagnosis and the context of death teased out. This is a complex and challenging task, and an analytical distinction has been made here between three modes of conceptualising overlaying. This chapter therefore also sets out a typology of overlaying in terms of overlaying as myth, thesis and discourse.

This chapter also discusses sociological concepts that can be used to gain purchase on infant overlaying as a socio-structural historical event to provide an explanation of its reported increase and subsequent decline. Particularly useful in this respect are sociological theories about the sequestration of death (Elias: 1985; Giddens: 1992; 1993; Lee: 2008; Mellor & Shilling: 1993; Prior: 1989; Stanley & Wise: 2011; Wilmott: 2000), intimacy (Giddens: 1992; O'Malley Halley: 2007), the family (Aries: 1962; Donzelot: 199), motherhood and mothering (Blaikie: 1995; Davin: 1978; Dyhouse: 1978; Lewis: 1980; Oakley: 1990), the infant and child (Hendrick: 1997; Jenks: 2005; Jordan: 1987), child protection (Ferguson: 2004; Jackson: 2000), infant mortality (Armstrong: 1986; McLeary:

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1 See Appendix One for a discussion of overlaying in relation to Sudden Infant Death Syndrome (SIDS).

1933), domestic space and the bed(room) (Crook: 2008), and the body (Howson: 2004; Inglis & Howson: 2001). From this, the thesis offers an explanation of why the diagnosis of infant death in bed as overlaying first increased and then subsequently declined between 1880 and 1906.

Acceptance of overlaying as an explanation of infant death in bed often owed more to attitudes about working class mothers and infant mortality than to the actual death of individual infants, and it is not surprising that overlaying appears in the wider discourse of maternal ignorance (Dyhouse: 1978), where it was used in support of ideas about neglect (Strange: 2005: 246-7). In this sense, the discourse of overlaying had a discursive function beyond the immediate explanation of an infant's death.

Overlaying deaths became a point of intersection around the temperance movement, medicine, forensic pathology and the inquest, class and poverty, national efficiency and physical deterioration, as well as ideas about infant welfare, morality, gender roles and maternal culpability. The high level of acceptance of overlaying as an explanation of infant death in bed can be seen in the way it became accepted not only in public discourse and by officialdom, but also by mothers themselves. This is demonstrated when overlaying was offered by a mother as the only possible explanation of the death of her infant (Wellcome: GC140/1/21). In this way, 'the overlaying mother' was constructed through discourse, via the body and (amongst other things) ideas about space and time, and it came to have a reality over and above (dis-embedded from) the incidence and actuality of such deaths. Consequently, a central question in the exploration of infant overlaying is, how was infant death in bed given meaning in terms of overlaying and how did such an explanation come to prevail between 1880 and 1906?

As noted earlier, an analytical separation between the myth, thesis and discourse of overlaying provides a useful means of distinguishing the ways in which the idea of overlaying has been used. This section elaborates and provides examples of the way each category is commonly represented. Firstly, the myth of overlaying:

"In Victorian times, a common cause for infant death was 'overlaying'. This was when a mother accidentally smothered an infant by rolling over on it in bed. Mysteriously, most of us have never heard of the term now that contraception is available" (Freely: 1996:8).

This citation represents the common-sense understanding of infant overlaying: an infant death caused by careless neglect or wilful act. The suggestion that overlaying was a common-place event in 'Victorian times' is underscored by the suspicion which accompanied such deaths, that it was in fact the concealed infanticide of an unwanted child. Despite the decline in reported cases after 1910, the myth of overlaying clearly persisted into the late

twentieth century. The term myth has been carefully chosen because it captures three important features of overlaying: the supposed antiquity of overlaying as a death event; the fictitious (i.e. socially fabricated or constructed) nature of the overlain infant / overlaying mother as they were commonly represented; and the beliefs that existed around overlaying deaths. The myth of overlaying represents taken-for-granted knowledge or the common-sense of overlaying that placed it within broader social understandings and beliefs about such deaths and their causes. Behind the myth of overlaying are the deaths of individual infants often recorded and reported as overlaying deaths. The deaths of these infants and the myth of overlaying existed in an iterative relationship of mutual reinforcement whereby an infant found dead in bed with its mother was construed as an overlain infant while it was also thought that mothers overlaid and caused the death of their infants when sharing a bed.

Secondly, is the overlaying thesis which derived from a series of knowledge claims and challenges. Medical practitioners, forensic pathologists, coroners, jury members, parents and others approached the issue of sudden infant death in bed from a series of overlapping discourses which attributed such deaths to causes originating from the social and material circumstances surrounding them. The overlaying thesis formed part of the official discourse of overlaying and represented the medico-legal knowledge-claim that an infant found dead in bed, in the absence of clinical evidence to the contrary, should be understood to have occurred as a consequence of overlaying:

“The drunken woman is a reckless, depraved, dissolute being, with only half a mind and no conscience, who goes stupidly to bed with her baby in her arms when she is drunk, quite careless of the consequences. Inquests are held on these deaths and juries call them accidental, but they are truly deaths due to culpable negligence.”  
(Westcott: 1903: 67)

The overlaying thesis is specific to place and time, emerging in England and most prevalent between 1890 and 1906. The overlaying thesis is a complex of socially relative, taken-for-granted knowledge and reality claims that produced ‘as fact’ that such deaths were caused by mothers literally overlaying their infants. The existence of overlaying as a death event about which such knowledge-claims eventuated forms the basis of my discussion of overlaying death as a socially constituted event.

Thirdly is the discourse of overlaying, which is a term intended to convey all that can be thought, done or said about something - in this case overlaying - including all actions, interactions and non-linguistic symbols (Gee: 2005: 10). In this sense, use of the term follows Foucault’s broad meaning of discourse (Layder: 1994: 97). The discourse of overlaying produced a public issue that served to construct overlaying death as a personal trouble (Mills: 1967: 8) and the responsibility of individual mothers. The consequence of this



was to increase the number of deaths attributed to overlaying several fold, and relatedly to construct individual women as culpable for the death of their infants at a time when high rates of infant mortality posed a challenge throughout England.

This is not to suggest that mothers categorically did not cause the death of their infants by overlaying them either accidentally or deliberately. Although some infants may have died in this way, for all such deaths the overlaying diagnosis was a socially constituted diagnosis of infant death that owed little to forensic pathology and much to the social context of the death with all that that involved. In this sense, the overlaying death represents an explanation that was constructed through the (in)appropriate social ordering of space and time in relation to maternal and infant bodies. Working class, often impoverished women woke to find their infant, with whom they had been sharing a bed, dead beside them. There are many variations on this, as will be shown throughout the thesis, but they all share this core feature.

### **Overlaying revisited**

Infant overlaying in its historical context has been explored by social, medical and historical researchers and within this context the issue is generally approached in one of two broad ways. For some, overlaying is accepted as being a largely unproblematic representation of death (in which an overlaying may or may not have been accidental (Johnson: 1981; Sauer: 1978; Behlmer: 1982; Ross: 1994: 187; Kilday: 2002: 168)); while others challenge the overlaying thesis as a misrepresentation of deaths which should instead be understood as caused by Sudden Infant Death Syndrome (SIDS) (Zuck: 1995; Savitt: 1979; Hansen: 1979; Prior: 1989; Williams et al 2001; Russell-Jones: 1985). The first approach does little to shed light on the issue of historical overlaying, and it is mentioned here only because it demonstrates that death by overlaying remains an accepted diagnosis of infant death within some historical studies. Some of this work also links overlaying to infanticide by suggesting that overlaying deaths were intentional rather than accidental. The second approach offers some challenges (albeit from within the context of forensic pathology) to the overlaying thesis, and is discussed in more detail below. In addition, there are approaches outwith these two groups of research. These include the work of Rose (1986), which suggests that all explanations of overlaying must be considered as possible and probable; also Burney's (2000) work, while not completely refuting overlaying as a cause of death, quite rightly points toward overlaying as a class and gender based pathology of infant death; and Strange's (2005: 246) research which proposes the overlaying diagnosis occurred due to the 'empty vista of medicine', that is, an inability of medical practitioners to provide an adequate

pathological explanation of such deaths.

Within the 'overlaying as misrepresented SIDS' approach, the medical study of historical overlaying deaths by Williams et al (2001) directly challenges the work of Templeman (1892) in Dundee regarding the period 1882-1891. The basis of Williams et al's challenge is clear - "Overlaying or SIDS?". Their article examines the aetiology of Templeman's overlaying cohort and compares it with eight characteristics of SIDS. Of the eight characteristics identified by Williams et al, five of the characteristics present in SIDS do not correlate with Templeman's Dundee cohort (Williams et al: 2001: 46). Interestingly, Williams et al identify two characteristics that were used repeatedly in support of the nineteenth century overlaying thesis, namely the seasonality of deaths, and the day of the week on which the deaths occurred, with both overlaying and SIDS showing an increased incidence in the winter months and at weekends.

Hansen (1979) too compares overlaying to SIDS, but her emphasis is on the historical interpretations of overlaying as a means of infanticide. She suggests that SIDS was a significant cause of death in such cases, but her rather unhelpful conflation of overlaying with infanticide presents only a very limited view of overlaying when compared with the historical sources. In these, overlaying was by no means completely subsumed within the category of deliberate infanticide, nor was it seen as a cause of high infant mortality, but the supposed truism that overlaying was a significant factor in both is still often repeated (Hansen: 1979; Berman & Choate: 1975; Behlmer: 1982).

As part of her argument, Hansen proposes that infanticide by overlaying was a 'cause celebre' in England in the mid nineteenth century. In fact, the number of infant deaths by murder was often inflated in rhetorical attacks on infanticide by adding to them the number of infants found dead and suffocated in bed (Behlmer: 1979: 405). There was a cycle of moral panic around infanticide through the nineteenth century, but this was by no means widely attributed to overlaying in the way Hansen suggests (Rose: 1986; Savitt: 1979). Hansen refers to Templeman's (1892) Dundee study and his statement that overlaying occurred through the "ignorance and carelessness of mothers, drunkenness, overcrowding and according to some observers, illegitimacy and the insurance of infants" (Hansen: 1979: 335) as support for her claim. However, Templeman quite clearly distanced himself from the role that deliberate infanticide played in such deaths. In addition, Templeman's inclusion of all apparent suffocations in bed, including being suffocated by bedclothes, breasts and pillows, extended the scope of his study well beyond the issue of overlaying in its literal sense, and Hansen's failure to recognise this leads her to overstate the relationship between overlaying and infanticide.

A link between overlaying, infanticide and fertility control is also claimed by Hansen. Her opinion that “Infanticide was felt to predominate among the working classes [sic] who wished to avoid the responsibilities of parenthood” (Hansen: 1979: 342), is a view also promoted by Sauer (1978) and by Savitt (1979: 854), who identified the intentional destruction of infant life as frequent in Western society into the twentieth century. Behlmer too claims a link between overlaying and infanticide (Behlmer: 1979: 118) by emotively referencing “investigation of ‘crushed blackened choked [infants] in helpless agony beneath a mass of vile maternity”. However, he fails to comment that this was claimed by a correspondent to the Liverpool Mercury as part of an attack on the work of the local coroner. There is no evidence to suggest that its writer had any professional involvement with infant welfare or that it is anything more than an emotive outburst. Behlmer also reports an increased incidence of suffocation deaths between 1881 and 1890, but fails to identify the change in reporting practices in 1886 that combined the previously separate categories of 'overlaying' and 'suffocated by bedclothes' into one category, 'suffocation in bed', which was responsible for the supposed increase. In 1885, the last year that the Registrar General reported overlaying deaths as a discrete category, the number of deaths was 247, with suffocation in bed 863. In Behlmer’s comparison year, 1881, the figure was 126 for overlaying. By 1890, the figures had been combined and suffocation in bed was the cause of death attributed for 1517 infants. Consequently, while there was an increase during this period in both categories, the absolute numbers remained low and the combination of the categories led to the erroneous impression that overlaying deaths had soared.

Savitt is among those who claim that nineteenth century overlaying deaths should be viewed as SIDS, and also accepts the prevalence of infanticide as a relatively unproblematic cause of death: “Given the relative frequency with which the intentional destruction of infants occurred in the Western World up until the 20<sup>th</sup> century [ ] infanticide [...] was a major problem the magnitude of which historians are still exploring” (Savitt: 1979: 854). Sauer (1978) also promulgates the idea of high levels of infanticide in nineteenth century England, but takes this further in assuming infanticide and abortion occurred as normalised practices of fertility control: “Infanticide and abortion were basically alternative methods of dealing with an unwanted child” (Sauer: 1978: 82). But Sauer, like many others, fails to explain why, if women were practising fertility control through this means, they would wait until after the neo-natal period. That is, why would a woman wait for more than a month before murdering her child when infanticide at, or soon after, the time of birth would have been far easier to explain and manage? In this respect, incidents where an infant was born into a chamber pot or privy, although on the face of it suspicious, were treated in a relatively

unproblematic way within the legal system.

Rose, however, contests the significance of overlaying to overall rates of both infant mortality and infanticide and states that: “Suffocation assumed significance out of proportion” (Rose: 1986: 177). He also describes an increased interest in the subject during the 1860s and again in the 1880s in terms of a moral panic around infanticide. Rose assumes that overlaying deaths did occur, caused by either intemperance or overcrowding, but also that some deaths were due to SIDS and others to infanticide. Rose cites the 1908 Children’s Act and reduced alcohol consumption as the main reason why rates of overlaying declined from 1908 (Rose: 1985: 180), but also comments that changes in the way such deaths were reported made these changes difficult to chart. Nonetheless, for Rose “the ‘demon-drink’ school was right all along” (Rose: 1985: 180) as he concludes that overlaying most often occurred in consequence of drunkenness on the part of mothers.

Current literature does not generally recognise overlaying as a socially constituted category of death which emerged from a particular confluence of social circumstances surrounding such things as gender, class, infancy, motherhood, family and nation, which in turn have to be understood within spatial and temporal fields that are themselves socially constituted. The attribution of overlaying remains entirely dependent on the social and situational context of the death, with pathology neither able to corroborate nor disprove the diagnosis. It is, therefore, not surprising that the diagnosis of overlaying has been accepted in some contemporary sources.

## **The sociological problematic: categorisation, sequestration and overlaying**

### **(a) Categorisation**

An overlaying death is the death of an infant thought to be quite literally caused when the infant was ‘laid over’ by another person during sleep. Overlaying occurred at night and usually in the parental bed. In practice, however, the overlaying death was not as straightforward or concise as this may at first suggest. The possible confluence of factors and interpretations constitutive of such deaths extended far beyond this one-dimensional view of overlaying, to create a social complex in which the death of an infant in bed was constructed as wholly preventable. It is around this idea of unnecessary infant death that other aspects of overlaying, such as maternal ignorance and culpability, were also constructed. In consequence, it has been claimed that overlaying deaths provide the best example of the ambiguity surrounding charges of maternal neglect and ignorance in the late nineteenth and early twentieth centuries (Strange: 2005: 246-7). This is because infant overlaying death is now seen as occurring as a consequence of both maternal care and maternal culpability.

An often stated explanation for these changes is given in terms of there being real, rather than categorical, changes in infant deaths related to institutional or system 'needs' or 'demands' (Davin: 1978: 9; Jamieson: 1998: 44; Oakley 1990:53; Yeo: 1999: 203). However, although the practices of mothering may have been shaped by forces from 'above', these were by no means the only influences on the way mothering was actually undertaken. During the period of my research, motherhood and the mother / infant relationship was the subject of significant scrutiny, yet the cases detailed later in the thesis show that women were not constrained to prescribed behaviours but followed a range of strategies despite the risk of official condemnation. When these strategies apparently failed to safeguard the lives of infants and overlaying was diagnosed, coroners' juries often (usually) treated the women concerned sympathetically.

From 1886, the Registrar General (BPP: 1886: c5138) re-organised the way that overlaying deaths were categorised and they were no longer reported as a readily identifiable discrete category: instead, all infant deaths thought to be due to overlaying or entanglement in bedclothes were combined and reported as a single figure. Neither historians nor contemporary sources discussing such deaths (Behlmer: 1982; Burney: 2000; Hansen: 1979; Johnson: 1981; Kilday: 2002; Prior: 1989; Ross: 1994; Sauer: 1978; Savitt: 1979; Williams et al 2001; Zuck: 1995) have paid particular attention to this change and the new category was generally accepted as unproblematic. This change in reporting method is likely to account for some of the sudden increase in the number of deaths subsequently attributed to overlaying between 1885 and 1906, but it does not fully explain what happened because it does not account for the increased awareness of overlaying which occurred from 1880 on and neither does it explain the decline in the public discourse about it from 1906. In addition to the Registrar General's change, analysts of the day also began to collect and collate their own data on overlaying (Jones: 1894: 40). This was sometimes taken from inquest records, where sudden infant death in bed became coterminous with a conclusion of overlaying. In some cases, inquest registers have been annotated with references to 'death in bed' (e.g. London Metropolitan Archive: COR/A/009). In addition, deaths from natural causes, such as bronchitis, were often recorded as due to asphyxia or suffocation, and these deaths may have been reinterpreted as suffocation and therefore overlaying.

Figures produced at the time by individual sources are extremely difficult to verify because they are often not adequately referenced or recorded, although coroners' records do seem to form the basis of many claims that there had been a large rise in overlaying deaths. Some coroners maintained their own records of overlaying deaths but drew vastly differing conclusions about both the nature and number of such deaths (Danford Thomas: 1892: 45;

Schroeder: 1920; Troutbeck: 1904: 5; Westcott: 1903: 67) while coroners' juries rarely returned verdicts other than 'accidental death' or 'natural causes'. It is these completely contradictory features of overlaying that suggest there is more to the issue than at first seems apparent. From 1900, when the number of deaths reported as suffocation in bed reached its annual peak at 1750 (BPP: 1900: Cd761), the number of deaths attributed to overlaying and suffocation in bed declined.

There are, however, other stories of overlaying - the stories of the individual mothers and infants as told at the time, usually told within two or three days of the death by the mother, father, relative, neighbour, doctor and pathologist, to the coroner and jury at an inquest. These stories tell in minute detail the circumstances of the infant's death and often run counter to the myth of overlaying. The case of William Wheeler is a case in point.

William was five weeks old when he died on 27 December 1907. He had been born at full term. William was breast fed and had had a slight cough since birth, but his mother was not concerned about this and thought that William was otherwise healthy. William had not had any other illness in his short life. Born in Battersea, south-west London to mother Esther, William lived with his parents and three older siblings in a rented room in a shared house, where Mrs Alice Hall was the landlady. The family, consisting of unemployed Mr Wheeler, a heavily pregnant Esther and three young children, had moved into Mrs Hall's house two weeks before William was born and had been there for seven weeks by the time of his death. Mr Wheeler had been out of work for nine weeks in all and had not, by William's death, paid any rent to Mrs Hall for the family's room, but she said that they were a sober, steady family and knew that Mr Wheeler had been looking for work. The Wheelers lived in poverty-stricken conditions, the rent had not been paid, the family had no food and there was no fuel for the fire in their room. At 6.30pm on Boxing Day evening, 26 December, Mrs Hall invited the Wheelers into her rooms, four doors away, for some tea. She gave them a meal of sandwiches and oatmeal stout<sup>2</sup> and Esther ate two or three sandwiches.

The family returned to their room at 2am, at which time Esther and the children went to bed. The three elder children slept at the foot of the bed, with Esther at the head with baby William on her arm. The room was sparsely furnished and the only bed (a full sized double) was shared by the family. Esther had fed William at midnight while the Wheelers were with Alice Hall, and he did not want to be fed again at 2am before the family went to sleep. Esther went to sleep with William on her left arm. Alice Hall brought cups of tea to the Wheelers at 8.45am, on the morning of 27 December. When she entered their room, she could see Esther

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2 Oatmeal stout was ale with oatmeal added during the brewing process. It was thought to be a nourishing restorative and was recommended for lactating mothers and invalids.

asleep on her side with William still on her arm with the three elder children asleep at the foot of the bed. Alice could see half of William's face which was partially buried in Esther's breast. Alice could also see a slight stain of blood on Esther's night shirt and, on approaching the bed, saw some blood trickle from William's nose. Alice woke Esther saying "I am afraid the baby is gone", Esther held William up, his body was still warm and she saw that he was dead.

Alice Hall then went to get Mr Wheeler, and when he entered the room he saw Esther with William still on her arm and she said, "I think the baby is dead". William's hands were clenched and he thought that it looked as if William had been in some pain. Mr. Wheeler saw a little blood and milk coming from the infant's nostrils. The other children remained asleep at the foot of the bed. Esther thought that she might have suffocated William by holding him too tightly. Baby William had not been insured at the time of his death. The pathologist recorded that the doctor first called to the scene had supposed William's death was caused by overlaying, but that in his revised opinion, the death had been caused by suffocation due to acute broncho-pneumonia and bronchitis (Wellcome: GC/140/1/21).

In light of numerous low-key and ambiguous stories of infant death in bed such as in the case of baby William, how did the myth of overlaying come to hold a prominent role in the diagnosis of infant death? How did it achieve credibility, what purpose did it serve and how did it shape the lives of women as mothers?

In part, overlaying emerged as a diagnostic category of infant death against a background of increased recognition of the social value of infant life and population monitoring of a kind which called for deaths to be accounted in terms of pathology. In the case of overlaying death, the official requirement to attribute cause to a death could not be satisfied by pathology and social context came to dominate diagnoses of infant death in bed. Although this 'empty vista' in medical understanding of infant overlaying death has been rejected by some (Armstrong: 1986: 222), it merits further exploration because, as discussed elsewhere, there was considerable disagreement about the physiology and pathology of overlaying which did indeed leave a space in which other explanations became possible. But this does not fully explain why the overlaying thesis came to dominate the explanation of such deaths when other explanations were possible. As will be shown, overlaying was generally and ostensibly represented as a primary cause, although it was almost always linked to broader issues such as maternal ignorance, infant mortality or temperance.

### **(b) Sequestration**

The sequestration of experience has been explained by Giddens as a means of ensuring

ontological security through the separation of particular activities and events from the everyday social world, where events posing an existential challenge to social life are concealed and controlled (Giddens: 1991b: 161). The sequestration of experience occurs in conditions of modernity where there is an emphasis on control and the subordination of nature to human purpose (Giddens: 1991b: 144). For many, the consequence of sequestered experience is that direct contact with factors linking the individual to morality and finitude is lost (Giddens: 1991b: 8). Two forms of sequestration are particularly relevant here. These are the sequestration of birth and reproduction and the sequestration of death.

The sequestration of experience as Giddens conceives it separated individuals from the moral reference points of pre-modern culture and replaced these with internally referential systems that protected individuals from the disturbing existential parameters of life (Giddens: 1992: 180-1). In this sense, the sequestration of experience represents a break with tradition which allows modern institutions and systems of control to intrude across the “pre-existing external boundaries of social action” (Giddens: 1992: 175). In conditions of modernity, moral and ethical frameworks are replaced with the ontological security that comes from institutional routine (Giddens: 1992: 175). Giddens's claim is that within the ‘reflexive project of self’, the sequestration of experience serves as a form of repression and “a forgetting” linked to “mechanisms of shame”, which instils “the feeling that one is worthless, one’s life empty and one’s body an inadequate device” (Giddens: 1992: 175). Giddens’s ideas about sequestration offer a perspective from which to explore the socialisation of the mother / infant relationship and the social construction of overlaying as a death event, around the dependence of infants placing them in a mediated relationship with the persons and processes involved.

Giddens’s (1991b; 1992) work also provides a useful theoretical framework for exploring processes of change in relation to practices around motherhood and infant welfare. The sequestration of reproduction represents the privatisation and socialisation of previously held ideas about the reproductive process, with reproduction made ‘special’ and separated from the main ‘arenas’ of social activity (Giddens: 1992: 174). In the pre-modern period, relations between nature and the succession of the generations were coordinated by traditional forms of practice (Giddens: 1992: 180) and delineated by the biological and transcendental. Reproduction, previously understood in terms of the natural order as a fragmented and disputed set of practices, was ‘sequestered’ and became ordered through a system of internal referents - “orders of activity determined by principles internal to themselves” (Giddens: 1992: 174).

The sequestration of death as a particular form of sequestered experience has been



explored within sociology (Elias: 2001; Giddens: 1991b; Lee: 2008; Mellor & Shilling: 1993; Stanley & Wise: 2011; Willmott: 2000). In general, discussion of sequestered death concentrates on changed attitudes to death and its management within society, and in particular on the increasing privatisation and individualisation of death in modernity. A central theme that emerges concerns the management of death so that it does not interfere with or limit daily life.

The predictability or routinisation of day-to-day life in conditions of modernity serves to provide protection against strokes of fate such as death, disease and illness (Elias: 2001: 7) by colonisation and control of the future (Giddens: 1991b). Human mortality and the inevitability of death can threaten social life in two distinct ways; firstly by undercutting individual life projects and identity, and secondly through the destabilisation of social institutions by rendering them “absurd and futile” (Willmott: 2000: 650). By developing strategies to manage mortifying incidents, individuals and institutions maintain a coherent sense of identity and reality (Mellor & Shilling: 1993: 411; Willmott: 2000: 650). In this way, the threat of death itself is managed and made more predictable. The suspension of knowledge about mortality is an essential aspect of this strategy and one way that this is achieved is by excluding direct contact with death and dying from everyday life (Elias: 2001). In order to achieve this, death is socially organised and managed by experts with specialist knowledge and skills, and confined within institutions such as hospitals and mortuaries that limit contact with dead and dying bodies. Expert discourses, for example medical knowledge, serve to contain death and in this sense people no longer die of ‘mortality’, but of disease and illness (Willmott: 2000: 652) and this facilitates an “active forgetting of our mortality” (Willmott: 2000: 654). For Elias, this repression of death occurs in two ways: the first is through a Freudian psychological repression of death by the individual; the second is through the process of civilisation which serves to suppress the dangerous “elementary aspects of human life” (Elias: 2001: 11).

However, such explanations of the social ordering of death as a sequestered or repressed experience become problematic when considered in relation to the sudden death of an infant in bed which is, by its nature, resistant to sequestration. The infant who shows no signs of illness or disease is not routinely constructed in terms of death and dying, and its presence within the sphere of everyday life is therefore not limited, transformed or curtailed before death. The sudden death of an infant in the home, in a bed or cot, poses a challenge to the security of all who come into contact with it, including those who have known the infant in life and those who have contact with the infant subsequent to its death. Such deaths breach both the physical and social boundaries between the bodies of the living and the dead

(Mellor & Shilling: 1993). In contrast to other (adult) deaths, the mediated experience of sudden infant death does little to attenuate its impact on the individual. Instead, the risk posed by sudden infant death can raise the “existential sensibilities” described by Giddens (1991b: 169), potentially creating all infant life as precarious and therefore destabilising to the individual and society more generally.

The socialisation of infancy entailed, amongst other things, attributing the infant with an identity and life project of its own and, subsequently, also entailed incorporating the infant into the life projects of others. This was not possible when infant life was so precarious and in situations where high infant mortality prevailed the socialisation of infancy remained problematic. The infant, whose death was always pending – visible on the horizon of action – could not be socially integrated because of the existential challenge this posed in the event of its death. In this situation infant life could not be socialised unless it was also sequestered. In this way, infants and infancy were sequestered with the precarious period of their existence defined and contained. Although ostensibly in the care of their mother, the care and welfare of infants became an area of specialist knowledge, expertise and increasing intervention and the role of mother became one of protection: protecting the infant from death and protecting society from the existential challenge presented by sudden infant death. In this way, the threat of imminent death was allayed by the blame apportioned to individual women following the death of their infants. Infant death was transformed from the random, unpredictable and uncontrolled sudden death of an infant in bed, into the death of an infant by the culpability of its mother. In this way sudden infant death in bed was also reconstituted as a predictable and preventable death. Ideas around the sequestration of infancy presented in this thesis expand on current ideas around sequestration and provide an analytical and explanatory means of interrogating the research materials detailed in the following chapters.

Central to this discussion is the complex social constitution of the taken-for-granted reality of overlaying embedded in common-sense knowledge. The overlaying thesis in the period focused on here served as a framework (of knowledge and reality) for ordinary understanding as well as professional diagnosis of overlaying as a socially constituted process of death attribution. Through this, the death of an infant in bed was considered to have occurred as a consequence of overlaying regardless of (or in the absence of) any causal pathology of death, with this based on the contextual evidence that the infant was in bed with another person (the mother) at the time of its death. Eye-witness testimony and professional examination usually failed to establish evidence of actual overlaying. It is therefore important to examine in concrete detail the overlaying discourse as it was drawn on and sometimes countered to gain purchase on the way that the lived experience of maternal

culpability and overlaying were enacted, because it was through this means that overlaying formed an integral part of knowledge about sudden infant death in bed.

There is also a common-sense understanding that constructs infants as pre-social, natural beings dependent for their existence on maternal care. Within this, the requirements of the infant must be met by the mother who, in meeting these, is herself constructed as the carer for the infant. Against this the socially constructed meaning of infancy and motherhood underpins my exploration of overlaying deaths. The mother / infant relationship is also shaped by membership of the nation, by prevailing ideas about national identity, public expectations and normative requirements (Davin: 1978; Yeo: 1999). This influences even the most intimate and natural aspects of the mother / infant relationship such as bed-sharing and feeding practices. Such practices are contentious even now and arguments over the dangers of bed-sharing and the efficacy of breast feeding have taken on ideological aspects in present-day debates on child rearing and development, as witnessed in infant welfare campaigns such as 'Back to Sleep' and 'Breast is Best'. This was no less so in the period explored in this thesis, when the rearing of infants became an issue of considerable public scrutiny. At that time mothers became the focus of campaigns to reduce infant mortality in the cause of national improvement and this was reflected in discourses such as that around 'national efficiency' (Searle: 1971). In this way, the formerly domestic and private task of infant-rearing became a public issue which allowed, indeed required, the penetration of the domestic sphere by the state and its representatives. The 'policing' (Donzelot: 1997) of mother and infant sleep practices (in some situations) was demonstrated in the vilification of women 'proved' to have overlaid their infants, so that the daily lives of women as (potential as well as actual) mothers were shaped by the way that they reared their children, organised their homes and spent their time. But there is a paradox here, in that within the context of the inquest, juries largely remained sympathetic to women whose infants had been found dead in bed and 'overlaying' deaths were generally regarded as accidental.

The role of the body in overlaying death is therefore extremely important, because it is the physical interaction of maternal and infant body that is presented as the cause of death and it is via the body that overlaying is socially constituted and experienced. The material reality of overlaying is organised around the 'here' of the body and the 'now' of the present (Berger & Luckmann: 1991: 36), which represent its corporeal, spatial and temporal aspects. This is at the core of overlaying because it is quite literally the sharing of the same spatial and temporal location that is seen as causal in an overlaying death.

Until relatively recently, the body has been absent from sociological work (Foucault: 1991:25; Howson: 2004: 3; Inglis & Howson: 2001: 299; Smart: 1985: 75). Analysis of the

social body is a more recent occurrence in sociological thinking and is underpinned by recognition that the body has a social context, history and culture. Along with this, the body has a central role as a source of knowledge and understanding, undermining the earlier association of the body with the 'natural' and so outwith the realms of sociology (Inglis & Howson: 2001: 299). Investigations of the body within historical contexts have identified changing ideas about the body and its relationship to the state during the eighteenth and nineteenth centuries (Howson: 2004: 122; Foucault: 1980). The emergence of a more social way of thinking about the body at this time is attributed to, amongst other things, anxiety about urbanization, population growth and the proximity of people, and these in turn were linked to societal needs for productivity (Howson: 2004: 125) and newly combined mechanisms of control occurring through expansions of knowledge and power.

The use of surveillance in its broadest sense provided a mechanism through which disciplinary power regulated the body in order to meet the requirements of changing social organisation, operating through technologies that made the scale, object and modality of power exercised over the body of a different quality from that which had previously existed (Smart: 1985: 85). The body therefore has a direct role in the political field and "power relations have an immediate hold upon it; they invest it, mark it, train it, torture it, force it to carry out tasks" (Foucault: 1991: 25). Relatedly, the body holds an important position in my investigation of infant overlaying deaths as a social phenomenon that was subject to regulation, with discourses around infant welfare portraying the maternal and infant body as having a defined and (in)correct role in relation to one another in terms of disposition. That is, overlaying death was seen to occur as a consequence of transgressions by the mother of prescribed behaviours regarding infant care, welfare and sleep practices.

The body can be considered as a force of (re)production (Foucault: 1991: 26) invested with relations of power and domination and most useful when it is productive and subjected (Foucault: 1991: 26). This is no less so for the maternal (re)productive body. Such a body has been described by Foucault as the 'docile body' (1991: 136-7), a body that can be subjected, used, transformed and improved, and which can be understood and made productive through discipline, not as punishment, but as self-interested compliance. Discipline is not manifest in any one single institution but is dispersed yet remains focused in individual details (Foucault: 1991 139). In this sense, women as mothers became the proponents of such discipline. Discipline proceeds from the organization of bodies in space and time (Foucault: 1991 136-7) and is a technique of power which provides procedures for training or coercing (individual and collective) bodies (Smart: 1985: 85). The infant body, however, routinely breaches such discipline and must be constrained or remain un-socialised.

So, for example, the discipline of individual maternal and infant bodies became the subject of discipline through the family, medicine, and the inquest. This understanding of infant and maternal bodies can also be expanded through ideas of reflexive motherhood and the sequestration of infancy to provide analytical purchase on the research materials discussed in the thesis. Foucault also states that disciplinary space is divided into as many sections as there are bodies and that the control of activity through time represents the greatest utility of both time and body (Foucault: 1991: 149). In this regard, overcrowding and poverty, which served to limit the space available to each body within the home, could also undermine bodily discipline and its functional aspects as it corresponds to Foucault's ideas about the best utilization of the body in space and time (Foucault: 1991: 153). The practice of bed-sharing therefore transgresses this separation of bodies and in this way challenges bodily discipline. In relation to this thesis, ensuring productive and effective means of (re)producing the national population are witnessed in discussions of national efficiency, infant mortality and maternal ignorance, where the role of women as mothers and the productivity of the maternal body are both seen as undermined by ignorant and neglectful motherhood.

The feature of disciplinary power that Foucault identified as bio power, as literally power over life, involves the means by which the state and its agencies manage the life of the population at the level of individuals as well as collectivities (Howson: 2004: 125). Foucault has described three mechanisms of disciplinary power and their influence on the individual. The first is hierarchical observation, which involves a mechanism that coerces by means of observation and is "an apparatus in which the techniques that make it possible to induce effects of power, and in which conversely, the means of coercion makes those on whom they are applied clearly visible" (Foucault: 1991: 170). In the case of overlaying death, such observation must make visible the most intimate aspects of the home and mother / infant relationship and, for example, is seen in the work of midwives, health visitors, doctors, police and the judiciary. The second, normalisation judgement, makes comparisons, demarcates the space for differentiation, and provides the rules that should be followed. The field measures in quantitative and hierarchical terms the value and abilities of the individual, specifies permitted limits of difference and marks the boundary of normal and abnormal (Foucault: 1991: 170). Ideas concerning 'maternal ignorance' and the 'good mother' are organized in these terms. Third is the examination, which combines both the previous mechanisms with the purpose of establishing the visibility of individuals in order that they can be differentiated and judged (Foucault: 1991: 184). In combination, the network of welfare monitoring and the idea of the good mother provide a powerful force for the construction of women's experience of motherhood and in particular regarding infant death

in bed.

Giddens rejects Foucault's idea of biopower in favour of a framework that separates the administrative development of modern institutions from the socialisation of nature and reproduction (Giddens: 1992: 31, 173). This allows a more iterative relationship between the individual, institutions and society in the regulation of the body, and is a helpful way to think about and explore the social processes involved in evaluating and categorizing infant deaths generally and those deemed to be overlaying deaths in particular. Ideas around bodily discipline are further embedded in ideas around discourse and can be understood as one means through which ideas relating to bodily discipline are circulated.

A further aspect of the overlaying discourse was manifested as the common-sense knowledge of overlaying. It was through common-sense knowledge that the conventions of the discourse were known and came to underpin claims about overlaying detailed in this thesis. Common-sense knowledge forms one aspect of the overlaying discourse and in this regard the discourse can be also understood as a 'place' where relations of power are exercised and enacted (Fairclough: 1989: 43). It is, therefore, through language use that the ideological properties of discourse central to power and struggles for power can be usefully explored (Fairclough: 1989: 17), because this makes visible "unequal relations of power" (Fairclough: 1989: 1). Ideas around discourse provide a helpful means of interrogating the research materials discussed in this thesis. This is particularly useful in regards to discussions around power and interaction. In the period with which this thesis is concerned, the inquest system with its coroner, jury, verdict, death registration and post-mortem can be understood in terms of 'technologies of power' that formed part of a general system of surveillance operating across space and time. Exploring their operations also casts light on other aspects of overlaying deaths, such as material conditions, relations of the body, gender and class. In this way, exploration of the overlaying discourse also provides a means to interrogate the power relations embedded in the practices and positions of those individuals involved. The ability to utilise or undercut the overlaying discourse reflects the position of some individuals and their relations to other people in terms of their authoritative knowledge of overlaying.

Gee (2005:14) highlights the dynamic relationship between language and context in discourse analysis. Discourse shapes and coordinates material reality, social practices and the inner personal world of the individual (Gee: 2005: 32). For example, the 'caring mother' is a situated identity that is performed and recognised by particular characteristics, with the activities and identity involved among other things coordinated by ideas about infant welfare perpetuated by groups such as the medical profession, and the category also acts to

coordinate related roles, such as 'good father / provider'. The category 'caring mother' is characterised in particular ways, and in order to be seen as caring mothers women must enact appropriate associated behaviours and activities. This also highlights that meaning always has context (Gee: 2005: 14).

Pregnancy forms the period of life that sees the coexistence of maternal and infant bodies. The pregnant body currently holds a 'special' status and the period of pregnancy / incubation is marked out and separated from other periods of life for both the mother and the infant, but this has not always been the case. In pre-modern times, pregnancy was not separated from everyday life as a "special kind of experience" (Howson: 2004: 132), but during the nineteenth century pregnancy and childbirth were redefined by medicine in terms of a clinical event. Howson states that it was in the twentieth century that changes in obstetric knowledge made possible both a social and a legal distinction between the mother and foetus (Howson: 2004: 135), making women responsible for the welfare of the foetus. However, as will be shown, the time frame for such changes must be challenged and changes should be seen as occurring much earlier than claimed by Howson. By the mid-nineteenth century, the behaviour of pregnant women was being influenced by ideas of responsible motherhood and legislation relating to pregnancy, and medical knowledge of foetal development was constructing the foetus as a separate (though not independent) entity. Indeed, current debates about protecting the foetus from unhealthy maternal conduct have their origins in the period of my study as does the idea of modern pregnancy as a public experience (Gatrell: 2005: 56; Howson: 2004: 137).

In overlaying death, maternal and infant bodies come together in specific space and time: the bed and the bedroom and household sleep practices. The bed(room) in this sense should be understood as a socially constituted space organized around bodily discipline and activity embedded and reflected in social relationships of the family. The bed(room) is the site of both the maintenance and breach of the nuclear family and its taboos (conjugal and incest). Present day sleep practices, where clearly demarcated sleep-areas and surfaces are represented by an equally clearly demarcated bed(room), became part of the normal arrangement of most homes in Britain only during the twentieth century (Crook: 2008). The arrangement of the home now incorporates designated rooms for sleep organized around familial relationship, so that the (two) members of the primary conjugal relationship are separated from other members of the family, who in turn are provided with rooms organized around gender and age, so that room-sharing is restricted to those of similar age and gender. Even now, such arrangements are not necessarily practised in all households and known breaches of these arrangements may involve monitoring by a number of social agencies.

These ideas emerged from what Elias (1994) termed the ‘civilising process’ and Giddens (1991b) late modernity, and accompanying ideas about sequestration. The resultant organization of the bed(room) was informed by the idea of privacy and “the functioning of normal bodies and minds, the governmental agency of space and the moral integrity of nuclear families” (Crook: 2008: 15). Along with the more generalized configuration of public and private spaces (Crook: 2008: 22), the private space of the home was further subject to spatial organization in a way that linked space to function: the activities and practices of the family were allocated specific temporal-spatial locations within the home. This was so for the conjugal relationship as it was for the preparation of the family meal or toileting. Such changes reflected the shifting connection between physical proximity and physical and moral contagion and the concerns this caused (Crook: 2008: 18) and were an extension of changes already occurring in the spatial reorganization of prisons, barracks and hospitals identified by Foucault (1991). Here segregation, regulation and isolation identified a particular body with a particular sleep space and the prisoner, the soldier and the patient were each readily surveilled in the ordering of beds (Crook: 2008).

The ‘decongestion’ of the sleep space (Crook: 2008: 18) both represented and remedied the congestion of the body and mind, and the control and organization of the bed(room) can be taken as a mechanism and manifestation of body technology and body discipline. Concerns about the housing of the working classes can at one level be understood in these terms, where proximity of bodies in slum dwellings was a source of visceral horror and fear. Bodies heaped on beds shared by brothers and sisters, mothers and fathers, in unclean and disordered settings, were viewed as a source of both physical and moral corruption. The remedy entailed reconfiguring bed(room) space and time with the aim of preventing the mingling of bodies. This could be interpreted as an intervention and control of the most intimate settings of life, although at the time these settings were not considered by all to be intimate. However, such changes are also part of a reconfiguration of intimacy itself (Giddens: 1992), so that the sharing of a (separate) bed(room) became a means of defining intimacy and governing its conduct.

This had significant consequences for the mother / infant relationship because, once established as socially distinct from its mother, the infant like the mother was governed by ideas about intimacy in turn shaped by ideas of what is appropriate around gender, age and conjugality. Importantly, the mother / infant relationship because of its biological aspects was necessarily in constant breach of the rules of intimacy and bed(room) space and time. This was not only because of the physical proximity of mothers and infants during breast feeding, but also because the introduction of the unregulated body of the infant into the organization



of the bed(room) caused breeches of prior routines of sleeping, feeding and toileting. Although these settings were not always viewed as intimate, they were over time (re)constructed as such, with intimacy becoming defined, valued, controlled and, importantly, internalised as part of the subjective understanding of the relationship between mother and infant.

Crook claims that by the end of the Victorian period, sleep space was “privatized, medicalised and psychologized” (2008:16) and that from 1880 the bed became a distinct site of privacy. While discussing improvements in housing for the working classes, in my view Crook fails to recognise the lived experience of people, who could not afford the relatively high rents of the new artisan dwellings and instead lived in tenemented buildings where many families had one or two rooms and shared water and toilet facilities. The bed as a distinct site of privacy would have been particularly problematic in the many single room households where all family activities occurred in the same space. Such households were not uncommon and in some areas indeed formed the majority. Thus although the bed(room) was reorganized and reconstituted, Crook fails to recognize the distinction between the theory and practice of what happened when it came to bed-sharing during the nineteenth century and into the first decade of the twentieth. Certainly moves towards a privatized, medicalised and psychologised bed(room) were underway during the period of my research, but as the discussion in later chapters will show, for many people this remained outside the realm of the possible.

The practice of bed-sharing was and is influenced by a broad range of socio-cultural factors (O’Malley Halley: 2007: 107) and studies have shown that socio-economic position is the main factor around which attitudes and practices to bed-sharing are organized (O’Malley Halley: 2007: 107). But focusing on the practicalities of mother / infant bed-sharing (warmth, convenience and limited space) should not be at the cost of a broader understanding of factors that influenced a mother’s decision to bed-share with her infant. The issue of parent / child bed-sharing occurred against a background of ideological and practical debates that were concerned not only with bed sharing and child rearing but also with adult / child touch (O’Malley Halley: 2007: 106). Bed-sharing still raises concerns about “what constitutes appropriate touch” in particular in relation to incest and child sexual abuse. For O’Malley Halley “ideologies of adult-child touch are part of larger patterns of social ‘power’ that reveal and reproduce mainstream conceptions of gender, sexuality, race and class” (O’Malley Halley: 2007: 2), and she utilizes Foucault’s idea of normalization to explore the issue. O’Malley Halley addresses the contemporary situation, pointing out that child-rearing advice encourages women to focus on themselves as the solution to child-

rearing problems, and this is no less relevant to my discussion where maternal culpability provided the explanatory cause of overlaying death.

The concept of intimacy must also be explored in relation to infant overlaying death. Intimacy has been described as “close association and privileged information, empathy and understanding, love and care” (Jamieson: 1998) and also as a quality of relationships, derived from equality and mutual self-disclosure (Giddens: 1992). During the nineteenth century, intimacy was more closely associated with personal relationships, with the family at the centre of its reconfiguration (Jamieson: 1998: 18). At this time marriage and parenthood gained emotional significance as the fear of loss through death diminished (Jamieson: 1998:18). Children were then increasingly protected from the adult world and their dependency increased (Jamieson: 1998: 18). Implicit in this is the idea that high rates of mortality restricted people’s ability to develop intimate relationships and that as mortality decreased so intimate relationships intensified.

Interestingly, in Jamieson’s view increased dependency rather than equality occurred in conjunction with heightened intimacy. At the same time, the home became the setting of the private and increasingly intimate relationships of the family (Jamieson: 1998: 18). But this did not operate to the exclusion of the state, with an increasing range of interventions shaping the personal relationships of the family, especially those of mother and infant, as motherhood became an issue for public policy (Jamieson: 1998: 41). In contrast, Jamieson also suggests that until the mid-twentieth century, “parent-child relationships were not as a rule highly emotionally intense with family life orienting around children’s needs” (Jamieson: 1998: 27) and the material circumstances of the family (including high mortality) could have acted to limit the growth of intimacy. Overall, then, Jamieson’s work indicates that the trajectory of intimacy between 1850 and 1950 cannot be charted in uniform terms, and the mother / infant relationship could not be completely incorporated into a framework that had adults as its core subjects. This is because Jamieson frames her discussion of parent-child intimacy around two key issues: the balancing of parenting between mothers and fathers, and whether the parent / child relationship is moving toward equality and disclosure (Jamieson: 1998: 43), and does not engage directly with the issue of mother / infant intimacy and its reconfiguration during the nineteenth and early twentieth centuries.

In his exposition of intimacy, Giddens (1992) discusses changes in motherhood and mother / infant intimacy as occurring as part of broader social changes in the conditions of modernity, around the socialisation and sequestration of reproduction and its separation from sex and sexuality (Giddens: 1992: 180-1). Through this process, motherhood became increasingly isolated from other social activities and subject to increased intervention. For

Giddens, the social invention of motherhood and the changing relationship between mothers and children is linked to the emergence of romantic love (a central aspect of the transformation of intimacy) and claims that “patterns of parent-child interaction altered substantially for all classes during the ‘repressive’ Victorian period through the separation of work and home and the increased emphasis on emotional warmth between parents and parent and children” (Giddens: 1992: 42). The role of the infant in the new arrangements of family and intimate relationships, however, remains under-developed because, while motherhood feeds “directly into some of the values propagated about romantic love” (Giddens: 1992: 42), it is unclear how changed ideas of motherhood articulate with transformation of intimacy in relation to the position of the infant. Giddens suggests that claims about the rights of the child – unable to articulate needs – are made by adults within authority relations where decisions can be “defended in a principled fashion” (Giddens: 1992: 109, 191). However, this must surely draw on a broader framework of ethics and represents a further intrusion of institutions into the mother / infant relationship, and in my view simply defers the problem of intimacy based on equality and disclosure.

Throughout the time-period covered by this thesis, the social construction of mother and infant were undergoing significant transformation. As motherhood became explicable in social terms, so infancy and childhood became increasingly delimited social identities. The social separation of mother and infant enabled infant life to be separately recorded and accounted and the infant and child became social entities in their own right. Until this point (and through the period detailed in this thesis) the social context of an infant’s death was almost entirely governed by the social positioning of its mother. Apart from gender, most of the infant’s social attributes were drawn from the mother’s positioning and so, at one level, the infant was constructed as an adjunct without a separate social identity, the “sometimes inconvenient appendage of the mother” (Armstrong: 1986: 224). The consequences of this, however, are troubling because the infant is lost in such an analysis. The infant, especially the newborn, is located through the position of its body in space and time, but it is the social positioning of the mother that was taken as a proxy for the infant’s own social position. Attention is thereby immediately drawn to the mother and her circumstances because, although the infant was emerging as a social entity, there were as yet few hooks on which to hang the social aspects of the infant, apart from its constitution through death (Armstrong: 1986: 212). In this sense, the infant's exit from life marked the point at which its social attributes became fixed. For Armstrong this marks the emergence of the infant as a social being, while the discourses of childhood for Jenks (2005) imply that “the child is part of a social structure and [is] thus functional within a network of relations, a matrix of partial

interests and a complex of forms of professional knowledge” (Jenks: 2005:61). This conception of childhood allows for its variability in space and time and also recognises that it is, in part, through the ordering of space and time that the notion of childhood, and therefore infancy, is constructed within any particular society. Infants have a role in society that is distinct from their existence as individuals within biological relationships, and this is constituted through a series of competing, complementary, parallel, interdependent and hierarchical discourses (Jenks: 2005: 61). The contingency of childhood carries with it its correlate, the contingency of motherhood, because just as childhood speaks of relationships, so too does motherhood which is always dependent on the idea of the child - whether present or absent, born, miscarried or aborted.

For Giddens, the idea of ‘motherhood’ emerged as a consequence of the split between reproduction and sexuality in reflexive modernity, with this providing the context to plan families around discourses concerning normative family size and child-rearing practices (Giddens: 1992: 174). The invention of motherhood that Giddens describes (1993:42) derives from ideas of romantic love following the disjuncture between reproduction and sexuality. This had significant repercussions for parent / child interaction, which altered substantially over the Victorian period (Giddens: 1992: 42). The social invention of motherhood gave shape to the idea that mothers should have affectionate relationships with their children and give special attention to the needs of infants, but at the same time parents were advised to maintain authority by not becoming too friendly with their children (Giddens: 1992: 98). In Giddens’s analysis, motherhood was constructed as an aspect of the female personality and central in construction of self identity. Despite disagreement about its origins, it has been claimed that the importance of what we currently understand as motherhood emerged in the mid-nineteenth century (Giddens: 1992; Jamieson: 1998) when femininity was constructed as synonymous with motherhood and women in their capacity as mothers were viewed important to the building of the British nation-state (Yeo: 1999: 202). Despite its apparent personal, intimate and individual nature and the ideological emphasis on the domestic sphere, motherhood has nonetheless been “centrally involved in very public and historical processes” (Yeo: 1999: 202) and shaped by social forces in an “unequal relationship of power” (Yeo: 1999: 202).

The changed constructions of infant and mother occurring over the time period of the research materials discussed in the thesis took place around re-organisation and control of space and time. The delineation of infancy as a distinct temporal phase emerged from (amongst other processes) inquiries into mortality and the monitoring of the population and groups within it. In the latter part of the nineteenth century, infants began to be identified as

emergent social entities immediately following their first independent breath, but during this time still-births lingered in an unclear conceptual space between foetus and infant. This temporal delineation of infancy conformed to an idea of time marked in uniform terms and the demands of demographic quantification. A clearly defined period of infancy also facilitated epidemiological investigation of infant deaths, as chronological and biological life became inextricably linked in social constructions of the body's transit through time. Although, infancy is an "arbitrary convention which can be historically located" (Armstrong: 1986: 217), at the time of my research it was being established as a biological factual given.

Time was therefore a factor in constituting the infant, and chronological time became a means of defining infant growth and development from the point of conception. The birth of an infant was understood by medicine to be viable and therefore appropriate after a specified length of gestation. Any attempts to contravene this, for example through the procurement of an abortion or violence towards the newborn through infanticide, became punishable under the law. The development of the embryo and foetus was clearly defined in medical texts, and the distinction between the two also marked in temporal terms so as to define stages of normal development, as well as the signs of prematurity and thus (non) viability. In addition, scales of infant and child development were also being outlined which made possible the construction of 'the normal child'. The control of infant time, however, went far beyond the description of coincidence in physical and temporal aspects of infant growth. The activity of the infant became heavily prescribed around 'proper' routines of waking, sleeping, feeding, and parental contact, with the consequence that the infant's body became the subject of temporal control in terms of rest, nutrition and excretion (Jenks: 2005: 67). Most importantly, infant mortality was increasingly seen as a temporal aberration. It is within this context that infant care took on a new significance, beyond the immediate concerns of the family, to become an issue for society generally.

The infant fed on demand in the parental bed was constructed as in contradiction to the prescribed spatial and temporal pattern of appropriate infant care that had come into being. Indeed, this was seen as a disruption to the social order. Jenks (2005: 67) identifies a concerted strategy to control space as primary to disciplining at the societal level and he also proposes that:

"Spatiality has various aspects beside that of region including distance, movement, proximity, specificity, perception, symbolism and meaning: the space makes a clear difference to the degree to which [...] the causal power of social entities (such as class, gender, the state, capitalist relations, patriarchy) are realised." (Jenks 2005: 76)

It was through the spatial organisation of the home environment and the intervention of non-family into the space of the home that overlaying was constituted, with the temporal and

spatial aspects of infancy therefore assuming greater importance in the latter part of the nineteenth century (Jenks: 2005: 67; Ferguson: 2004: 54). The temporal and spatial constitution of the home is important to any exploration of overlaying as it was within the home that the majority of such deaths occurred, and it was during the period of my research that the home underwent significant changes in the way it was constituted and thought about (Ferguson: 2004: 43).

The spatial organisation of infancy during the late nineteenth century became more complex, with an increased segregation and demarcation of child space which reflected the broader spatial reorganisation of English society. Children began to be limited to designated spaces and prohibited from others. For example, children's space in the work place was severely curtailed and its limits clearly defined, while other spaces such as schools became designated as child space. There was a progressive containment of children in private spaces that happened at the same time that domestic labour was withdrawn into the home space (Jenks: 2005: 89-89). For Aries (1962), the spatial separation of children from adults is the most important feature of modern childhood. And for Ferguson (2004: 36), there was a clear point at which the public area of the street became seen as off limits to unaccompanied children and children became gradually more confined to the child spaces of home and school, with their presence increasing seen as taboo in newly designated adult spaces such as the public house,

Jenks (2005: 74) includes in this prohibition the parental bedroom, but over the period of my research the 'parental bedroom' was still seen as a space for infants and young children. This is of course a distinction made on the basis of social class, because within wealthier families infants could be afforded a designated space within the home, the nursery. However, this did not always mean that they enjoyed their own bed-space, because bed-sharing between a nurse and an infant was still commonplace, although many household manuals suggested this practice should be discouraged. Generally, the nursery nurse was not the focus of the same attention as the working class mother, who shared a bed not only with her infant but also with her spouse and other children in poorer homes. Within these homes, often only one, possibly two, rooms in a shared dwelling, the provision of clearly demarcated child space would have been impossible and the multi-purpose use of space was a common feature.

Work, leisure, household activity, sleep and presumably conjugal relationships were often all conducted in the same space. For example, the accoutrements of daily work, such as rags for 'picking' or goods for resale, were placed beneath the bed at night, the family shared the space of the 'parental' bed, and food was cooked on an open hearth, all in one room. The

use of space saving devices is also recorded at this time, and there were incidents of infants being suffocated by being accidentally trapped in folding beds, and of infants dying by falling through the spars of upturned chairs being used as make-do cribs. Also, the multifunction use of the hearth for heating, cooking and hot water was at odds with the safety of children, with legislation introduced in 1908 making it compulsory to use fire-guards to prevent the numerous, often fatal, accidents that occurred each year when children fell into unguarded fires. In a middle-class nursery, using a fire-guard may have been a simple matter, but in the space limited multifunction household which used the hearth for purposes other than heating, using a fire-guard was not. Child space in such circumstances was a luxury that was beyond the means of many households.

The role and value placed on infants, infancy and infant life is then contingent on broader social conditions and as such varied from place to place and from time to time. As later chapters will demonstrate, an increased awareness of sudden infant death in bed (generally interpreted as overlaying) emerged as an issue in the 1880s, was elaborated following the Annual Report of the Registrar General for 1890, and reached its height in 1906 with the publication of an editorial in the Lancet that was particularly damning of 'overlaying mothers'. However, concerns about overlaying emerged against a broader background of concerns about infant mortality and welfare (Armstrong: 1986; Lewis: 1980; McLeary: 1933). It has been claimed that childhood was being re-conceptualised at this time (Jenks: 2005) and one of the ways this occurred was through the way children became the increased subject of legislation protecting their welfare, preventing their exploitation and governing their control. The legislative focus on childhood and children reflected what has variously been described as a shift in the worth of children (Zelizer: 1985: 3), a re-conceptualisation of childhood (Steedman: 1990), and a shift in child image (Jenks: 2005: 64).

The increased affective value of the child occurred at a time when the economic dependence of children was also increasing, and the latter has been given as explanation of the former. The contribution of a child to the family economy was being diminished by the protective legislation of the nineteenth century, which restricted the economic activity of children most notably by their controlled and reduced participation in paid employment. This, together with the time demands of compulsory education, extended the period that a child was financially dependent. Children became a greater economic burden, a position that has continued and increased into the twenty-first century, when the dependence of a significant proportion of children has been extended into a period that was previously thought of as adulthood. Accompanying this, there was a marked change in the discourses

relating to childhood and the social value placed on the child (Ferguson: 2004:88) at a time when the immediate economic benefit of the child to the family was being restricted. But the family itself was not the only arena in which these changes were becoming apparent and in this sense the broader context of the nation was also relevant.

Declining industrial productivity, a falling birth rate, high infant mortality, poor national health, urban poverty, international competition, and the aftermath of the South African War (Davin: 1978: 9; Robb: 1998: 58), have all been cited as causes of the fear of degeneration that 'haunted' late Victorian Britain (Robb: 1998: 58). It is not surprising that infant life took on new meaning and importance as the population became recognised as a national resource (Davin: 1978: 9), and also not surprising that women as mothers became a focus, because of their role in bearing and rearing children (Robb: 1998: 58). As "population politics" (Yeo: 1999:203) took on greater importance for the state, so "medicine and science spotlighted women as mothers of the race" (Yeo: 1999: 202). However, as Robb (1998: 58) points out, there was no consensus as to the proper maternal role and sometimes mutually reinforcing but sometimes contradictory discourses rooted in science, morality and nation building proliferated. One example of this is the eugenics movement of the period, which saw disputes about who should and should not be encouraged to motherhood. Nation and race became synonymous in these debates (Robb: 1998: 58; Yeo: 1999: 202) and in the context of empire and international competition, "The strength of the nation, and even the future of the empire, was said to rest on their [mothers'] shoulders" (Yeo: 1999: 201).

It was not only a question of increasing the national population, but of increasing it with the right infants borne by the right mothers. Improved motherhood informed by the ideas of eugenics was seen as a solution to the perceived problem of race degeneration and national decline, framed in terms of individual mothers within the context of the family. This emerged as a powerful ideology of motherhood in the early part of the twentieth century where the duty and reward of women was to raise healthy children. The correlate of this, however, was that infant mortality and poor child health were also laid firmly at the door of purportedly ignorant and neglectful mothers (Davin: 1978: 13). Davin argues that this ideology of motherhood transcended class, but she also proposes that working and middle class women were positioned and criticised differently, with middle class women seen as having too few children while working class women were seen as having too many.

### **(c) Overlaying and infant mortality**

Infant mortality (usually represented in terms of the number of deaths of infants under one year of age in relation to the number of live births in a population) emerged as a socio-



medical problem during the twentieth century as a consequence of nineteenth century measures to monitor and record the general population (Armstrong: 1986: 211). The Registration Act (1834) introduced the idea that death should be attributed according to pathological cause and this became a requirement for death registration, marking the move away from 'natural cause' as a sufficient explanation of death. An analysis of death around age divisions was first conducted for the Registrar General's Annual Report for 1839, but it was not until 1857 that infant death under one year was reported and 'infant mortality' was not reported as such until 1877 (Armstrong: 1986: 211). The 1870s and 1880s mark the point at which a significant public awareness of infant mortality emerged through which 'the infant' was recognised as a discrete entity (Armstrong: 1986: 212), with the infant originally constituted in terms of its death. Although data regarding infant death had been collected before this time, they had never been collated in a way that reflected the death of infants under one year as a discrete group. Armstrong (1986: 214) makes the oversimplified claim that it is only from an early twentieth century perspective that infant mortality had existed prior to the late nineteenth century. This does not, however, allow for the gradual emergence of 'the infant' through the second half of the nineteenth century, which is witnessed in increasing public concerns about infant death, welfare and infanticide. Armstrong is in fact focusing on the point at which these ideas were consolidated in an 'official' recognition of the infant in the collation of government statistics. By concentrating on the Registrar General's statistics, Armstrong misses the gradual nature of the changes outlined, changes which should be seen as reflected in the Registrar General's framework, rather than emerging from it.

Armstrong (1986: 213) suggests that housing, nutrition and hygiene were the means through which the domestic sphere was drawn into the discussion of infant mortality, giving motherhood and maternity a new status (Donzelot: 1997). The 'new' status and meaning given to motherhood were, however, constructed in terms of responsibility and blame. Increasingly infant death was not understood as the 'social problem' claimed by Armstrong (1986), but instead constructed in terms of lack of maternal care, resulting in the discourse of 'maternal ignorance', with infant mortality its consequence (Newman: 1906). In this way, infant death was presented as caused by individual mothers who did not care adequately for their children, rather than in terms of the class and gendered pathology of infant death suggested in this thesis. Armstrong refers to the social conditions of the infant and mother. However, it would be more fitting if the discussion was framed in terms of material conditions shaped by socio-structural factors impacting on housing, nutrition, education and marital history, because a mother's ability to protect her child should be understood in terms

of her socio-structural position and ability to command resources. This is important in any exploration of the discourse of maternal culpability where, for example, poverty was often seen as a consequence of individual factors and 'fecklessness', rather than as a consequence of social structural positioning. This is particularly the case for infant overlaying deaths.

The age of the deceased has been identified as a factor shaping responses to death and the construction of infant mortality during the nineteenth century supports this idea, although Prior claims that the death of an infant in the nineteenth century did not warrant the attention currently paid to infant death (Prior: 1989: 83). While this may have been the case in some respects, the ways in which attention was or is given are important to note. Also it is useful to perceive the latter part of the nineteenth century as being transitional, because during this period a changing attitude to infant death warranted not necessarily less attention, but instead attention of a different kind, focusing on infant mortality in aggregation rather than on the death of individuals. This transition is shown with regard to 'still birth', where during the nineteenth century such deaths were not fully accounted and the 'still born' infant was not registered and its burial went unrecorded. This is a position persisting into the twentieth century but which would be unthinkable today.

Prior also proposes that the social value of an individual correlates with an increased possibility that a body will undergo a post-mortem examination following their death (Prior: 1989: 83). This claim is difficult to reconcile in the case of infants found dead in bed because of variability in the way that such infants became the subject of both an inquest and a post-mortem examination. For example, in coroner John Troutbeck's south-west London jurisdiction, all such cases were subject to post-mortem examination and inquest and in Prior's terms this would suggest that infant life held much greater social value in Troutbeck's jurisdiction than in the rest of London, clearly not a supportable line of argument. Also, the idea that post-mortem examination was an instrument wielded primarily against the working class (Prior: 1989: 3) does not hold true for working class infants in most of London circa 1900, and in any case it needs to be noted that without an inquest taking place there was no mechanism for paying a doctor to perform a post-mortem examination. Consequently post-mortem examinations were inextricably linked to the institution of inquest. But at the same time, social factors were undoubtedly interwoven with clinical factors in the selection of cases for post-mortem examination and social factors generally remained relevant in the attribution or suspicion of cause in death and disease. This is seen quite clearly in the cases of infant death, where marriage was viewed as a protective factor when it came to cases of infanticide, with unmarried women more likely to be accused of the crime (Cripps Lawrence: 1870: 276).

In the case of overlaying death, the role of the coroner in the attribution of cause took on greater significance because of the sudden unexplained nature of such deaths. The Coroner's Act (1887) allowed a coroner to investigate when a person was thought to have died a violent, unnatural or sudden death. The infant body found dead in bed could be interpreted as either an unnatural or sudden death; but while classified as a violent death by the Registrar General, overlaying was never discussed in these terms in any of the inquests and case notes investigated in my research. Indeed, in his case notes pathologist Dr Freyberger, for instance, routinely reported an absence of 'external signs of violence' in cases which raised a suspicion of overlaying. In the case of an overlaying death, if a GP was willing to certify that the cause was known, then there was no legal requirement to hold an inquest unless the coroner decided otherwise. An inquest would also be held if a GP would not certify the cause of death, or if the coroner was not satisfied with the certification provided by the GP. Because constructions of unnatural and violent death were open to differing interpretations, coroners interpreted their role and the situations they encountered in a variety of ways. The consequence was that some overlaying deaths were recorded with no inquest taking place, and other deaths, recorded as due to natural causes, were subject to an inquest and the cause of death modified often by a verdict of 'accidental death'. Inspection of coroners' registers for the period my research covers show a routine combination of cause and verdict - 'suffocation' or 'asphyxia' and 'accidental death' - were used to denote overlaying deaths.

Attribution of unnatural death depended on medical-legal definitions, but also relied on social characteristics of the deceased (and in the case of new born infants, their mothers), such as gender, age and social class. Whether seen as accidental, sudden or violent, an overlaying death was usually considered to be unnatural and therefore viewed as a potential source of social disorganisation and disruption. This is seen when overlaying was constructed as a problem of intemperate working class women who lived in impoverished conditions. Both the immediate and broader context of the death were also significant in the inquest process. Also the death of an infant found dead in bed aroused suspicions which were increased if the death also occurred in a multi-occupancy dwelling in a poorer area, factors which denote the role of class and poverty in the identification of overlaying deaths. Later, as already noted, the situational or spatial factors were relocated to the 'cot' as the incidence of co-sleeping reduced, and this may have led to the identification of earlier overlaying deaths with the later twentieth century idea of SIDS or cot death.

In 1906, the Medical Officer of Health for the London Borough of Finsbury, George Newman, published his "Infant Mortality: A Social Problem", and Newman's work has since

been acknowledged as pivotal in addressing the issue of infant mortality in England (Garrett et al: 2006: 3). However, its seemingly progressive title is belied by Newman's identification of what he defined as the real problem, not infant mortality due to social conditions, but infant mortality as a problem confronting the nation because as he states "a nation grows out of its children" (Newman: 1906: 2). The loss of infant life was the loss of "a vast army of small human beings that lived but a handful of days" (Newman: 1906:2). Then, as now, a low rate of infant mortality was taken as an indicator of a healthy community, with the assumption that as life became more healthy, so the death rate should steadily decline. The problem Newman faced (as many before and since have done) was that, although the ordinary death rate was falling, this was not reflected in the rates of infant mortality. Indeed, at the time he was writing in many places the rate of infant mortality had increased despite the "marvellous growth of science and preventative medicine" (Newman: 1906: 2), with approximately 120,000 or one quarter of all deaths each year being the deaths of infants.

This 'social problem' was exacerbated by a rapidly declining birth rate, which for Newman meant that "this loss of life is now operating in conjunction with a diminished income" (Newman: 1906: v), a situation which he took to be indicative of race degeneration. Importantly, a high rate of infant mortality was "an indication of the existence of evil conditions in the homes of the people - which are, after all, the vitals of the nation" (Newman: 1906: vi). And it is here that for Newman the problem lay. That is, the problem was for him 'in fact' a problem with the people and the individuals responsible for the care of each infant. The result for him was that the social problem of infant mortality was not caused by social factors beyond individual control – such as poor housing or poverty - but by the people themselves, by their lack of hygiene and poor household economy. In particular, Newman viewed mothers as culpable in the deaths of their children:

"Poverty is not alone responsible, for in many communities the infant mortality is low. Housing and external environment alone do not cause it, for under some of the worst external conditions in the world the evil is absent it is difficult to escape the conclusion that this loss of infant life is in some way intimately related to the social life of the people" (Newman: 1906: vi)

Newman's argument is conducted in naturalistic terms and presents advancing civilisation as mastering nature and subverting the otherwise natural order of high rates of infant mortality. This use of the terms 'people' and 'individual' can, however, be reinterpreted as mother(s) because, as he later states:

"This book will have been written in vain if it does not lay the emphasis of this problem upon the vital importance to the nation of its motherhood" (Newman: 1906: 257)

And it is motherhood which was seen to be at the root of infant mortality:

“It becomes clear that the problem of infant mortality is not one of sanitation alone, or housing, or indeed poverty as such, *but is mainly a question of motherhood* (italics in original) (Newman: 1906: 257)

But ‘motherhood’ in turn then unpacks as mothers and ‘the mother’. The domestic education of mothers was seen as crucially important for “efficient motherhood” (Newman: 1906: 256), while the broader social context provided only indirect influences on the child:

“Who depends for its life in the first twelve months, not upon the state or the municipality, nor yet upon this or that system or crèche or milk-feeding, but upon the health, the intelligence, the devotion and maternal instinct of the mother” (Newman: 1906: 258)

Consequently, for Newman, the first requirement in addressing the issue of infant mortality was:

[A] higher standard of physical motherhood [...] we must first attempt to solve the problem through the mother. (1906: 258)

It was mothers, rather than women in general, who required this special attention, adequate feeding, education and improved health because it was through control of women as mothers that improvements in infant mortality and national standards could be obtained. Newman quite clearly links infant mortality, maternal responsibility and the national good in an argument proposing that the activity of mothers must be constrained in order that infants could be efficiently raised to adulthood for the benefit of the nation. In light of Newman’s ideas and argument, it is not surprising his work has subsequently been described as controversial (Garret et al: 2006: 4) or that Newman himself has been identified as chief proponent of the thesis of maternal ignorance because of his claim that the infant death rate was “more largely due to maternal ignorance and neglect than to any other single cause” (Dyhouse: 1978: 257-8).

It is perhaps the work of Newman (1906) that led Lewis (1980) to state that child welfare became a national issue for the first time during the twentieth century. But as this thesis has already commented child welfare was actually seen as significantly important to the nation at a somewhat earlier period and most notably during the latter half of the nineteenth century. Awareness was further increased when Britain engaged in the South African War of 1899 to 1902, and it was at this point that the physical condition of men volunteering for the army brought to light the poor physical condition of the population (BPP: 1904: Cd2175). The campaign to ‘glorify, dignify and purify motherhood’ that Lewis identifies as emerging after the South African War was in fact a continuation of the situation existing previously, with infant mortality and welfare already viewed as an issue connected

to maternal care and responsibility. By the time comments were being made about the physical failings of army recruits, women had already been cast as responsible for the physical care and well-being of their offspring. It was in this context that Maurice (1902: 81, 85) was able to lay the blame for everything from short stature to flat footedness at the door of mothers and maternal ignorance. This is why, as the infant welfare movement developed into the twentieth century, the education of mothers became the main thrust of the various campaigns, and led to what Lewis describes as the ‘gap’ between official policy regarding maternal and child welfare services and the major needs articulated by women at the time (Lewis: 1980: 14).

By the turn of the twentieth century, child welfare and infant mortality had been closely linked to what had become the issue of national efficiency, with the cost of infant mortality identified as a loss to the nation which would impact on national wealth and status (Newman: 1906; Searle: 1971). The individualisation of infant death and welfare, of which Newman’s ideas are an example, saw such problems as originating in individual moral failure, taken one step further by apportioning blame on mothers for all manner of social conditions that impacted on infant welfare, such as poverty (routinely attributed to the ‘feckless’ behaviour of mothers) and poor domestic hygiene (blamed on the bad habits of mothers rather than on a lack of municipal sanitation and hot water). Lewis does not overstate the case in claiming that infant mortality was seen in particular as a “failure of motherhood” (Lewis: 1980: 19); and in the context of many infant deaths, this acted to locate responsibility predominantly with working class mothers. Indeed, overlaying was seen primarily as a cause of death for working class infants found dead in bed with their mothers, again highlighting the class and gender based pathology attributed to such deaths.

The collation of infant mortality statistics over the nineteenth century and early twentieth century helped to make visible not only the numbers of infants dying each year, but also the attributed cause of each death and its relationship to the population in general. The geographic distributions of death rates, together with the temporal variability seen with deaths at differing ages, at differing times of the year, and from year to year, introduced the idea that spatial and temporal factors influenced mortality rates. It became apparent that, if the organisation of space and time could have a detrimental influence on rates of mortality, then control of these factors could be used to influence rates of mortality in a positive way.

Interest in infant mortality as a social issue had taken on significance in the 1860s in relation to infanticide (Behlmer: 1979), although it was not until later in the century that infant mortality became a problem that had at its centre the social construction of child survival as a technical problem (Ferguson: 2004: 5). The parent-child relationship became

more extensively regulated during the 1880s, and it was the emergence of child welfare agencies at this time that marked the changed meanings of child maltreatment and saw a reconstitution of the relationship “between the state, parents, children and civil society” (Ferguson: 2004: 26). These changes concerned not only relationships within the family but also the relationship between the family and society more generally, with a subtle ideology of care emerging at the time “that possess[ed] the high ground, defie[d] opposition and exercise[d] a continual control over the child in the name of what [was] best for them” (Jenks: 2005: 40). These new regimes of child rearing marked the transition of action from exterior space to interior space (Jenks: 2005: 79), from the public to the private sphere, with increased control over the child within the home also involving a control over mothers, shaping not only what it was to be a child but also what it was to be a mother:

“Surveillance, in the form of childcare, proliferates in its intensity and penetration through agencies of midwives and health visitors, nurses and doctors [...] and so on through layers of scrutiny and isolation, all constituted for the child’s own good.” (Jenks: 2005: 68)

For Ferguson (2004: 26), these new practices emerged from the specific socio-historic context, where capitalist development and urbanisation brought together the ‘masses of people’. However, these changes could equally be seen as demonstrating modern relations of power (Jenks: 2005: 68). Whatever their origins, the consequence was to bring an “individualising gaze” (Rose: 1986), because the close proximity of the classes led to an attempted control of the ‘poor and dangerous’ by making them visible through social intervention (Ferguson: 2004: 29). The new ‘visibility’ of the individual covered not only adults but also the children and infants of the poor, who became constructed as the adults of tomorrow.

This increased visibility of the child was also demonstrated in nineteenth-century medical texts, knowledge of which enabled the monitoring of the foetus before birth, measuring it against a scale of normal development. Such texts became common-place in the nineteenth century and also informed medical jurisprudence, which resulted in clear guidelines about the viability of the foetus at different stages and the signs of its (pre)maturity. These texts were used not only to gauge the correct development of a foetus, but also to identify it as prematurely delivered, miscarried or aborted.

Regulation of the mother / infant relationship by enforcing spatial and temporal routines was seen as essential for the protection of the infant, and this included when and where sleep was permissible. The scrutinised mother was also constituted as part of the mechanisms of scrutiny because there were situations in which it had become necessary to protect the infant from the mother. Also, to prevent bed-sharing, the mother had to accept the

requirement of separate sleeping, feel responsible for enforcing this, and bear the guilt of an infant death should she fail. Such things could not be monitored in any other way because the mother had responsibility in theory and practice for infant care. In this respect, the role of men was peripheral: for instance throughout pathologist Dr Freyberger's case notes men are repeatedly shown as deferring to the instruction of women in relation to child birth and infant care and as receiving instruction from mothers, mothers-in-law and neighbours. The change to single sleeping could only be achieved through the complicity and coercion of the mother, gained around the discourse of the 'ignorant, careless and feckless' mother. This was a "far more intrusive correction and training of the psyche" (Jenks: 2005: 79), because for the mother it marked both the public shame of the inquest and private guilt of the 'failed' mother, with the mother drawn into a relationship with childcare professionals "all conspiring together for the child's own good" (Jenks: 2005: 82). This process bears out the transformation from direct physical control of the body to the mediated control of the psyche proposed by Foucault (1991).

The idea "that it is possible through social intervention to protect children from avoidable harm and even death" (Ferguson: 2004: 3) is relatively recent and emerged in the late nineteenth century. Ferguson identifies this as the modern form of the 'child problem' and locates its origin to the period between 1890 and 1914 (Ferguson: 2004: 77), when he claims child survival arrived "on the scene" (Ferguson: 2004: 5). It is not by chance that this coincides approximately with the thesis of infant overlaying gaining increased acceptance following the Registrar General's Report of 1890. From this time, overlaying, which had generally been presented in terms of an accidental death, was increasingly viewed as a product of maternal neglect. The events surrounding such deaths were, however, rarely so straightforward because both care and neglect could be represented in the act of bed-sharing and the 'caring' mother was also portrayed as likely to overlay her infant through her attentiveness. Child protection work brought into question the values and practices of the working class and challenged the strategies that they employed in their daily lives (Ferguson: 2004: 36), especially around the practice of bed-sharing and in the case of overlaying.

Child protection was seen both in terms of a child's physical protection from abuse and also their moral protection (Jackson: 2000: 7). Importantly, the innocent child was viewed as subject to the corruptions of the environment, including through the infant's exposure to adult knowledge. It became essential therefore to protect the child from negative environmental influences, and it was considered that such influences could derive from the infant's own mother. Risks and risk avoidance were understood to occur in several ways, but importantly this included the moral risk posed by the sharing of adult space and time



(Ferguson: 2004: 100). This was constructed not only in terms of risk to the child, but also in terms of potential threat and risk to the future, including the production of future citizen subjects, again reflecting the constitution of infants in terms of the adults they would become. Consequently, 'the child in danger' could become the 'dangerous child' and adult; with child protection acting in terms of "what they were going to be" (Ferguson: 2004: 100). Children were seen as both at risk and as potential threats to social order, signifying disorganisation and disruption. The home was seen as the space where children were at risk but it was also be the place where they could be closely monitored and protected. In consequence, the focus of child protection became centred on the home as a locus of moral corruption and risk, and at the same time the means of maintaining social order:

"The focus of social intervention shifted from men to woman, or more accurately, to mothers and children and involved a literal shift of focus from the public to private domain. As nineteenth century runs into twentieth, the key metaphor becomes dirt, reflecting political fears and questions involving the training of women as housewives and mothers to have clean and orderly homes and children" (Ferguson: 2004: 67)

The compilation of national infant mortality rates (IMR) in the latter part of the nineteenth century was important in bringing to public attention the high number of infant deaths. There is, however, a distinction between the perception of an individual death and of the aggregated statistical reporting of deaths. The deaths of individual infants had not, thus far, caused great outcries of public concern, but once aggregated, the vast numbers of anonymised infants which were presented in statistical accounts and reports constructed infant mortality in terms of the subsequent cost of these deaths to the nation. The changed perception of infant death from a private to a public concern subsequently made it possible for the overlaying thesis to become dominant during the period.

Here, Mills's (1967: 8) distinction between 'personal troubles' and 'public issues' is helpful in understanding the way that infant mortality became a issue for public concern. Personal troubles occur regarding the individual and their immediate relations with others and relate to the delimited arena of personal experience and relationships. The resolution of personal troubles lies within this arena too, because troubles are principally private matters. 'Public issues', on the other hand, transcend the local environment and interpersonal life and relate to the way that 'personal milieux' are organised, mix and overlap to form the larger structures of 'social and historical life'. A public issue emerges when public values are challenged. However, personal troubles and public issues can occur conterminously rather than as binaries, with personal troubles being transformed into public issues and infant mortality and overlaying death provide examples of this. The personal trouble of an infant

overlaying death at one and the same time is constructed as the public issue of infant mortality, with the contested ground of an infant overlaying death bringing together both the 'personal troubles of the milieu' and the 'public issues of social structure'.

Mills suggests that a public issue emerges because of a crisis in institutional arrangements, and certainly overlaying as one particular form of sudden death can be understood as emerging from a crisis in institutional arrangements focused around Britain's changing role as a nation and concerns about national efficiency and (re)production (Newman: 1906; Searle: 1971). That is, public concern about infant overlaying was promoted within the context of the nation-state as part of wider concerns about infant mortality and adult deficiency and the consequence of these for the nation. In Mills's terms, then, it is necessary to understand the "interplay of the intimate settings" of the home and bed with "their larger structural framework" (Mills: 1967: 158) and adopt a position that views overlaying in terms of the "history-making unit" of the "dynamic nation-state" (Mills: 1967: 158), because:

"When we understand social structures and social changes as they bear upon more intimate scenes and experiences, we are able to understand the causes of individual conduct and feelings which men [and women] in specific milieux are themselves unaware" (Mills: 1967: 162)

Along with the transformation of infant mortality into a public issue, death and its social management were also being transformed in the nineteenth and early twentieth century. It has been suggested that during the twentieth century death has become privatised but this is not a straightforward process (Stanley & Wise: 2011), and also while for some people some aspects of death, for example contact with the deceased body, have been sequestered, knowledge relating to death, along with its frequency and causes, has become more visible. It is therefore necessary to understand infant mortality and infant overlaying in this broad context. Ferguson (2004) comments about the sight of death being relatively commonplace at the beginning of the twentieth century, but by this time mortality rates generally had diminished and improvements were being made in reducing the rate of infant mortality specifically. The recording of deaths and their reporting in statistical terms helped increase people's awareness of the deaths that occurred, and information about death became more readily accessible and communicable as a consequence (Ferguson: 2004: 139). At the same time, the bodies of the deceased were being increasingly hidden away, and this can be seen with the 'viewing' of the body during an inquest being moved from its quite literal central position in the process, to the isolation of the coroner's mortuary where it was closed off from the proceedings and the participants guarded from its presence.

It is therefore important to distinguish between knowledge of death as a population

issue where high numbers of anonymous infants died, and the personal experience of an infant death. This distinction was mediated by a direct relationship to the bodies of the infants concerned and gave rise to the apparent paradox of death being privatised while at the same time the subject of increased public awareness and scrutiny. It was the public accountability for and monitoring of death that fed into public discussion of infant death (Ferguson: 2004: 132), rather than direct experience of the death of children and overlain infants in particular. This public focus constructed death as far more disruptive to the social order than the personal and private experience of infant death. The idea that death became privatised has also been challenged by Prior (1989), who emphasises the increased visibility of death in today's society. As has already been stated, this was already discernible c1900, where there had been a move from the private loss of an infant toward the public loss of a potential citizen. Far from being invisible, infant death was being taken into the public domain in a way that no such death was allowed to pass unmonitored by the state. Interest in the death of infants as a population issue emerged in the context of the expanded role of the state and around the cause of 'national efficiency', and witnessed the proliferation of official roles including coroners and public health officials, prescribed roles for forensic pathologists, midwives and doctors, and the growth of child welfare organisations.

This is particularly relevant to overlaying deaths, where a previously private event became the subject of public scrutiny and through the office of the coroner a surveilling focus was brought to bear on such deaths. In this process, women and their ability to care for their infants came under scrutiny and maternal care and infant death became an issue of public regulation through discourses around 'maternal culpability' and 'infant mortality'.

The process of attributing cause of death also became increasingly important through the period and in this regard a number of influences were crucial. Generally, the medical history of the deceased was the primary source of evidence for the doctor certifying death, but in the case of the death of a newborn infant the evidence available was usually minimal. Also, the precipitating factors around age, class and gender that were normally considered central were not given significance in the case of infant death, and because of this the social circumstances of the mother took on much greater importance (Ferguson: 2004; Prior: 1989: 94). In addition, competing perspectives and professional knowledge, such as those of the coroner and the pathologist, produced claims to causal explanation with a tension between the discourse of pathology and discourses concerning the social context of the death. On occasions when the pathologist's view of overlaying became dominant, the role of social factors was minimised, with attention directed away from the mother's socio-economic status and toward the body and disease, a shift that relocated the official gaze from (external)

situational to (internal) biological causes.

Prior (1989) and Armstrong (1986) offer contrasting explanations about the role of pathology and social factors in their constructions of infant death and mortality. Prior suggests there was a changed understanding of death and disease occurring through the nineteenth century, moving away from the 'zymotic nosologies' based on socio-geographic space toward a 'germ theory' of disease based on the physical body (Prior: 1989: 39), and this gave pathology a greater credence while reducing the role of the 'social' in the explanation of death and disease. This is in contrast to Armstrong, who identifies infant mortality as recast in terms of the social sphere at the start of the twentieth century (Armstrong: 1986). In considering the merits of their arguments, it is important to note the distinction made between clinical (pre-death) knowledge of the patient and pathological (post-mortem) knowledge of the patient in medical discourses at the beginning of the twentieth century. Thus, while it is clear in Dr Freyberger's accounts that the role of socio-economic processes was made peripheral, in the accounts of others, such as in St Pancras with Dr George Danford Thomas, it is not. For these latter cases, although medical discourse had great influence, the medical view encompassed the social context of the death in a way that often gave social context primacy over pathology in readings of the death scene. Reading the death scene and events leading to it was part of the GP's role and this illustrates the divide between clinical and pathological knowledge of the body which is seen in the contemporaneous debates between doctors, coroners and pathologists. In these, clinical knowledge was seen to denote a situated knowledge of the body and disease before death, with pathology denoting a de-contextualised reading of the dead body undertaken in a mortuary. This has been described as the exclusion of humanity from explanations of death, replacing earlier explanations grounded in human existence and agency (Prior: 1989: 43). The later decrease in the number of overlaying deaths reported annually may reflect this change in focus, where the agency of the mother was replaced with causal explanations rooted in the body, demonstrating the shift from external to internal causation. Anatomical pathology represents the ordering of a physical space but it must also be understood as ordering an epistemological space and this led to death being constructed in terms of isolated physiological events rather than through 'social' disease (Prior: 1989: 45). This is reflected in pathologist Freyberger's accounts, while social context predominates in the inquest reports of Danford Thomas in St Pancras. However, because overlaying deaths leave no pathological evidence to be found in or on the body, a focus on the pathology of overlaying at the cost of social and material factors left only an empty vista.

## Conclusion

This chapter has rejected the relatively unproblematic acceptance of overlaying death seen in current and historical literature and suggested instead that infant overlaying should be understood as a complex socio-structural category of death amenable to sociological conceptualisation and analysis. The categorisation of overlaying death informs and is informed by the discourse of overlaying and other discourses around class, gender and medicine, among others. Most importantly, the overlaying thesis supports the nineteenth century discourse of 'maternal ignorance', which placed responsibility for infant mortality on women as mothers and constructed such deaths as both unnecessary and preventable.

During the nineteenth century, social change in the form of urbanisation and population growth set infant mortality against a background of the nation state and national efficiency, and as a consequence the previously private relationship between mother and infant became an issue for public scrutiny and control. The intervention of the public gaze into the formerly private space of the household ensued. The central role of the body in control and discipline was seen in a promulgated reorganisation of household space especially in regards to the bed and bedroom, but with this having variable practice. The issue of bed-sharing became significant in this context, because the presence of the infant body in the bed(room) breached emerging ideas about discipline, routine and control. In the event of an infant death in bed, there was an assumption that the infant had been overlaid. However, this owed more to attitudes about morality, working class mothers and infant mortality than to the actual death of individual infants

The sequestration of experience in terms of reproduction, birth and death was complex, but included the increasing sequestration of infancy itself as a period of life. The sequestration of infancy served to protect individuals and society from the precariousness of infant life at a time of high infant mortality when sudden infant death in bed posed an existential challenge that could not be managed in the way of other, more predictable deaths. Such deaths were increasingly constructed as the responsibility of individual mothers and this limited their consequences for others, thus helping to preserve ontological security. This entailed the separate categories of the mother and infant as social entities, with the role of the culpable mother marked out as special, eventuating in a concurrent reconfiguration of both motherhood and infancy.

This chapter has set out the sociological concepts that will be taken forward to investigate and analyse infant overlaying death, in particular ideas around intimacy, social organisation of space especially with regard to the home and bed(room) and infant care framed against a background of (non) normativity. These are used to cast light on practices

of motherhood and ideas about the 'ignorant' or 'good' mother and serve to support my theorisation of reflexive motherhood and maternal culpability. It also draws on ideas of structuration and uses sequestration as a means of developing the idea presented in this thesis that infancy, precarious in times of high infant mortality, was subsequently socialised and controlled during the late part of the nineteenth century. Of particular importance throughout the discussion that follows, and building on the theoretical framework set out in Chapter One, this chapter has explained how ideas around discourse can be used to explore and analyse socio-structural conditions of action, and shows how these can be applied to investigating individuals in specific grounded circumstances.

### **Outline of the following chapters**

Chapter Three outlines the public discourse that surrounded overlaying during the nineteenth and early twentieth centuries. It details the changing way that overlaying was constructed through the period and analyses its transformation in terms of the myth and thesis of overlaying, and suggests how these reflected underlying changes in power / knowledge marking out, among other themes, the specialisation of medical knowledge and the increasingly role of the state. Such changes are also explored through ideas of increased social differentiation and integration.

Chapter Four explores overlaying in terms of a routinely accepted form of infant death and sets this against the material and social conditions experienced by inhabitants of Somers Town, St Pancras, London c1900. In particular, this chapter explores conditions that had their origins beyond the immediate context of mothering that were faced by women in the day-to-day care of their infants. These included the physical organisation of space in the Borough, poor housing and sanitation, overcrowding and poverty. It shows that in the context of infant death under such conditions, mothers and others were confronted with (or accepted) overlaying as an explanation of sudden infant death in bed. This occurred despite high rates of infant mortality in the Borough. The ready acceptance of overlaying as a cause of death in these circumstances was largely informed by the myth of overlaying which gave meaning to sudden infant death in bed. In this sense, the research material also points to the inevitability of the overlaying diagnosis under such conditions. What it also highlights is that although women were constructed as instrumental in such deaths their culpability was not inevitably constructed in terms of retribution or punishment. Instead, such deaths were routinely construed as occurring by accident and coroners' juries supported this with their verdicts.

Chapter Five uses the case notes of pathologist Dr Ludwig Freyberger to detail and

analyse sudden infant death in bed. The case notes provide detailed descriptions of the circumstances of death in relation to individual named infants. They also provide detailed information about the context of the deaths including about their families, home, social position, health, and importantly, detailed information regarding the bodies of the infants discovered through post-mortem examination. This chapter sets out the domestic figurations which provided the context for sudden infant death in bed and also shows, how the setting of the household, and the relationships within and beyond it, influenced interpretation of such deaths. In addition, this chapter points up the different ways in which the infant body was constructed. Drawing on the idea of infancy as a sequestered period of life, this chapter shows that infant bodies were constructed as both passive – unable to resist overlaying and compliant during post-mortem investigation – but at the same time active – unruly, breaching norms of intimacy, and causing disorder. This suggests that infants, infant care and mothering must be analysed in a way that de-centres the physiological requirements of infants and instead views these individuals and practices in terms of their social construction.

Chapter Six details the dispute between coroner John Troutbeck and pathologist Freyberger on the one hand, and the GPs of south-west London, on the other. It explores the dispute as it played-out and drew on the discourse of overlaying as an (un)problematic diagnosis of infant death. It shows the actors in networks of interdependence with other individuals and institutions divided by the discourse around axes of acceptance and rejection of overlaying as an explanation of such deaths. Overlaying and the discourse surrounding it provided a diagnosis of death that supported or undermined the position of the protagonists. In this respect, overlaying became a point on which the dispute hinged with the discourse further entrenched or transformed. The actions of Troutbeck and Freyberger undercut the discourse of overlaying and it was subsequently permanently undermined but not completely eliminated. This chapter therefore marks a further transformation of the discourse of overlaying which saw its role in interpretation and diagnosis of sudden infant death in bed greatly diminished.

The substantive chapters of this thesis (Chapters Three to Six) are ordered in such a way that the investigation progressively drills down through levels of socio-structural conditions and action. It looks first to the discourse of overlaying and details its transition over the nineteenth and into the twentieth centuries using the typology of overlaying myth, thesis and discourse to explain the transformation. It then moves on to explore and analyse the lived space and physical conditions of overlaying c1900 by setting the inquests of overlain infants in the context of Somers Town as a socially constituted location. This positions individual overlaying deaths in relation to broad socio-structural conditions and the

overlaying discourse. The investigation then moves into the domestic sphere where the household, family and bed(room) space provide the setting for the immediate context of sudden infant death in bed. Here, the investigation shows how the overlaying discourse served to inform interpretation of, and provide meaning to the deaths and how this was employed by individuals in reflexive practice. The investigation then moves away from the deaths of individual infants and again presents the overlaying discourse as part of the socio-structural conditions of individuals but in circumstances where overlaying had become dis-embedded from its domestic setting and was played-out through networks of individuals who could draw on the discourse to support their practices and positions. In this way, the discourse of overlaying is explored and analysed through a series of levels from general socio-structural conditions in extensive networks to particular instances of individuals in context in the domestic setting and figuration.

Thus far, the thesis has set out the theoretical and conceptual framework that will inform this investigation of overlaying as a socio-structural historic event. It has also stated that these ideas must be supplemented to include two further investigatory concepts, those of sequestered infancy and reflexive motherhood. The research materials will set the experience of individuals, grounded in their day-to-day practice, against this theoretical background to explore, elaborate and challenge current understanding of historical overlaying. In the following chapters the features of overlaying death will be unfolded to reveal the intricate detail of its enactment. They will also show that overlaying was a complex of meaning and sense-making that was employed reflexively by individuals who were enmeshed in extensive networks and a wider socio-structural context.





## **Chapter Three: This Annual Slaughter: Overlaying, Intemperance, Neglect and Disagreement**

“A 2-month-old girl [...] was found in cardiorespiratory arrest beneath her unconscious mother. Full autopsy examination failed to reveal any features which would give an indication of the nature of the terminal event. [...] a situation mimicking classical ‘overlaying’” (Mitchell, Krous and Byard: 2002: 133)

“Overlaying is accidental suffocation of an infant by a sleeping adult. It is an uncommon occurrence but is most likely to occur when an infant is placed to sleep under covers on a soft mattress between two adults. Parental fatigue, intoxication and sedation increase the risk. Some infants are extremely susceptible to even a transient airway occlusion. There are no specific autopsy findings. (Byard: 2004: 37)

### **Introduction**

This chapter explores public representations of overlaying in the nineteenth and early twentieth centuries as they occurred in official publications, the national press and professional journals of the day, and charts medical, legal and general interest in overlaying and examines the way that women as (potential) overlaying mothers were portrayed as ignorant, neglectful and feckless. It also shows the way that the discourse of overlaying was deployed across a wide range of issues such as infant mortality, national efficiency and temperance, with a lack of consensus (especially within medical discourse) about the overlaying diagnosis. This chapter addresses the ways in which the discourse of overlaying was employed to shape the behaviour and practice of women as (potential) mothers, and shows that overlaying offered a conceptual container into which all manner of infant death could be placed and explained. The overlaying thesis is prominent in the material detailed in this chapter and shows that the medico-legal definition and acceptance of overlaying was often presented as unproblematic by medical and legal practitioners. Discussion here also draws on the myth of overlaying as a long-standing and self-evident explanation of sudden infant death in bed. There were a few voices of dissent to the overlaying thesis, most notably from Thomas Wakely, the first medical coroner of England who, in 1855, challenged the idea of overlaying death; and also from coroner John Troutbeck and Dr Ludwig Freyberger, both of whom appear prominently elsewhere in this thesis.

Following discussion of the ways in which the term overlaying was frequently used during the nineteenth this chapter provides a detailed analysis of reports of overlaying death from the early part of century. This shows the way that overlaying gained prominence as an explanation of infant death during the last two decades of the century with an increase in

both the numbers of deaths reported and also the increased attention that these deaths were given in the press. The role of the Registrar General and official requirements regarding infant mortality were central to the way that overlaying deaths were reported and perceived. This suggests that the re-categorisation of infant suffocation deaths over this time-period contributed to an increased sensitivity to both the possibility and the frequency of such deaths. The issues that surrounded the diagnosis of infant overlaying and suffocation in bed in terms of pathology remained unresolved throughout the period, a point which offers support to the claim that overlaying was reinterpreted in terms of its social construction rather than through changed medical scientific understanding of such deaths. The correspondence of coroner Walter Schroeder (1920), previously deputy to coroner George Danford Thomas, provides an example of the ideas about infant overlaying that came into being after the first decade of the twentieth century, when the overlaying thesis all but disappeared from discussion of infant mortality. The sources offered here represent an important insight into the discourse of overlaying and demonstrate its increased significance through the nineteenth century and decline in the early part of the twentieth century

### **Overlaying, overlying, overlaid: a death in need of definition**

Overlaying, in its literal sense, is the death of an infant in bed where the child is overlaid partially or wholly by another person restricting the breathing to the extent that the infant dies through an inability to breathe. This apparently straightforward and popular construction of the term is used frequently in discussions of infant mortality and welfare both currently and historically. Despite its apparent self-explanatory nature, the term is also often used in a range of circumstances that render its interpretation problematic when exploring texts. The term ‘overlaying’ has been used to describe suffocation caused in any of the following ways:

- Laid over by a sleeping parent or sibling
- By the bedclothes being pressed against the infant’s face
- By the infant’s face being pressed against the mother’s breast
- Being swaddled too tightly
- The infant itself moving or rolling so as to obscure its own breathing with a pillow
- Being overlaid by a domestic cat
- Being deliberately smothered by whole or part of another body during an act of infanticide
- The infant being ‘stupefied’ by breast milk containing alcohol consumed by the mother rendering it insensible and thus more susceptible to any of the above.

Despite the lack of exactitude, the terms ‘overlaying’ or ‘overlying’ were used in a relatively unproblematic way in nineteenth and early twentieth century texts, with overlaying portrayed as a routine cause of infant mortality during this period. The typical scenario involved an apparently healthy infant placed in the parental bed, perhaps fed at some time during the night, and being subsequently found dead in the morning. Either one or both parents (but usually the mother) might have been present as well as one or more siblings. The infant was generally found by the mother or sometimes the father upon waking and no explanation could be given for the death. Death was often certified as due to suffocation or asphyxiation, and if an inquest was held the verdict was generally that of ‘accidental death’.<sup>3</sup> Prosecutions for neglect, the possible charge for such deaths, were extremely rare in these circumstances.

Although reports of overlaying do appear in the first half of the nineteenth century, they were not frequent and did not seem to prompt the moral outcry or controversy which occurred in the latter part of the nineteenth century. The cases were reported as part of the general reporting of inquests in quite ordinary terms, the reports were short and to the point and the language used was matter of fact:

“Another inquest held at the Lansdown Arms, Shouldham Street, Marylebone, before Mr Stirling, and a respectable jury, on view of the body of Elizabeth Dillock, an infant six months old, who was overlaid by the mother. Verdict “Accidentally suffocated” (The Times: 16 December 1837: 7: B)

The following year, in 1838, another overlaying case also caused little controversy, although the report contained more detail of the circumstances of the infant’s death (The Times: 14 December 1838:3: D). In this case, it was reported that the child, Elizabeth Briggs, was found dead on the mother’s arm and so this was defined as an overlaying death in the broad sense that the term was used. Elizabeth’s death was “occasioned by suffocation as a consequence of being overlaid by its mother” (The Times: 14 December 1838:3: D). The parents were “respectable persons” living in Camberwell. The mother was “much shocked” at finding the “babe apparently quite lifeless in her arms”. The surgeon who was called to the house said that “the poor little infant had been suffocated by the mother overlaying it”. The jury returned a verdict of accidental death.

The coverage of Elizabeth Briggs’s death shows that overlaying was often viewed in a sympathetic way, but that this was dependent on the social context of the death and perception of the mother’s character. Elizabeth’s parents were ‘respectable’ and her mother showed an appropriate emotional response to the death by being ‘shocked’. This was not

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3 For a discussion of the methodological problems associated with coroners’ definitions see Atkinson: 1971.

always the case, however, as can be seen with the death of Sarah Simpkins, aged two months, where the mother received less sympathy because of her intemperance:

“It appeared from the evidence that [the] deceased’s mother was extremely addicted to intoxication; and that during the whole of Monday last she was out drinking. On coming home about 8 at night she took the deceased away from a fellow lodger, who had had care of the child, and went to bed with her, being herself at the time in a state of drunkenness. About an hour afterwards, the child’s father, who had been out at work all day, came home, and on going up to the bed found the child lying dead by the side of its mother having evidently been smothered by her accidentally”  
(The Times: 9 October 1841:6: E)

The jury expressed the view that “regrettably” the evidence was not such to “render the case cognizable by the criminal court” and recorded the verdict as “Died from being smothered by being overlaid by her mother, when the latter was in a state of intoxication”.

There is a marked difference between the cases of Elizabeth Dillock and Elizabeth Briggs on the one hand, and Sarah Simpkins on the other, for while in the first two cases the deaths were viewed as accidental, in the case of Sarah Simpkins’s death, her mother’s consumption of alcohol was interpreted as a sign of her culpability. It must, however, be pointed out that, based on this report of Sarah’s death, there is no clear evidence that she was overlaid by her mother; she was found by her mother’s “side” and the assumption of overlaying was made because they were in bed together and the mother was drunk. The reporting of the case seems to suggest that the mother was condemned because of her alcohol consumption (to which she was ‘extremely addicted’) rather than because of any direct physical evidence of overlaying. Later in 1841, The Times published an extract from the Registrar General’s Annual Report for 1839, with the number of infant deaths recorded as due to overlaying by the mother reported as 32; the total number of infant deaths in London for the same year was 8839 (The Times: 31 December 1841: 3:C).

An interesting report by a General Practitioner (GP), James Adams, appeared in the Lancet, in 1843. Adams claimed to have conclusive post-mortem evidence of an overlaying but his claim was not well received by Thomas Wakely, then editor of the Lancet. Adams’s report is unusual in that he claims the overlaying occurred, but that death did not follow immediately but was instead delayed<sup>4</sup>:

“The child had been remarkably healthy from birth, and nothing unusual in its appearance was observed on the evening previous to its death, nor at two o’clock of the following morning, at which time the mother lifted it from the cradle into the bed where she herself slept. Between the hours of five and six o’clock, a.m., the mother awoke and gave her child the breast, before rising to attend to her household affairs; and at half-past six o’clock, on going to the bed to see the child, she found it dead.”

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4 See Behlmer: 2003 for a discussion about the uncertainty around diagnosing death in the nineteenth century.

(Adams: 1843: 401-402)

Despite Adams's assertion that the child had been overlaid, he did not 'blame' the mother, and instead he suggested that tiredness caused by her industriousness was the likely cause of the infant's death. Adams observed from the woman's report that she fed the child and rose immediately, leaving the child in bed (and alive), but did not preclude overlaying as a cause of death: "That the child took suck so shortly before death does not, I conceive, militate in any way against my opinion" (Adams: 1843: 402). In Adams's view, then, overlaying did not always prove immediately fatal but could cause injuries that led to an infant's death at a later time. Thomas Wakely, as editor of the Lancet, completely disagreed with Adams's diagnosis and replied:

"The proof of the child having been "overlain" is exceedingly incomplete, and, from personal observation of scores of such cases, we can assure Mr Adams that the evidence is far from justifying such a conclusion. - Ed" (Lancet: 1843: 1033: 402).

This was not to be Thomas Wakely's only reference to infant overlaying deaths in his long career as doctor, coroner and editor of the Lancet; and indeed it was the subject of his attention for a number of years to follow:

"Who has not heard of cases of "overlaid" children found dead in bed? A few years since the metropolitan newspapers teemed with reports of such cases: the country journals still exhibit similar records. Yet we believe it may be stated as a fact, that not one child out of two hundred who has been found dead in bed has lost its life in consequence of having been overlaid. In Middlesex, fourteen years since, the constables, in cold weather, made incessant applications for inquests in such reputed cases. Several facts, however, soon occurred, which led to a conviction that other causes than pressure produced the death in instances where children were found dead in bed." (Wakely: 1855:103)

Wakely clearly rejected the overlaying thesis, instead calling for an epidemiological study of the deaths of these infants. His suggested method for this involved the development of a framework for post-mortem investigations that regularised the collection of data:

"If all post mortem examinations were to be conducted on one uniform plan, enough would doubtless soon be discovered of exact resemblance in a series of causes to enable practitioners to ascribe the cause of death to precise and adequate influence: we hope soon to be enabled to issue a tabular form for the reception of a record of all useful facts found on a scientific examination of every human body." (Wakely: 1855:103)

It is apparent that Wakely had gone some way in collating data on overlaying deaths and had begun to identify regularities in the seasonality and week-day patterns of infant deaths reported as overlaying:

"The greatest number of such bodies found dead are discovered in the months of

December, January, and February; the next greatest number in September, October, and November. The spring months-namely, March, April, and May, exhibit them in the third degree; and, beyond all question, the least number are found in the summer months-June, July, and August. Of the days of the week when such bodies are found dead, the greatest number are seen on Sunday mornings, next on Monday mornings, and the fewest on Saturday mornings.” (Wakely: 1855:103)

Wakely also noted that death occurred in “ninety five instances out of every hundred, after three o’clock in the morning. Not one out of a hundred of such bodies is discovered dead between nine and twelve at night” (Wakely: 1855:103). Wakely clearly held strong views on the issue of overlaying and considered such deaths “overlooked and misunderstood” (Wakely: 1855:103). He saw it as the duty of coroners and medical practitioners “to set the public mind right on this deeply interesting subject” (Wakely: 1855:103), and he also commented that the notion of overlaying was so widespread and pervasive that “Even jurors, from previously conceived erroneous notions, are often disposed to rush inconsiderately to wrong conclusions” (Wakely: 1855: 103). The investigation of these deaths, Wakely suggested, would enable medical practitioners to provide evidence “against the impertinent audacity of hired bullies, who but too frequently are absurdly styled learned gentlemen” (Wakely: 1855: 103). In his experience, which at the time amounted to some fourteen years and “hundreds” of examples of infants found dead in bed, Wakely claimed to have seen:

“Only two instances [...] in which the proof was conclusive that the little creature had been destroyed by the pressure of the persons who had been lying with them in bed. Even in one of those cases the question might have been fairly raised, whether the signs of pressure visible on the body had not resulted from contacts after death with the person who had slept with the deceased infants” (Wakely: 1855: 103)

Wakely was also sensitive to the feelings of parents who had been blamed for the death of their infants through what was described as “mismanagement, carelessness or criminal neglect” (Wakely: 1855: 103). But despite his call for a scientific analysis of such deaths, the overlaying thesis came to dominate and overlaying remained the formal diagnosis for many infants found dead in bed over the following fifty years.

Wakely was not completely alone in his concern about the validity of overlaying as a diagnosis of infant death. Over the following years, despite a general acceptance of overlaying as an explanation of infant death in bed, there were occasional voices of dissent. Cripps Lawrence, a London GP, provides an example of the concern expressed in some quarters. Cripps Lawrence described two of his own cases where overlaying had been suspected but where post-mortem examinations had subsequently identified disease as the cause of death. These cases caused Cripps Lawrence particular concern because they both involved single women and it was his view that single women were more likely to be

suspected of neglect or wilful intent to destroy the lives of their infants (Cripps-Lawrence: 1870: 276). His concern was well-founded, because frequent links were made at the time between illegitimacy and high infant mortality and infanticide (Cripps-Lawrence: 1870: 276). Later, The Times reported the number of infants overlaid by their mothers in the year 1871 as 277 (The Times: 18 October 1873: 7: E)

Up until this point in time, overlaying had been reported in the press and recorded by the Registrar General but was not taken as being of any great moral concern. Overlaying had briefly been linked to the moral panic about infanticide which occurred in the 1860s and Wakely noted a similar concern prior to 1855, but despite this, reporting of overlaying deaths seem to have continued much as before. As discussed elsewhere in the thesis there were occasions when alcohol was seen to be instrumental in the death of an overlaid infant, but this was viewed as a problem of the individuals concerned, rather than being taken as an indicator of widespread moral decay or collapse. During the 1880s, however, a shift occurred in the way that overlaying was portrayed and it began to be raised more widely as an issue of moral concern. In 1881 a poem about overlaying appeared in the Liverpool Mercury (Tickle: 1881: 5). This was highly emotive and should perhaps be viewed more as a work of fiction than as a factual response to the overlaying issue. It nonetheless suggests that overlaying was being viewed as an issue that arose from the moral condition of the families in which overlaying deaths occurred. The poem also conjured up an image of domestic life that was not conducive to a healthy society and showed authorities, in the shape of Liverpool City Coroner Clarke Aspinall, as blind to the problem:

O Aspinall with gentle spirit blest,  
Yet round whose feet Death's billows ever surge,  
Reaching our ears in many a doleful dirge,  
Can death-wave lift to heaven a darker crest,  
Than that which bears the babe upon its breast,  
Crushed, blackened, choked, in helpless agony,  
Beneath a mass of vile maternity?  
O tell us, sir, by what strange freak of law,  
The man who lifts his drink-besotted hand,  
And deals his wife the life-destroying blow,  
Should in the felon's dock a culprit stand:  
While drunken mothers, an increasing-band,  
Grown callous to the deed, their babes may crush,  
And pass unpunished, without shame or blush? (Tickle: 1881: 5)

Despite the grim picture suggested by Tickle's verse, overlaying continued to be reported ostensibly as a routine and relatively unproblematic diagnosis of death until 1890 and the Report of the Registrar General. Information regarding the number of infant deaths due to overlaying, suffocation by bedclothes and the newly combined category of suffocation



in bed between 1880 and 1890 are shown in Table 1 (Appendix 2). However, changes in the recording of overlaying death and its categorisation were made during this period, and these were set to change the public profile of overlaying for the following twenty years. The re-categorisation served as a pivotal point in the construction of overlaying as a moral issue of significance to the nation and national well-being. In addition, the 1890 Report assumed a clearly stated causal relationship between overlaying, alcohol consumption and intemperance. Under the heading of ‘Violent Deaths’, the Report states that overlaying deaths in the year 1890 accounted for 1517 infant (under one year) deaths, the “largest number in any preceding year“ (BPP: 1890: C6478: xv). It also claims that mortality from overlaying had been slowly increasing from 136 (per 100,000 births) to 174 in 1890. However, it did not highlight that a decline had occurred in the five years 1881-1885 (from 130 to 124), showing the variability of infant deaths rather than the continued year on year increase that the 1890 Report suggested. In addition, there was no mention made of the changes made to the reporting of infant suffocation deaths in 1886, a change which combined categories, so that what was once reported separately as “overlaying” and “suffocation by bedclothes” were subsequently reported under the single heading of “suffocation in bed“. Overlaying had, until this point, been the smaller category with perhaps one or two hundred deaths per year, and “suffocation by bedclothes” the larger category with over one thousand deaths per year. Once the categories were combined in 1886, infant deaths were frequently referred to in medical journals and press under the blanket term of overlaying. The change in statistical reporting reflects a classificatory change in recording rather than a real change in the number of such deaths, but it most certainly fuelled concerns because many assumed erroneously that there had been an increase in the actual number of overlaying deaths. As can be seen from Table 1 (Appendix 2), although there was an increase in the total number of deaths, from 1886 it is impossible to identify whether or not this was due to an increase in what had previously been recorded as overlaying death.

### **Overlaying and suffocation deaths 1890-1920**

The Registrar General’s 1890 Report made a number of influential points regarding the incidence of overlaying, noting that more deaths occurred in the winter months than in the summer months “doubtless owing to the heaping up of bedclothes in the colder weather” (BPP: 1890: C6478: 15), and also showing weekday variations in the pattern of deaths. Interestingly, these were the patterns that had all been identified and noted by Wakely in 1855 but, as has been indicated, Wakely had not drawn the same conclusions as the Registrar General (Wakely: 1855:103).

The most influential section of the 1890 Report did not, however, rely on the Registrar General's own recorded figures of deaths, but instead on the adjusted figures following coroners' inquests into cases of infants found dead in bed. The exact period covered is not stated, but it included 2020<sup>5</sup> inquests in which the cause of death was recorded as suffocation in bed and the day of the death was stated on the coroner's certificate. Of interest to the Registrar General was the pattern of deaths as they related to days of the week, and the Report noted that more deaths were seen on Sunday (283 per 1000) than on any other day of the week. The Report however, was careful to point out that:

“In interpreting this table, it must be held in mind that the deaths from overlying on any given night will be referred to the day succeeding that night. Thus a woman going to bed with her infant on, say Saturday night, if she finds on waking the next morning will describe the death, of which the precise hour is unknown, as having happened on Sunday morning and so with other days.” (BPP: 1890: C6478: 15)

By examining overlaying deaths as reported by the coroner, the Registrar General cast severe doubt over his own reporting of such deaths and introduced the idea that many such deaths were going unreported. This highlights one of the problems in researching reported overlaying deaths because there was a strong possibility that the cause of death could be amended following an inquest. Deaths previously recorded as perhaps due to bronchitis or pneumonia could be amended by the coroner and the death register annotated to show an overlaying 'accidental death'. This process accounts for the discrepancy between figures reported by the Registrar General in the 1890 Annual Report and the number of deaths reported by coroners for the same period, which suggests that overlaying death was perhaps more likely to be the diagnosis following an inquest than when a death was merely certified by a GP.

The explanation for these deaths and the conclusions drawn in the 1890 Report clearly state the causal role of alcohol in overlaying deaths and links this to the dissolute behaviour of working class people who spent whatever money they had on alcohol, being seemingly constrained in this behaviour only by their lack of funds and the need to work:

“Now, there is one explanation, and as far as can be seen only one, of this curious distribution, and that explanation is that it is determined by differences in the amount of intoxication on different days of the week. Saturday afternoon is the most general holiday and pay day, and is also a day on which public-houses are in full activity. Monday is also in some places a workman's holiday and a day when public-houses are fully open, and on Monday the wages of Saturday are as yet probably not exhausted. This last condition will also apply to Sunday, which also is a non-working day; but on Sunday the public-houses are partially closed, and the facilities

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5 The figure of 2020 was repeated in the many discussions of overlaying that followed the Registrar General's 1890 Report and formed the basis of subsequent discussion about the prevalence of overlaying.

of obtaining drink diminished; so that the smaller proportion of deaths on the night of that day, as compared with Monday night finds a probable explanation. Monday night passed, begins the real working part of the week, and the infantile deaths fall off in number, the proportion getting less and less as the week's money is gradually exhausted, until on Friday night there is again a slight rise, probably determined by that day being also in some industries and places, a pay-day. Such seems the only explanation that can be suggested for the distribution of the deaths from overlying; but if this explanation be the true one, it can scarcely be doubted that a similar interpretation must be put upon the very similar distribution of infantile deaths from other causes than overlying, as shown in the second column of figures in Table G, which gives the daily distribution of deaths of infants concerning which inquests have been held but other verdicts found than "suffocation in bed"; these other verdicts being to a very large extent such unsatisfactory findings as "natural causes", "convulsions" and the like. It is impossible to believe that an infant is more likely to die *ceteris paribus*, on one day of the week than another from "natural causes" or from "convulsion" and the suggestion now offered is that these findings by juries are to a large extent mere aliases for the overlying of an infant, or neglect of its requirements, by a drunken parent." (BPP: 1890: C6478: 16)

The Registrar General's Report quite clearly framed overlying as occurring as a consequence of alcohol intoxication on the part of parents, and presented the pattern of deaths, being highest on Sunday and lowest on Friday, as reflecting the household economy and the parents' opportunity to purchase and consume alcohol. Incidentally, as referred to by the Report deaths identified as due to 'All Other Causes' also showed a similar weekday pattern and this was clearly attributed to the failure of the inquest process to correctly identify such deaths as being the consequence of overlying rather than as occurring by chance.

The conclusions drawn in the 1890 Registrar General's Report with regard to overlying not only reinforced the overlying thesis but informed discussion for a number of years to come. Following its publication, the assumed association between overlying and alcohol consumption was often repeated and the 1890 Report referenced in support of this view of infant deaths. With seasonal patterns of death being causally attributed to the tighter swaddling and heavy bed clothes used in the winter, and the weekday pattern being attributed to the consumption of alcohol and the habits of the parents, overlying was constituted quite clearly as a phenomenon of the poorer classes. There was limited independent research or analysis of the data used by the Registrar General, and the explanation that infants died in bed because their parents were dissolute and drunken became a generally accepted part of the overlying thesis after 1890. An example of this is to be found in the work of Jones (1894) and Templeman (1892), with a detailed discussion of their work provided later in the chapter.

Unsurprisingly, because of the attention given to the subject by the Registrar

General, overlaying also began to draw more attention in the medical press and in 1890 a suggestion was made that bed-sharing between adults and infants should be made illegal and that parents should be held legally responsible for overlaying deaths, although as the writer conceded, enforcement of such law would be difficult (Lancet: 1890: 3472: 613). A few months later there was a report of an overlaying case in London's City Road Work House. The Medical Officer of Health for the parish had warned of the dangers of bed-sharing and overlaying and had recommended on two previous occasions that cribs be provided for infants in the 'laying in' ward, but this request had been ignored by the Poor Law Guardians, and mothers had been allowed to take their young infants into their beds (Lancet: 1890: 3482: 1136). Interestingly, there was no suggestion that alcohol was involved in this death and the strict supervision of the workhouse laying-in ward would have prohibited alcohol consumption. In this case, it was the simple act of bed-sharing that was thought to be the cause of the death.

In December 1891, a report of inquests held by the St Pancras coroner appeared in The Times. George Danford Thomas was influential as a coroner, Chair of the Coroner's Society and a keen proponent of the overlaying thesis. He stated that:

"During the recent severely cold weather, the mothers had, in some of the cases, nestled their children too closely to them, or had overwrapped them in their desire to keep them warm. The Coroner, in each instance, remarked that the children could have been kept equally warm in a cot if sufficiently covered, care being taken to leave the head uncovered. At least 200 children in his district alone had died in consequence of the parents persisting in having the children in bed with them, instead of placing them in cots." (Danford-Thomas: 1891: 8)

Although firmly convinced that infants were regularly being overlain by their mothers, Danford Thomas remained moderate in his treatment of the mothers who came before him in the coroner's court, blaming their ignorance rather than condemning them as wantonly neglectful. Danford Thomas raised the issue of overlaying frequently until his death in August 1910. In 1892, he again felt it necessary to draw "attention to the relatively large number of infant deaths attributable to overlaying" which he reported as "600-700 in London". Danford Thomas's explanation of overlaying death was again in terms of an accidental event and shows none of the recrimination seen in the explanation given earlier by the Registrar General. Danford Thomas is a clear supporter of the overlaying thesis although, as is common among many commentators, he conflated overlaying with other causes such as smothering by bedclothes:

"It was due, in his opinion, either to the child slipping under the bedclothes when the mother's arm on which it lies becomes relaxed in sleep, or to its being drawn too near and pressed against the breasts. Either explanation is quite feasible, the former as accounting for mere accidental self-suffocation, such as also occurs when an

infant is put to bed closely wrapped in a shawl; the latter as explaining the purely reflex act by which a sleeping parent may turn upon and smother her child.” (Lancet: 1892: 3566: 45)

Again in 1892, in response to the Registrar General’s Report, the question of overlaying and the high Saturday night and Sunday morning death rate was raised by a correspondent to the Lancet. He also linked overlaying to alcohol consumption and described the consequences as “really a form of infanticide” (Lancet: 1892: 3599: 435). The editorial response, however, proposed that there was more to the issue than alcohol consumption, commenting that the temperance movement and the prevention of drunkenness would not prevent all overlaying deaths and insisting that the only prevention was a ban on bed-sharing, for “over and over again it has been shown to be directly and almost inevitably accountable for a certain constant loss of infant life” (Lancet: 1892: 3599: 435). It was assumed that bed-sharing persisted among the poorer classes through ignorance and laziness but also through not having the means to provide a cot for the infant, and a number of recommendations for constructing an “extemporised crib or cradle” (Lancet: 1895: 3739: 1073) appeared over the following thirty years as coroners, medical officers, GPs and infant welfare organisations issued instructions on preparing a cot from drawers, apple crates, old boxes and the like. This simple solution would, according to some, prevent any further cases of infants found dead in bed:

“It is a simple matter to expose and condemn the practice which is mainly accountable for overlaying of infant children. Neither is there any difficulty in prescribing the only possible preventative of this so called accident. A box, a basket – in short any one of twenty simple contrivances – might form a extemporised crib in cases where a cradle or cot-bed is not obtainable [...] The careless, the indolent, and the drunken (it is notorious that the great majority of cases of overlaying have occurred in Saturday night) continue to neglect even such an elementary safeguard” (Lancet: 1895: 3739: 1073)

Here it becomes apparent that the 1890 Report by the Registrar General had become part of the discourse around overlaying death, bed-sharing and intemperance.

In 1892, Charles Templeman, a Dundee GP, conducted a study of 258 cases of suffocation of infants (Templeman: 1892: 322-329). Templeman referred to the 'usual signs' of an overlaying death in his discussion although circumstances meant that in a majority of cases he had not physically examined or conducted post-mortem investigations of the bodies. Despite this, his study provides a good example of the way that overlaying had become a category of death that encompassed more than overlaying in its literal sense. For Templeman, overlaying included death by being pressed against the mother’s breast, suffocation by bedclothes and suffocation by being overlaid by a parent. He summarises the

general histories collected during his investigation as follows:

“The child is put to bed in its usual health. When the mother retires, or at some other time during the night, she places the child on one of her arms, and puts it to the breast. At that time nothing unusual is observed. The mother falls asleep with her infant still at the breast and resting on her arm, and in the morning when she awakes she finds it in this position dead” (Templeman: 1894: 322)

Templeman’s claim that infants died as a consequence of being placed on their mother’s arm, and that they were generally found in this position dead, is not supported by the testimonies detailed elsewhere in this thesis from the case notes of pathologist Ludwig Freyberger, where infants were usually laid on the bed or pillow and less frequently on the mother’s arm.

Templeman identified the cause of such deaths as overlaying and attributed this to a variety of causes including ignorance and carelessness of the mothers; drunkenness; overcrowding; and “according to some observers” (Templeman: 1892: 324) illegitimacy and the insurance of infants, although the latter was an explanation from which he distanced himself.

Templeman claimed that many parents were unaware of the risks but that others had “utter disregard for the child’s life”, emphasising that “it has long been notorious that a very large proportion of these deaths occurred between Saturday night and Sunday morning, and early in my official career I was struck by the frequency with which I was called by the police on Sunday mornings to examine the bodies of infants found dead in bed besides their mothers” (Templeman: 1892: 325). Templeman stated that 118 of the 258 deaths (46%) were found on Sunday mornings. His explanation for this echoes that of the Registrar General in 1890, claiming that pay day fell on a Saturday and alcohol intoxication, although often denied by the parents, was the chief cause of overlaying deaths. He also suggested that the evidence of neighbours usually corroborated drunkenness on the part of the parents.

Templeman did concede that parents might stay up later and sleep longer on Saturday night / Sunday morning because they did not have to “rise for their work early in the morning [and] sleep more soundly than usual”, but dismissed this explanation as unlikely. He also noted a seasonal pattern to the deaths but attributed this to overcrowding, with as many as five children sharing the parental bed during the colder months. Culpability was an important aspect of overlaying deaths for Templeman and he suggested that making it illegal to bed-share with an infant under the age of two years (Templeman: 1892: 328) would make the apportioning of responsibility to the parents much easier. He also commented that in none of the cases he investigated had a prosecution take place:

“Can nothing be done to arrest this serious leakage of life? There is no doubt that deaths from overlaying are distinctly preventable and such being the case, the responsibility for its occurrence ought to be fixed on someone. When, however, we come to inquire into the degree of culpability to be attached to the parents, we at

once meet with a difficulty. The physical appearances, both internally and externally, give us no clue in determining whether the death has been accidental or homicidal.” (Templeman: 1892: 327)

This points to the core of the overlaying issue: although overlaying could be explained as accidental due to carelessness and ignorance or to intemperance and dissolute behaviour, there was always an underlying inability to prove the motive for an overlaying death or to identify its cause in absolute terms, and with this came the fear that countless infants were being quietly murdered.

In 1894, a report on infant mortality appeared in the journal of the Royal Statistical Society, under the title ‘The Perils and Protection of Infant Life’ (Jones: 1894). It offered a comprehensive analysis of the data then available on infant mortality, and suggested that the majority of perils to infant life were to be found in the home and were the responsibility of neglectful parents:

“The larger proportion of the preventable deaths of young children are not due to causes directly under municipal or State control, but are due to the habitual and general neglect of duty and responsibility by parents and guardians” (Jones: 1894: 3)

These deaths included the deaths of infants from violence, with it being in the space between ‘accidental’ and ‘intentional violent deaths that the category of ‘suffocation in bed’ was to be found and where overlaying deaths were recorded. Jones’s use of the category ‘suffocation in bed’ follows the categorisation used by the Registrar General after 1885, that is, that suffocation in bed included deaths attributed to overlaying, smothering by bedclothes and ‘other’ causes of suffocation in bed. Jones claimed that the majority of deaths were due to overlaying and smothering by bedclothes; but whatever the cause, these deaths were recorded as death by violence and he classified violent deaths as either ‘deaths by accident or deaths by design’. In Jones’s opinion “Simple carelessness is often only passive neglect, and [...] it is difficult in many cases to determine when such passive neglect becomes actually criminal” (Jones 1894: 3). Jones also suggested the overlaying was an ancient cause of death dating back to biblical times and cited the judgement of Solomon, noting that this biblical event too occurred “with dissolute people” (Jones: 1894: 39)<sup>6</sup>. This representation is a typical example of the way history was used to legitimate myth of overlaying. Interestingly, Jones did not compare infant mortality rates for 1881-1890 with ‘suffocation in bed deaths’ for the

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6 Book of Kings 3:16-28, two mothers present the same story to Solomon for judgement. Soon after the birth of their respective children, one woman woke to find that she had smothered her own baby in her sleep. She took her dead son and exchanged it with the other's child. The following morning, the woman discovered the dead baby, and soon realized that it was not her own son, but that of the other woman.

same period to see if there was any correlation, although he did mention elsewhere that infant mortality had risen from 1881 (130 per 1000 births) to 1890 (151).

Table 2 (Appendix 2) shows analysis of infant suffocation deaths by gender between 1881 and 1890 in terms of number and rates per million births. The Table shows that in over twelve thousand cases the difference between male and female deaths was only 231. Jones placed emphasis on the weekday and seasonal pattern of suffocation in bed, and he repeated the findings of the Registrar General's Annual Report for 1890. He compared the days on which infants were found dead in bed (presumed suffocated) with "Apprehensions for Drunkenness" in Liverpool for the year 1891. Jones compared arrests for drunkenness on Saturday with infants found suffocated on Sunday and provided a graph that for him showed "Identical curves", which were "very striking" and could not be "regarded as accidental" (Jones: 1894: 41). Accepting Jones's assumption that Liverpool can be taken as typical when considering the issue of drunkenness, other problems with his analysis still remain.

Overlaying deaths were primarily attributed to the mother of the infant but even when both parents were present the infant was usually reported as being by the mother's side, toward the wall or away from the father. In other cases, the mother was the only adult in the bed. Despite this, Jones provides no information regarding the gender distribution of the 'apprehensions for drunkenness'; and when the public nature of arrests for drunkenness is considered, it is likely that a high proportion of the cases would have been of male arrests. Jones provides no evidence of female drunkenness or arrests. Neither does he provide a seasonal analysis of the apprehensions for drunkenness to see if there are significantly more arrests in the winter months when the number of overlaying deaths also increased. These issues aside, the correlation identified by Jones is no more than that - although Jones himself claimed there was a causal relationship between the variables, there is no evidence to substantiate this claim. Despite these obvious problems, Jones's article contains three important ideas: it reinforced the idea that overlaying was caused by neglect verging on criminality; it emphasised the link between alcohol consumption and infant overlaying; and it claimed infant overlaying death as an old and well-known cause of infant death. In this sense it also constructed infant overlaying death as preventable. These ideas together drew on the myth of overlaying and supported the overlaying thesis by suggesting that large numbers of infants were killed by drunken and dissolute mothers and that such loss of life was a drain on the nation's resources that could be prevented.

An inquest held in 1895 highlights the way in which overlaying was coming to be viewed by some proponents of the overlaying thesis as occurring in consequence of maternal neglect. The case occurred in Lambeth, and coroner Althestan Braxton Hicks showed no



sympathy for the mother of the dead infant, Alice Elizabeth Wigden who had died aged three weeks. The Child's Guardian, a publication of the National Society for the Prevention of Cruelty to Children (NSPCC), reported the case under the banner "Infant Slaughter By Suffocation" (The Child's Guardian: December 1895: 163). Alice Elizabeth had been found dead in bed with her parents. She was the second child of the family to die in such circumstances, and it was this fact which prompted Braxton Hicks's response:

"The Coroner: Do you remember that I cautioned you only last December, when your previous child died through being suffocated in bed, as the doctor says this child must have been? In spite of the caution I gave you then, and your husband was present at the time, you are here again, under similar circumstances, in less than twelve months." (The Child's Guardian: December 1895: 163)

The article goes on to claim that in London during the previous ten months, five hundred infants had died due to overlaying. This claim highlights the variation in statistics seen in reports of overlaying because, while coroners claimed several hundreds of deaths each year in London alone, the various reports of the Registrar General do not support their claim. This suggests that the causes of a large number of such deaths were actually decided at inquest and were classified under other headings in the relevant Registrar General's Report. Mrs Wigden had delivered four infants of which only one was still living (two had been 'overlaid' and a third had died in hospital), but despite this history of infant death in the family, the jury returned a verdict of accidental death. Again, the exchange in the court was reported:

"The Coroner: [To the Jury] Accidental death, gentlemen? Nothing else?

The Foreman: No Sir.

The Coroner: You are perfectly satisfied it was a pure accident?

The Foreman: Yes, Sir.

The Coroner: Very well, Mrs Wigden, you can go on smothering your children as much as you like, the jury say. The foreman says this was a pure accident, and the jury say, after all these warnings, it doesn't matter. Well. Gentlemen, if you think that is a proper thing to do, by all means say it was an accident; but we may as well hold no inquests at all – it is a perfect farce." (The Child's Guardian: December 1895: 163)

The medical press supported Hicks's condemnation of Mrs Wigden and went further in their challenge to the jury, who they perceived as suffering from a lack of intelligence:

"The commendable zeal shown by coroners in dealing with cases of overlaying is clearly of little practical value unless it be supported by the intelligence and good sense of their jurymen. Unfortunately for the public interest it is not always thus aided." (Lancet: 1895: 3770: 1380)

This highlights a feature that occurred repeatedly at the inquests of overlaying deaths, that is, a staunch refusal by juries to return verdicts other than accidental death or natural causes. It was a rare event for a jury to suggest any legal culpability on the part of the mother and

prosecutions, on the very rare occasion that they did, were for neglect rather than for manslaughter, infanticide or murder. The attitude of lay juries was in striking contrast to the attitude of many professionals and raises another important issue which has also been seen in more recent times in relation to cot death. This is the view that although the death of one child could be explained as accidental, the death of a second infant in similar circumstances should raise a suspicion of murder.<sup>7</sup>

A link between the drunkenness of mothers and the incidence of overlaying had been made in Tickle's letter in 1881 but this took on greater significance following the Report of the Registrar General in 1890. After this, the issue was revisited in the work of Jones and Templeman, but from 1900 intemperance and the consumption of alcohol received increased attention seemingly in connection with the growing temperance movement. Some notable members of the temperance movement promoted the overlaying thesis and linked overlaying with the drunkenness. Chief among these were William Wynn Westcott, coroner for North East London District, and the Reverend Benjamin Waugh, Director of the NSPCC. The work of these two men represented a reinvigorated interest in overlaying and a renewed onslaught on the drunken and dissolute behaviour of mothers. For example, in a scathing attack on the 'poorest' women of London, Westcott wrote:

“The poorest women of London are the most drunken: the overlaying of infants is most common amongst the poorest, and we may safely say that parental intemperance is the cause of many such deaths. The drunken woman is a reckless, depraved, dissolute being, with only half a mind and no conscience, who goes stupidly to bed with her baby in her arms when she is drunk, quite careless of the consequences. Inquests are held on these deaths and juries call them accidental, but they are truly deaths due to culpable negligence.” (Westcott: 1903: 67)

Westcott's condemnation pulled no punches and created an image of depraved mothers, stupefied by alcohol and callously neglectful of the needs of their children, regularly suffocating young infants, and being allowed to escape justice by juries who ignored evidence of maternal culpability. But although Westcott's words were emotive, his case is not well argued and his discussion of so-called “overlain babes” conflates causes and circumstances beyond overlaying by a drunken mother, as he includes all manner of infant deaths such as those caused by bed clothes and pillows, the lack of a cradle, overcrowding and poverty, and high rents and limited space. In addition, the source of Westcott's information is not recorded and the number of deaths he claimed was extremely high in

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7 Angela Cannings and Sally Clark were both convicted of murder following the death of a second infant from Sudden Infant Death Syndrome. Both convictions were subsequently overturned on appeal <http://news.bbc.co.uk/1/hi/england/wiltshire/3306271.stm> [Accessed 15/07/09]

comparison to the figures recorded by the Registrar General. For example, Westcott claimed 1774 overlaying cases had occurred “in London alone” in 1900, while the Registrar General reports only 1750 infants suffocated in bed for the whole of England and Wales. As already noted, the categories of suffocation in bed and overlaying were combined from 1886 onward and before this the figure for overlaying deaths had never been recorded as more than two or three hundred per year in England and Wales. Despite his high estimate of the number of overlaying deaths, Westcott was convinced that overlaying deaths were grossly under-reported, and, like Templeman (1892) and Jones (1894), he emphasised the unseen, hidden or deliberately concealed danger posed by this cause of infant death:

“We may feel sure that these numbers are too low, by reason of the gentle hushing up of many cases under the pseudonym of “convulsions”” (Westcott: 1903: 67)

For Westcott, as with Templeman, the problem was also one of attributing blame. The inquest system for him failed in this respect, with juries attributing the deaths to accidental causes when, in Westcott’s view they were “truly deaths due to culpable negligence” (1903: 67). The difficulty of this situation as Westcott saw it was that convictions for manslaughter could not be obtained in the criminal court because of the difficulty of proving negligence when the only witnesses to the death were the parents, neither of whom could be compelled to give evidence against the other. In fact, if a coroner’s jury returned a manslaughter verdict then a case could be referred for prosecution; but because the burden of proof in a criminal proceeding had to be made beyond reasonable doubt, and the standard for evidence was greater in the criminal court than in the coroner’s court, the likelihood of successful convictions was limited. Manslaughter verdicts, as noted elsewhere in the thesis, were in fact extremely rare and it is my surmise that juries, rather than despairing at never being able to obtain a manslaughter conviction, in fact thought that these infant deaths were caused by accident. This was certainly demonstrated in the case of Alice Elizabeth Wigden where the coroner, Braxton Hicks, made a direct challenge the jury on this very issue (The Child’s Guardian: December 1895: 163). Braxton Hicks went so far as to suggest that the mother had smothered her infant, and yet, despite this, the jury maintained that the verdict should be accidental death and Braxton Hicks’s conclusion was that Mrs Wigden could smother her children with impunity. Westcott, in contrast to Templeman, did not feel that the evidence of neighbours could be relied on in criminal proceedings to provide evidence of intoxication on the part of the parents because they were of the same ‘dissolute class’ and shared the same morals as the parents, thus making them unreliable as witnesses. Consequently, Westcott supported the introduction of legislation to prohibit adults from bed-sharing with infants, thus eliminating the need to prove negligence

or drunkenness.

One year after Westcott's article appeared the results of the investigations of the Inter-Departmental Committee on Physical Deterioration were published (BPP: 1904: Cd2175: 1904). This investigation did little to improve understanding of cases where infants were found dead in bed. The investigation was limited with regards to overlaying, and the few references made to supposed overlaying deaths only repeated the claimed relationship between drunken and ignorant parents and the death of infants in bed. The evidence given by the witnesses was largely anecdotal and even the leading questions of the examiners on the subject failed to identify anything new on the subject and the evidence remained hearsay. Despite these severe limitations, this report maintained that overlaying did occur due mainly to the drunkenness of mothers. The following excerpt is typical of the exchanges recorded between committee members and witnesses:

“Are many children overlaid in Sheffield? - Occasionally  
“Is that often done intentionally? - It happens on a Saturday night  
“When they are drunk I suppose? - It is largely due to intemperance: (BPP: 1904: Cd2175: Section 8165-8167)

Despite the weakness of its investigation into this particular aspect of infant mortality, the Committee on Physical Deterioration concluded that overlaying deaths occurred frequently as a consequence of neglect, carelessness and drunkenness, again reinforcing the idea that overlaying occurred mainly at the weekend due to the drunkenness of the parents:

“In certain overt directions, the disastrous consequences of this neglect are very palpable. Thus overlaying is described as frequent, and is the result of carelessness or drunkenness, the cases generally occurring between Friday night and Monday morning. The practice of placing a small child in bed with older people is, perhaps, sometimes defensible on the score of warmth, but it should be discouraged, and health visitors might properly point out its dangers, while at the same time, indicating that next to no cost would be incurred by providing a suitable box in which a child could sleep with safety.” (BPP: 1904: Cd2175: Section 283)

Following the publication of the report of the Committee on Physical Deterioration, The Times ran a series of articles summarising its main findings. The article on infant mortality was optimistic and even-handed on the issue of overlaying. Despite the ‘deplorability’ of neglect and ignorance, The Times asserted that these were the ‘most hopeful’ causes of infant mortality because they were the most amenable to being remedied. Neglect and ignorance were attributes that were difficult to measure but became manifest in their consequences:

“Neglect is proved by those extreme cases which come within the reach of the law, and are tried in court, and by the considerable number of deaths attributed to

“overlying”” (The Times 9 November 1904: 4: A)

Presumably, then, neglect took two forms, one general and prosecuted under the law and overlaying which was not. But in respect of these deaths, The Times points toward the moral panic that surrounded overlaying and raised the important question of whether or not the incidences of these deaths was indeed increasing, because:

“The tendency to think that evils to which attention is newly or strongly drawn are increasing is almost irresistible, and is responsible for innumerable fallacies. Such an impression, even when widely held by experienced persons, may be mistaken”  
(The Times: 9 November 1904: 4: A)

This article points to the possibility that overlaying had taken on the attributes of a professional as well as lay moral panic, a view which was in keeping with the hearsay evidence given to the Committee for Physical Deterioration, where witnesses related cases that they had ‘recently heard’ or ‘read’ about, rather than documenting cases that were part of their first-hand experience as practitioners.

Benjamin Waugh, Director of the NSPCC, was far less circumspect in expressing his view of the causes of “infant slaughter by overlaying” and it was the approaching festivities of the Christmas season that prompted a letter to The Times (Waugh: 1904:15) in which he drew attention to what he called the “slaughter of infants that accompanies this time of year”. As this indicates, he fully embraced the overlaying thesis and identified intemperance firmly as its cause. Further, Waugh accused Britain as a nation of doing nothing to limit overlaying as a cause of death:

“For some reason the feelings of the nation on this subject have been long dormant, and the vast human sacrifice still goes on. As a nation we certify each case and include the total in annual statistical reports. As we did last year, so shall we continue to do next. The infants who are still to be slaughtered are helpless, rendered so by their tender years. The coroners are as helpless as the infants on which they will have to look by the order of the state. The slaughterer is helpless under the weight of drink, which is paralysis to all the senses. Is this state of things to go on for ever? Are the resources of our civilization as helpless as the infants, coroners and drunken mothers?” (Waugh: 1904:15)

This emotive and apparently heart-felt plea from Waugh clearly identified overlaying as a significant cause of infant death caused by the intemperance of the ‘drunken mother’, and depicted this as perpetuated by the apathy of the nation. What was needed, Waugh suggested, was legislation, but he failed to state whether this would entail the prohibition of alcohol or of bed-sharing or both. He did, however, call upon the nation to “stir with shame and indignation, rise and make its will known” to enable parliament to “prohibit and prevent this annual Christmas drink-massacre of infants” (Waugh: 1904:15). Although others had identified the number of overlaying deaths as being higher in winter months, no one else had

made the claim that a higher number of deaths occurred specifically at Christmas as a result of festive alcohol consumption, and Waugh's letter prompted a string of correspondence on the issue (Troutbeck: 1904: 5; Rothera: 1904: 5; Wilson: 1905: 3:). The coroner for Nottingham, Charles Rothera, agreed with Waugh and drew attention to the fact that juries routinely accepted overlaying deaths as accidental and did not attribute them to culpable negligence, while the explanation of overlaying was a "gloss" placed over "other dreadful possibilities" (Rothera: 1904: 5). But despite his belief in the overlaying thesis, Rothera felt that apportioning blame was not an option that doctors or juries sought, and indeed, "Doctors would probably in a while find that convulsion rather than overlying was the cause of death and juries would jump at the cause of finding a loophole" (Rothera: 1904: 5). Despite this, Rothera called for legislation prohibiting bed-sharing.

John Troutbeck, coroner for South West London District and Westminster, also responded but opposed Waugh's claim and stated, not without irony, that:

"I believe that a considerable amount of injustice is done by such over-statements as are contained in the letter. The facts, when soberly judged, do not warrant the accusation of wholesale slaughter against the poorer classes" (Troutbeck: 1904: 5)

Troutbeck commented on the dubious use of statistics to support the case for the overlaying thesis, noting that "It has been far too easily assumed in the past that, because an infant has been found dead in bed with its parents, it must have been overlain" (Troutbeck: 1904: 5).

Troutbeck also stated that his suspicions were raised about the overlaying diagnosis because:

"a few years ago, on noticing that the confidence of the medical practitioner that death was due to overlying was in direct proportion to his lack of knowledge and experience in pathology" (Troutbeck: 1904: 5)

He also commented that for the previous three years (which coincided with his association with Freyberger) he had been able to obtain "much better evidence" which demonstrated that a large majority of the infants found dead in bed with their parents had not been suffocated but had, in fact, died of natural causes. Troutbeck went on to write:

"My experience has been that it is extremely rare for a mother to go to bed drunk with her infant, and so kill it. The inquiries of sober-minded people show that the great infantile mortality is due mainly to improper feeding because of the mother's ignorance and very rarely from wanton neglect" (Troutbeck: 1904: 5)

More correspondence supporting Waugh and attacking Troutbeck's view then followed (e.g. Wilson: 1905:13), with reference again made to the Saturday night / Sunday morning deaths, and generally Troutbeck received no support. Troutbeck's repeated reference to "sober-minded people" stands out in this correspondence and this was perhaps

aimed directly at Waugh. Troutbeck, like Wakely before him, was a minority voice in the debate about overlaying, yet perhaps his views were supported more generally by the public, as shown by juries in the coroners' courts whose views were interpreted as apathy by the more vociferous proponents of the overlaying thesis but which are perhaps best seen as recognition of the difficult circumstances involved.

The issue was again taken up in the Lancet in March 1905 (Lancet: 1905: 4254: 660) with coverage of inquests and subsequent correspondence in the Manchester press, following the overlaying of an infant in hospital there. In the press report, the overlaying thesis was fully accepted and the argument hinged on the use of cots for separate sleeping of infants, with one side supporting the use of a cot - even one constructed in a make-do fashion - and the other holding the opinion that infants were best kept in bed with their mothers, despite any possible risk of overlaying. This points up the view of overlaying as an accepted risk of bed-sharing. The Lancet pointed out that there was a significant difference between the highly monitored and controlled environment of the hospital where no alcohol was consumed, and the dwellers in the slums "where most of these deaths occur from the mothers being more or less drunk and too stupid or too tired to notice that the child they have with them in bed is being suffocated" (Lancet: 1905: 4254: 660).

The issue of overlaying reached its height in 1906, when a particularly damning editorial appeared in the Lancet regarding mothers of overlain infants. Referring to several cases of overlaying that had recently been reported, the Lancet showed no sympathy for any claim that overcrowding of the family bed was the cause of the overlaying deaths, treating all explanations as merely excuses for drunken negligence:

"How this may have been there can be little doubt that in a great number of cases poverty and the inability to provide a separate crib all pleaded by the parents as an excuse for the dangerous position which the infant occupies in their bed, and further, that a drunken or semi-drunken condition of both or perhaps only the mother is in fact the cause of the child's death. The parent's drunken negligence ought to make them criminally liable". (Lancet: 1906: 4301: 308)

Although the law as it then stood allowed prosecution of parents for neglect of their child, proof was often hard to establish because "The parents may live among neighbours whose standard of duty and decency is no higher than their own" (Lancet: 1906: 4301: 308), consequently convictions for manslaughter were uncommon and obtaining evidence from neighbours was difficult. For the Lancet, the alleged poverty of a family was no excuse for bed sharing because, as earlier commentators had suggested, a box or crate or drawer could be adapted for use as a crib. And although they conceded that additional bed clothes would be needed to provide "essential warmth" to a child, they also felt that parents would claim

that this, too, was beyond their limited means. The Lancet suggested that having the infant share the mother's bed led to the "least possible amount of trouble to his mother" (Lancet: 1906: 4301: 308) and went on to make this onslaught against parents whose infants died:

"On the other hand, it may be said that a decent and an intelligent woman, fond of her child and solicitous for his welfare, would never sleep with him in the bed which she occupies with his father, and that where the parents at the time of the child's death are so poor that they could not have assigned to him bed and bedding of some kind the question may be raised whether this poverty is not due to their own fault. In other words if decently behaved, frugal and industrious parents can put their children to sleep in conditions consistent with their health and safety, must we permit others to imperil human lives merely because by their improvident and self-indulgent habits they have put it out of their own power to do otherwise? Can we not provide for the punishment of these in order to prevent the sacrifice of life without dealing too hardly with cases of extreme poverty where this is the result of genuine misfortune" (Lancet: 1906: 4301: 308)

At times, the role of the mother in the situations to which the Lancet refers is obscured by reference to 'parents', but it cannot be doubted that women are the primary focus of the opprobrium dealt out in this editorial, where the substitution in terminology from mother to parent and back again to mother is arbitrary in its application.

For the Lancet, the mother of the 'overlaid' infant was neither decent, nor intelligent, nor fond of her child and her poverty was due to her own lack of decency, frugality and industriousness. In addition, the infant was exposed to the implied moral danger of sharing the marital bed. This swingeing condemnation of the mothers of infants found dead in bed is in such complete contrast with Wakely's editorial fifty-one years earlier that the two pieces, when juxtaposed, provide powerful indication of the change in attitude toward mothers and the issue of overlaying that had occurred in the intervening period. Rather than the epidemiological study proposed by Wakely in 1855, the Lancet in 1906 called for the mothers of overlain infants to be punished:

"Gentler measures such as education and advice, would affect but few instances, for the practice complained of. Education and advice would have little effect upon the drunkard and would entirely fail to touch those whose action is more or less deliberate and intentional." (Lancet: 1906: 4301: 308)

Punishment was seen as necessary and anything less would be ineffective because the mothers in question were not of a respectable class and would not respond well to education or advice because of their drunken habits, with their actions construed as "deliberate" and "intentional" (Lancet: 1906: 4301: 308). These mothers were also depicted as not valuing their infants and through their efforts contriving their deaths:

"We must not forget in dealing with this matter that the death of an infant in many families is, perhaps tacitly, regarded as a blessing and that in many those who would



not deliberately compass to look back upon it with no regret. Instances occur in which a mother in the course of her married life overlies not one but several infants, with the inconvenience to herself that she may have to submit to reproof at the hand of a coroner but with the certain result that she avoids the daily burden of bringing up a family” (Lancet: 1906: 4301: 308)

This editorial is the most extreme condemnation of mothers accused of overlaying their infants uncovered by my research, although strangely it occurred at a time when the number of reported deaths from overlaying actually began to decline with general interest in the subject on the wane. Why this is so is unclear. However, the diagnosis of infant death in bed had been constituted through the myth of overlaying and perpetuated by some professionals whose belief in the overlaying thesis led them to assume that careless, neglectful and drunken mothers suffocated their infants without conscience and without fear of punishment. After 1906, the discussion of infants found dead in bed continued but as an undercurrent in the more general issue of infant mortality.

The critical question that arises here concerns what it was that, between 1855 when Thomas Wakely made his claim about the rarity of overlaying and pointed out the problems in the diagnosis of infant death in bed, 1890 when the Registrar General linked overlaying straightforwardly to maternal culpability, and 1906 when the Lancet vehemently condemned all mothers of dead infants as improvident and drunken, led to such changes. Elsewhere in the thesis I discuss the confluence of influences, ideas and events that made such a heightened and blame-apportioning discourse possible.

In 1920, well after the issue of overlaying had diminished as an issue of wider public concern, the Children’s Act came under review and James Ollis, Clerk to the London County Council (LCC), wrote to London coroners soliciting their view on overlaying and a possible amendment to the section of the Act which dealt with bed sharing while intoxicated (LMA: LCC/PC/COR/1/65/ 9/10/1920). In response, Walter Schroeder, former deputy to George Danford Thomas and at the time coroner of London’s Central District, replied at length on the issue:

“There are very few ‘real’ cases of overlaying and I do not think that any magistrate would convict ‘neglect’ with the meaning of Pt iii of the Children’s Act on the sole ground that death had occurred from suffocation when the child was in bed with another person over 16 years of age. In England there is no law against a child being in bed with an adult.

“When I was a Deputy Coroner I gave much thought to the question of alleged suffocation of the child in bed and long ago came to the conclusion that only a small proportion of those whose deaths at first sight were attributed to “overlaying” or suffocation from deprivation of air were really due to these causes. Verdicts of suffocation in bed used to be found when the fact of the child having been found dead in bed with the parents or other adult person and from the external inspection of

the body by a medical practitioner and finding appearances indicative of the cause of death being suffocation. I decided (as did Mr Troutbeck) to have post mortem examinations in all these cases. In many, disease causing death was found and the external appearances were fully accounted for without mechanical interference with the child's breathing. That was markedly so when the PM was made by a skilled pathologist or medical practitioner who took interest in and gave time to his examinations. In a short period the alleged suffocation cases greatly decreased (I believe that has been so in other districts where PM examinations are ordered). There are of course, some typical cases and nothing but deprivation of air accounts for death.

On the question of drink being a main factor in suffocation cases I differ from a somewhat common theory. In my opinion there are very few cases traceable to the other occupants of the bed being the worse for liquor.

Sometime ago I read in a newspaper that a medical officer of health attributed the suffocation of infants to intoxication on the part of the parent and especially on Saturday nights [this] conclusion was certainly not arrived at upon reliable information. I can only conclude the opinion was formed and statement made upon other than tested fact.

For about twelve months I kept a list of the nights on which suffocation cases occurred and found there was no excess on Saturday and observed no evidence that the person or persons in bed with the child were the worse for liquor.

As doubtless you know I have always advocated the feeding of the child and then placing it in a cot and if the parents are unable to afford to purchase a cot, advised them to improvise one from a fruit box or drawer from a chest.

I venture to think that the cause of suffocation of children is to be found not in neglect or drink but from the mother being overtired from work or over anxious (after mistaken kindness) for the welfare of her baby. In my experience it is the 'natural' mother who unfortunately suffocates her baby, the mother who will not trust her child to others, feeds it with the breast milk and ignores suggestions to have it artificially fed and (erroneously) thinks for her child to be well cared for, it must be near so she can hear its slightest cry." (LMA: LCC/PC/COR/1/65/ 9/10/1920)

Schroeder's conclusion was that to amend the Children's Act would be against the public interest and unfairly harsh on the distressed relatives. Clearly he viewed overlaying as a rare event and saw the overlaying mother far from the callous and drunken character she had been previously portrayed. Times had changed.

## **Conclusion**

In the earlier part of the nineteenth century, reports of overlaying deaths tended to occur as part of the general reporting of inquests. Consequently the language used in these was largely factual, although on occasion (especially when drunkenness was thought to be instrumental in an infant's death) more details of the circumstances were given and the

reports tended to be longer. The respectability of the mothers concerned was taken as an indication of non-culpability, in contrast to drunkenness which led to culpability and blame apportionment. Respectable women (and this usually excluded the single mother) were also judged by their demonstration of appropriate emotional responses to the death of their infants, in contrast to the drunken mother who was construed as hardened to such loss. In later reports, the language in which overlaying was presented became more graphic with infants described as 'crushed, blackened, choked' and mothers as 'reckless', 'depraved' and 'dissolute'. These are extreme examples, but as the number of reported overlaying deaths increased in the latter part of the century, so too did the proclaimed outrage about infant overlaying, with the portrayal of overlaying mothers becoming more judgemental. The link between drunkenness and overlaying was strengthened within the official discourse of overlaying by the Annual Report of the Registrar General in 1890. This acted to legitimate such claims, and the daily and seasonal pattern of deaths was held as evidence that overlaying occurred as a consequence of drunkenness on the part of mothers, marking a change in interpretation when compared with Wakely's discussion in 1855. During the intervening period, infant mortality and infanticide had taken on increased significance and there had been a period during the 1860s when infant mortality and the fear of widespread infanticide had taken on the proportions of a moral panic (Rose: 1986: 177). Even sympathetic interpretations of overlaying tended toward portraying women as acting from ignorance or laziness. The significance of alcohol and intemperance grew through the second half of the century. The overlaying an infant while drunk was then written about in terms of infanticide and there were calls to make drunken overlaying a criminal offence. In some instances the language of the texts shows an openly suspicious attitude to the motives of overlaying mothers, such as 'you can go on smothering your children as much as you like', in a context in which 'smothering', as has been shown, indicated intent. The 'blessing' of an infant death to the 'improvident' and 'self indulgent' mother whose lack of decency and intelligence made her immune to the positive influences of education was depicted as a scourge on the nation. Women portrayed in this way were also shown as living in communities and among neighbours whose decency and moral standards were also questionable. It is perhaps this view that enabled juries – elected from peers – to be portrayed as lacking in intelligence and common-sense on some occasions. By the turn of the twentieth century, the terms in which overlaying mothers were discussed had reached its most critical and they were described in some texts as 'depraved', 'stupefied', 'callous', 'neglectful', 'reckless' and 'dissolute'. But the claims about the number and circumstances of such deaths went largely unsubstantiated, in many cases relying on anecdote and speculation. But despite

this, links were made between overlaying, infant mortality and the nation, with alcoholic degeneracy and infant mortality portrayed as a threat to the nation's physical and moral well-being.

This chapter has provided a detailed account of the discourse of overlaying as it unfolded during the nineteenth and early twentieth centuries. The views expressed are largely those of medical and legal professionals, along with others who (usually) had a professional interest in issues such as infant welfare, temperance and national efficiency. In this sense it represents an official discourse of overlaying. The views were relayed through national and professional newspapers and journals. This chapter marks out the clear distinction between two key strands of the overlaying discourse: the early dominance of the overlaying myth and the subsequent dominance of the overlaying thesis. This represents a significant change in the overlaying discourse during the time-period detailed here.

During the first half of the nineteenth century the myth of overlaying was dominant. Accidental overlaying, sometimes (but rarely) occasioned by excess alcohol consumption is portrayed as occurring infrequently. Mothers were sometimes seen as culpable in the deaths of their overlaid infants but this was not the main focus of the discourse and press reports of such deaths reflect this attitude. This represented the general acceptance of infant overlaying death as a (sometimes) regretful risk of bed-sharing and maternal care. In the second half of the century the overlaying discourse came to be dominated by the newly apparent overlaying thesis. Maternal ignorance was constructed as causal in overlaying death and this represented a view of overlaying as the outcome and unacceptable risk of bed-sharing and negligent maternal care. In this way, sudden infant death in bed interpreted as overlaying was transformed from a fateful event into an event caused by maternal neglect.

In terms of structuration, the changed discourse of overlaying reflects underlying changes in socio-structural conditions. This suggests that significant change had occurred in relation to the rules and resources that pertained to sudden infant death in bed as both a context and outcome of action. These can also be understood as changes to the constraints and enablements of action. In light of this, how can socio-structural changes represented by the transformed discourse be explained?

The discourse of overlaying was not an over-arching discourse relating to all people in all places. Instead it was relevant only to some people in particular contexts. The overlaying discourse and its subsequent transformation can therefore be usefully analysed in one of two ways. Firstly, through the relationship of the overlaying discourse to other discourses and socio-structural features. And secondly, through the constraints and enablements of the discourse seen through the people and contexts to which it was relevant.

The changed emphasis of the overlaying discourse over the time-period occurred against a background of other wide-scale social changes which have been referenced generally as modernity. At this point it is important to note, that although the conditions of modernity provided the context for the overlaying discourse to develop and transform there is no suggestion that the discourse was in anyway inevitable or necessary. There are, however, key features or conditions of modernity that made possible transformation of the overlaying discourse. Among these are the changed role of the state with concurrent changes in population control and monitoring, and the sequestration of death, reproduction and infancy. The expanded role of the state during the period entailed development of mechanisms to control and monitor the population and it is against this background that infant mortality was categorised and quantified. Between 1839 when the first aged analysis of death was produced and 1877 when 'infant mortality' was first reported as a discrete category, the social construction of infant overlaying also developed and was transformed from the earlier myth of overlaying to the modern overlaying thesis. The categorisation of death was also informed by another feature of modernity, the development of scientific medical knowledge which constructed disease and death as the subject of medical science. In this way, the myth of overlaying, as an accidental and fateful form of death, was replaced by the overlaying thesis that asserted a medico-legal explanation of such deaths. Such change can also be set against other changes in the way death was generally experienced and managed during the nineteenth century in terms of its sequestration.

In Eliasian terms, changes in the overlaying discourse indicate fluctuating balances of power. The shift in emphasis of the discourse from overlaying myth to overlaying thesis signifies a corresponding shift in power from lay individuals, especially mothers, to professionals and the state in regards to infant care, maternal culpability, the family and death. Such changes also represent the increasing social differentiation and integration of individuals, especially of mothers and infants, marking out their identity and social positioning. The widespread adoption of the overlaying thesis by medico-legal practitioners, however, followed a different trajectory from that of the common-sense myth of overlaying. The myth served to explain such death in terms of individual actions and practices and the death of infants was not viewed as occurring in consequence of the wider social context. In contrast, the overlaying thesis gained credibility through the social positioning of its proponents and demonstrated severe condemnation of overlaying mothers placing their actions against a background of widespread infant mortality and maternal culpability. This contextualisation of overlaying also represents the further integration of mother and infant into society.

The overlaying thesis provides a point of intersection between broad trends such as population control, the state and medicine and as such can also be understood in terms of a structural hermeneutic nexus where the meaning of agents (coroners and doctors) unfolds within a socio-structural context of the inquest and infant mortality. In addition, and as one strand of the overlaying discourse, the overlaying thesis also combines with other relevant discourses surrounding temperance and national efficiency. One reading of the discourse detailed here, therefore, casts light on both the internal schemas of individuals and also on contexts beyond the direct sphere of the overlaying discourse. In this way, the overlaying discourse can be read in terms of the structured meaning of agents-in-situ. What becomes clear in this regard is that the orientation of professionals differs from that of mothers in relation to the overlaying discourse and mothers are limited in their ability to engage the overlaying thesis despite being its (purported) central concern.

Despite the dominance of the overlaying thesis, inquest juries maintained a common-sense understanding of overlaying death which remained on the whole sympathetic to overlaying mothers. This apparent paradox is made meaningful by viewing it in terms of the incompatibility between existing general-dispositions (the overlaying myth) and the newer overlaying thesis. In this sense the overlaying thesis represented a change to generalised procedures for (some) medico-legal professionals which saw their role enhanced with concurrent increase in their status and power. Again this can be understood in terms of social differentiation and integration with specialised knowledge embedded in broader social structures. The overlaying thesis at the same time became important in cross-cutting discourses about medical knowledge, temperance, infant mortality, and national efficiency to which the general population (including jury members) were only marginally party.

The overlaying discourse marks out a historical and social trajectory in which the overlaying thesis as part of the discourse was taken on by a sometimes vociferous group of professionals while the myth of overlaying remains as the dominant context for others (seemingly the majority). That this occurred despite the possibility of the alternative path offered by Wakely in 1855 (the approximate temporal mid-point of change) is uncertain but this should also be understood in relation to the broad context of action. This supports the suggestion that a particular discourse is only useful in specific circumstances and maintains only while it is functional. In this case, Wakely's epidemiological approach to overlaying was in contradiction to other strands of the discourse and opposed both the myth and the later thesis of overlaying. When this was set against a background of high infant mortality and a moral panic about infanticide, Wakely's epidemiology of overlaying proved not to be useful.

What becomes apparent through this analysis of the overlaying discourse is that

there was a change in attitude toward the significance of sudden infant death in bed. The myth of overlaying clearly informed the overlaying thesis with its explanation of such deaths in terms of overlaying. But the myth was inadequate in terms of explanation as the broader social context changed. Instead wider social linkages served to recast overlaying as a social problem extended to relationships of non co-presence. And, as another feature of modernity, individuals became oriented toward the future and the prevention of needless infant death.

The debates detailed here were a matter of public discourse and there are methodological issues associated with claiming such discourse as representative of the everyday reality of a situation. In this case, however, it is clear that the reports in official publications, newspapers and journals reflect the practice of doctors and coroners in their day-to-day activities. The reports are grounded in particular situations and detail the way that coroners and doctors went about the business of interpreting sudden infant death in bed as overlaying due to maternal culpability. In some cases, the reports detail the accounts of individual doctors or coroners dealing with the death of named infants. In others, doctors and coroners related their experience of individual deaths to the broader context of other similar infant deaths. In other cases yet, they related their knowledge to other issues such as temperance and national efficiency. This is shown, for example, by Westcott who was a coroner, a doctor and a member of the temperance movement. As has been noted, although there were occasional voices of dissent from the overlaying thesis, the doctors and coroners reported here had considerable influence as its proponents and this served to influence medico-legal practice for many years. The influence of this view is apparent in the many reports of sudden infant death in bed that were routinely, and generally without challenge, attributed to overlaying. This is also shown elsewhere in the thesis where the assumption of overlaying underpinned interpretation of sudden infant death in bed and dominated the practice of people in-situ.

In reality, however, the issue was complex and contextual. In the majority of cases there was no eye-witness testimony, no medical pathology and no report of drunkenness on the part of the mother. In many cases mothers reported their actions in a context of care and risk reduction. And far from the ignorance and neglect suggested, mothers often acted with knowledge and care toward their infants whom they sought to safeguard. In this respect, the overlaying thesis did not portray the every-day reality and experience of mothers and the sudden death in bed of their infants. This also marks the apparent contradictions between the discourse and reality of overlaying and points toward the need for an explanation that is based in the socio-structural positioning of the actors concerned. There were, however, proponents of the overlaying thesis who appeared more sympathetic to overlaying mothers

and they generally looked to the context of such deaths for their explanation and it was here that issues of poverty and overcrowding came into play. In such cases, although the assumption was one of overlaying, the context mitigated attitudes toward the mother. Poverty and ignorance were constructed as the indirect causes of overlaying and this lessened the blame apportioned to mothers. At the same time this view did not operate in opposition to the 'accidental death' verdicts of coroners' juries. In these cases, coroners, doctors and jurors arrived at similar conclusions albeit via different routes. In these circumstances the myth and thesis of overlaying were not forced into opposition but instead were partially supportive and overlapping. This less extreme interpretation of the overlaying thesis is shown here in the reports of coroner George Danford Thomas where he suggested separate sleeping in a cot as a means of preventing overlaying death. The wide-spread interpretation of sudden infant death in bed as overlaying caused by mothers therefore underpins the discourse of overlaying and bridged the divide between the myth and thesis of overlaying as its dominant strands. It is only the apportionment of blame to mothers that varied and this was why the change seen in the overlaying discourse over the nineteenth and into the twentieth centuries should be understood as transformation rather than disjuncture. In this sense, it is only when the overlaying thesis was seen at its most extreme, for example with Braxton Hicks and Westcott, that other interpretations of sudden infant death in bed began to appear and gain support. The overlaying discourse was, therefore, also a means of bringing order and meaning to the otherwise messy everyday reality of sudden infant death in bed.

One other important strand of the overlaying discourse that becomes apparent through exploration of the texts discussed in this chapter was the demand placed on mothers to change or modify their behaviour and mothering practices. Mothers in this way were cajoled, commanded and implored to respond to the information given to them about infant care and overlaying and they were expected to develop a reflexive form of motherhood that incorporated ideas about separate sleeping, temperance and infant care. This signalled a move away from a form of mothering that was shaped by nature and the 'natural' experience of mothering, toward reflexive mothering shaped by influences distanced in space and time from the immediate context of practical mothering. The education of women in their role as mothers by medico-legal practitioners, welfare workers and others was shown as a means through which overlaying and infant mortality could be addressed, and women were increasingly judged on their ability to respond to new knowledge and incorporate it into their mothering practices. In this sense, mothering became a reflexive practice that could be accounted for in rational terms. By the time that Schroeder wrote to Ollis in 1920, the furore



about overlaying was all but over and the discourse had moved on. The reflexive mother is Schroeder's implicit norm and the problem was no longer seen as one of drunkenness or neglect, but instead the threat was seen to be posed by the 'natural' mother, the antithesis of reflexive mother(hood).

## **Chapter Four: Domestic Space, Overcrowding, Poverty and Bed-Sharing in St Pancras circa 1900**

### **Introduction**

This chapter explores twenty-one cases of recorded overlaying that occurred in Somers Town, London between 1899 and 1902 and shows that these were portrayed in public representations of overlaying as routine and regular cases of infant mortality. This chapter explores the role of physical space and its utilization in the life and death of overlain infants in Somers Town. It also asks the question of whether or not infant overlaying occurred as a consequence of overcrowded living conditions and poverty, or whether it was these conditions that led to a diagnosis of overlaying. The reports are taken from the St Pancras Guardian and the Coroner's Register for the period. Together with the records of the 1901 Census these sources provide information about the material setting of overlaying deaths in Somers Town, including details of employment, household composition, earnings and accommodation densities. They also draw a picture of other features of life in Somers Town such as crime, philanthropy and trade. These sources are supplemented by information about the area provided by Charles Booth's investigations of poverty which give a detailed picture of the lived environment of Somers Town. In addition, the reports of the Borough's Medical Officer of Health are also used to provide detailed information about infant mortality in terms of its frequency and cause during the period. Through a focus on the role of physical space in the life and death of overlain infants, the question of whether such deaths can be explained as occurring due to overcrowding and the subsequent close physical proximity of bodies is also addressed. Bed-sharing was a common feature of such overcrowded conditions and the possibility of its role in overlaying death must be acknowledged. This issue is explored though ideas about the organisation of domestic space in situations where clearly defined bed(room) space was not possible and suggests that current understanding (Crook: 2008) of the way domestic space was re-organised during the nineteenth century must also be revised in view of the discussion which follows.

Two key factors emerge as significant to the material well-being of the people of Somers Town during the period of my investigation; these are poverty and housing conditions. Management of the poor and their accommodation were the responsibility of the St Pancras Vestry, later the Borough of St Pancras, and this chapter will also explore the way in which governance of these issues developed during the nineteenth century and explore its role in shaping conditions within the Parish. The backcloth is the construction of poor and

working class households by official discourses of the time around issues of social welfare and improvement, which portrayed them as culpable for their poverty and living conditions. It is also against this background that infant overlaying was made public through the inquest process; but instead of the condemnation that might be expected to result from the discourse of overlaying, it is evident that coroners' juries routinely returned verdicts of 'accidental death' in such cases and that women were only sometimes (rarely) reprimanded when their infants died in this way.

### **St Pancras, London**

The metropolitan Borough of St Pancras covered an area of London from Hampstead in the north to Oxford Street in the south, Kings Cross in the east and Regent's Park in the west, and reflected the boundaries of the earlier parish of St Pancras that it replaced in 1900. The Borough contained a broad cross-section of the socio-economic classes resident in London at the time. From the well-to-do areas of Hampstead and Highgate in the north, to the poorer area of Somers Town in the south of the Borough, St Pancras was described as 'mixed [...] housing all classes' by Mr Shirley Forster Murphy, one time Medical Officer of Health (MOH) for the Parish. At the extreme south east of the borough, Thomas Coram's Foundling Hospital was located. The estimated population of St Pancras in the 1901 census was 236,936 (SPV: Sykes: 1905: 21), which made it one of the six largest metropolitan boroughs in Britain. The population of London in 1901 was approximately 4.6 million.

The material conditions that shaped the lives of people in St Pancras were inextricably linked to the built environment and the physical space that each house, family and person occupied. The daily life of individuals was influenced not only by their presence in St Pancras but also by the positioning of the parish as a Borough of London. In this way the death of an infant from overlaying in Somers Town must be understood as representing more than the loss of an individual life, and instead as part of a broader social pattern of death. In this sense, any explanation of infant mortality in terms of maternal culpability must be thoroughly explored in order to identify the recurrent features of such deaths and the socio-structural influences that underpin them.

The importance of the built environment and physical space to the events recounted here cannot be overstated. Development of St Pancras with its pattern of building, the influence of neighbouring areas, the role of industrial development, railways and roads, metropolitan governance and the development of London as a whole were all important features of the (social) landscape, as was poverty, the care of the poor, poor law and the parish workhouse. All of these things served to shape the lives of the people who were born

and died in the parish, as well as the people who moved there from elsewhere. At the end of the nineteenth century, St Pancras was a metropolitan borough of London with all that this entailed but was also subject to influences originating far beyond the parish boundaries. The overlaying deaths that occurred there must be understood in this context.

### **Managing the poor in Somers Town: the vestry and local politics**

Governance of London at the beginning of the nineteenth century was achieved via a collection of legislative measures and there had been, as yet, no systematic attempt to develop an overarching means of local government. Responsibility for the different aspects of local and metropolitan life was shared between central government, the Corporation of London and the local parish vestries. With the growth of London's population during the period, it became increasingly necessary to develop a means of administering London as a whole in order to provide the amenities that were becoming essential to the population's health and welfare. At this time much of what would later be considered London wide issues were administered locally and parish vestries oversaw business such as the provision of paving, lighting and cleaning of the streets, relief of the poor, and maintenance of the peace (Owen: 1982: 24).

Features such as roads and railway lines formed the boundaries of Somers Town and, like many places, transport links such as Euston Road and the Midland Railway at Kings Cross had a great influence on local conditions, both at the time of their construction and then as long-standing features of the area. But there were also other important political and economic aspects that shaped development in the area. Lack of an overarching authority, political struggle between competing authorities, demand for cheap housing and a rapid increase in population, all combined to shape the built environment of Somers Town.

Mostly farmland until the eighteenth century, building development began in Somers Town following the construction of 'New Road', later to become Euston Road. Designed as a northern bypass for London, New Road was intended to speed transport of animals and troops and was the route of London's first bus service from Paddington to Bank. Built during the eighteenth century, Parliament ruled that there should be no building within fifty feet of the road and many of the terraces that fronted onto the road were built with very long gardens to comply with the ruling. Similar houses were built in roads leading off the New Road, such as Charlton Street and Ossulston Street, the main thoroughfares of Somers Town<sup>8</sup>, and the consequence was that large areas of open ground were left bounded by houses facing onto parallel streets.

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8 Maps of Somers Town for 1870, 1896 and 1913 are provided in Appendix 3

Land leased to the architect Jacob Leroux in 1783, in what was later to become Somers Town, was developed as a self-contained suburban village for the well-to-do.

“The streets were laid out in rectangular form, the chief feature being Clarendon Square within which was built the Polygon, a fifteen sided figure comprising thirty-two houses. [...] [Leroux] built a handsome house for himself, [...] everything seemed to proceed prosperously, when some unforeseen cause occurred which checked the fervour of the building, and many carcasses of houses were sold for less than the value of the materials” (Roberts & Godfrey: 1952: 118)

What had begun as a middle-class settlement quickly developed into a slum (George: 1925:79). Within two decades the spacious gardens had been built over, with houses and yards completely enclosed within the gardens of other houses. Some properties had no windows on three sides; others could only be accessed via small alleyways underneath and between the existing houses. Ventilation, drainage and access were serious issues in such a densely built area and this situation was exacerbated as large houses, originally meant for single household occupation, were divided into tenements occupied by multiple household groups. Population density in the area increased and St Pancras became a parish where poverty was indicated by the outbreaks of typhus that it experienced (George: 1925: 85). It is clear that lack of an overarching authority or development plan had left the area vulnerable to ad hoc building developments and land usage.

By 1885, when the Royal Commission on Housing the Working Classes reported their findings, conditions in St Pancras, and particularly in Somers Town, had deteriorated. The MOH for the vestry (Mr Shirley Forster Murphy) gave evidence to the inquiry (BPP: 1885: C4404). What Murphy’s evidence provided was a picture of an area in which the health of the population was poor, overcrowding was rife, and where the political struggles between the vestry and other authorities had led to inaction. The concerns of the Commission regarding the detrimental consequences of overcrowding and poor housing were twofold. Firstly, there were the consequences regarding the health of the population, and secondly, there were the adduced moral consequences of living in such conditions. The Report also hinted toward corruption and nepotism within the vestry and a wilful neglect of the situation in which the population were living (BPP: 1885: C4402: 67). The consequences for the health of the population were certainly considerable. Reporting mortality rates of 70 per 1000 in certain parts of the parish, Murphy also stated that rates of 40 or 50 per 1000 were not unusual (BPP: 1885: C4402: 14).

### **Overcrowding: the single room system and sanitation**

Overcrowding was seen by the Commission as the central evil around which other problems were grouped (BPP: 1885: C4402: 12), with the 'single-room system' described as having consequences "beyond all description" BPP: 1885: C4402: 13). In his evidence to the Commission, Henry Taylor, a Visitor for the London School Board, described the conditions in his area, including a room which was rented for *2s 6d* per week:

"In Drapers Place, St Pancras, there was described to be a kitchen, 12 feet by 10, and only 6½ feet high, entirely underground. [...] And in that underground room there are two parents, two children over 14, and five children under 14, making nine in all" (BPP: 1885: C4402: 160)

Taylor stated that most of the families in his area lived in single rooms and this suggests that his evidence was not of an isolated instance but represented a commonplace situation. Overcrowding, high rents and poverty had led to the wide adoption of the 'single-room system' for families living in tenement buildings (BPP: 1885: C4402: 7). Tenement houses were described in the Report as those occupied on weekly rents by more than one family, where no common room was shared. The sharing of a common room was seen as a distinguishing feature of lodging houses which were, by previous legislation, subject to more stringent controls. Lodging houses were regulated separately and open to inspection by the police. Unlike lodging houses, tenement houses did not have legislation governing minimum cubic capacity of rooms. In tenement houses occupancy of single rooms was commonplace, as was multiple-occupancy of dwelling houses intended for single occupation. The Report estimated that there were 15,500 tenement buildings, some two thirds of the 24,700 houses that Murphy estimated to be in the parish (BPP: 1885: C4402: 75). Rents in these properties were from *2s* per room in comparison to *4s 6d* or more for rooms in 'model' dwellings. There were about 500 model dwellings in the parish, housing approximately 2000 people. In relation to an overall population of approximately 236,000, the positive impact of the 'model' dwelling in St Pancras was low (BPP: 1885: C4402: 66).

The causes of overcrowding were thought to be a consequence of a combination of factors. Among these were an increase in the population, the need for workers to be near their place of employment, displacement of the population due to demolition for improvement schemes, the building of the Midland Railway Depot, and the arrival of people into the parish from neighbouring districts (due to the leniency of the St Pancras Vestry in prosecuting landlords which allowed the occupation of cheaper single rooms and kitchens). For example, overcrowding in Drapers Place, (the subject of Taylor's evidence) was described as due to an influx of people following the development of the Midland Railway, where five hundred houses had been demolished to make way for the Somers Town Depot (C4402: 1885: 66).

Unfortunately, and despite the recommendation of the MOH, the St Pancras Vestry refused to adopt legislation (BPP: 1866: C90) that had made the overcrowding of residences illegal. The Sanitary Committee in St Pancras had, however, employed three inspectors to act as its 'eyes and ears in the parish' although the adequate functioning of the Sanitary Committee can be brought into question when it is considered that in 1885 the three Sanitary Inspectors were responsible for inspecting 24,700 dwellings of 236,000 parish inhabitants.

Although in general terms sanitation had improved in the latter part of the nineteenth century, mainly through the provision of drainage and sewage removal, much of the local building activity was still poorly executed and regulated. There was a lack of control by the vestry of new building and buildings were often used for purposes other than that for which they had been intended. In addition, the 'trades' of many of the poorer people, such as rag picking and costermongering, used the 'home' as a place of work and storage for 'goods' (Stedman Jones: 1976) and this prevented the separation of domestic and commercial or industrial space.

An interview given by Dr John Sykes, MOH, highlighted the attitude of the St Pancras Vestry toward housing and sanitary reforms in the parish. Interviewed as part of Booth's investigations, Sykes revealed his irritation at the vestrymen's adherence to office procedures describing himself as 'badgered', "What time did you come in today Dr? Will you please keep a record of how long this or that takes you?" and "He girds at the butter slurrp methods of some of his own vestry" and draws attention to the reluctance of the vestry to comply with regulations relating to housing "registration is almost a farce in St Pancras [...] several of the members of the vestry are opposed to registration and they are either small property owners or agents themselves or have connections or interests among that class and they effect their end by preventing the appointment of inspectors to do the work" (Booth: 1898: B214: 16-49). It is against this background of overcrowding, poor housing, poverty and political corruption that the life of people in St Pancras was set.

### **The habits of 'humbler people': a fear of air and overlaying**

One of the witnesses to give evidence at the hearings of the Commission for Inquiring into the Housing of the Working Classes was Lord Shaftesbury. Shaftesbury was the Conservative philanthropist Anthony Ashley Cooper, seventh Earl of Shaftesbury, who was a notable social campaigner on issues such as the protection of children in factories and mines, the welfare of chimney sweeps, and public health. The overall effect of overcrowding, and in particular of the 'single-room system', was claimed by Shaftesbury as physically and morally beyond all description:

“In the first place, the one room system always leads, as far as I have seen, to the one bed system. If you go into these single rooms you may sometimes find two beds, but you will general find one bed occupied by the whole family, in many of these cases consisting of the father, mother, and son; or of father and daughters; or brothers and sisters. It is impossible to say how fatal the result of that is. It is totally destructive of all benefit from education” (BPP: 1885: C4402: 13)

The subject of incest was raised frequently by witnesses as a cause for concern, but despite this, the Commission stated that the morality of the inhabitants of overcrowded dwellings was “higher than might have been expected looking amid the surroundings in which their lives are passed” (BPP: 1885: C4402: 13). The evidence presented by witnesses highlights the frequency with which bed-sharing occurred within this group of the population and its possible consequences on the incidence of overlaying death.

Incest apart, intemperance and a dislike for draughts seem to be some of the most seriously remarked habits of the humbler people of the parish. Referring to a pamphlet presented in evidence, the Commission asked rhetorically ‘Is it the pig that makes the sty or the sty that makes the pig?’ Were the ‘dirty and drinking habits’ of the very poor the cause, or the consequence, of their ‘miserable existence’? (BPP: 1885: C4402: 14). Intemperance was a considerable concern of the Commission, as well as being of concern to the public at large (Eyler: 2004: 205). In the Report many ‘evils’ were laid at the door of intemperate behaviour and poverty was seen as being exacerbated by the need to spend money on alcohol (BPP: 1885: C4402: 14). The ‘imperfect economy’ of the poorer classes was seen as both causing and being caused by the habits of alcohol consumption in an iterative relationship (BPP: 1885: C4402: 14). But not all of the evidence given to the Commission was so condemning of the people. A general lack of fresh air within dwelling houses was cited as both the cause of the ill health that was experienced by the working classes as well as the justification for men to frequent the public house. Within the pages of the Report there is a tendency to apportion blame for poor living conditions and this is often directed at the working class inhabitants themselves. For example, at a time when lack of fresh air was considered deleterious for health the poor are portrayed as having some responsibility for the way that their habitations were ventilated, with the Report claiming that it was not the scarcity of fresh air but the people’s habit of avoiding it that was an issue. Torrens, who earlier had introduced the Artisans and Labourers Dwelling Act (1868), was a member of the Commission and questioned Murphy on the subject of ventilation:

“Can you state for the Commission what your experience is of the reluctance of the humbler sort of people in crowded dwellings to allow the ordinary mechanical means for the circulation of air to operate [...]? – I can state that there is a very strong objection on the part of the people living in these houses to have anything like



a current of air entering their rooms. They are far more afraid of air than people of a higher social grade.” (C4402: 1885: 71)

This line of questioning continued in a more sympathetic tone from Collings, another member of the Commission, who also questioned Murphy on the issue of draughts:

“Is it not difficult, and in fact, almost impossible, to obtain circulation of air in a room [...] such as we have been speaking of without getting a draught? – Quite so. And a draught is very dangerous to people packed away as you have described? – It may be a choice of evils to some extent, but at the same time I think that if I chose for myself I would rather have the draught than the closeness.” (BPP: 1885: C4402: 72)

It may have been a choice of ‘evils’, but nevertheless, the overall impression given in the Report is that the ‘humbler people’ were making wrong choices when it came to conditions within their homes.

The evidence of the Inquiry gives considerable insight into the housing conditions experienced by the people of Somers Town in the closing years of the nineteenth century, and it also provides a glimpse of the wider attitudes of the people who were charged with overseeing their welfare. In this context, infant mortality was portrayed as occurring in consequence of overcrowding but also as in consequence of carelessness on the part of mothers:

“Carelessness on the part of mothers is an accompaniment of overcrowding, and to these causes was ascribed [by the witnesses] the high death rate among infants under five years of age” (BPP: 1885: C4402: 14)

There is also clear indication that many of the people in Somers Town were poor and living in overcrowded conditions, often with whole families living in single rooms within tenement housing where facilities and sanitation were limited. The housing stock was in poor condition and the local authorities were not always willing or able to deal with the problems this posed. Bed-sharing was primarily portrayed as a moral issue for the Inquiry, but it may also have been a significant factor in overlaying deaths and a contributor to infant mortality. The people of St Pancras were living in poor conditions, but they were also viewed as responsible for exacerbating those conditions with their insanitary ways, immorality and intemperance.

### **Infant mortality in St Pancras**

High rates of infant mortality were commonplace in nineteenth century Britain, and although rates varied from district to district and from decade to decade, they nevertheless remained unacceptably high. As already discussed, interest in the causes of infant mortality increased

throughout the latter part of the century, and took on greater importance when it was realised that infant mortality was increasing despite a steady decline in general mortality rates. Mortality in the general population had decreased from 22.6 per 1000 (1851-55) to 17.6 per 1000 in 1896-1900. This compared to an infant mortality rate of 156 deaths under one year per 1000 births (1851-1855), which remained the same in the period 1896-1900. Rates of infant mortality had fallen slightly in the interim (138 in 1881-1885), but had then shown a steady increase, so that by 1900 the rate of infant mortality was the same as it had been fifty years earlier (McCleary: 1933: 3).

The MOH Reports for St Pancras provide area level data on infant mortality for the years 1890-1902. The administrative areas of St Pancras in the period were Regent's Park, Tottenham Court, Gray's Inn, Camden Town, Kentish Town and Somers Town. Somers Town maintained a higher rate of infant mortality through the last decade of the nineteenth century and in the first years of the twentieth century (Fig 1: Appendix 2). Infant mortality in Somers Town (1898-1902) was higher than that in St Pancras and London as a whole.

In 1898, as Table 3 (Appendix 2) shows, Somers Town ranked midway in the Table of administrative areas for the number of infant deaths per 1000 births (183.9). This compares favourably with Tottenham Court (227.2) and Gray's Inn (192.6) but is considerable higher than the better areas of St Pancras such as Camden Town (141.2) and Kentish Town (150.1). In 1898, Somers Town had a higher rate of infant mortality (183.9) than both St Pancras as a whole (170.5) and London (167.2). In 1899, infant deaths in Somers Town increased by 14 per 1000 birth to 197.9, but the area remained third in the ranking as there was also an increase in infant mortality in the Borough as a whole. The reason for this increase is unclear but was apparently dependent on local conditions. This does not compare favourably with the rate for London which remained constant. By 1900 there were considerable improvements in infant mortality rates across St Pancras. Overall, the Borough had a reduced infant mortality, down 18.3 to 160.9. One exception to this was Regent's Park which increased from 148.9 in 1899 to 183.3 in 1900, an increase of 34.4. Previously ranked sixth in the borough, Regent's Park had the highest rate of infant mortality in 1900. Again, the reasons for this are unclear. In Somers Town, ranked second in 1900, infant mortality was reduced by 15.1 on the previous year's figure to 182.8, only fractionally lower than Regent's Park. The infant mortality rate for London also fell in 1900 by 7.5 to 160.0. In 1901, Somers Town was ranked first highest area in the Borough for infant mortality at 194.0 per 1000 births, an increase of 11.2. This is contrary to trends within the Borough, where generally, the trend was downward 6.2 to 154.7, and for London, down 10.6 to 149.4. By 1902, Somers Town had returned to its position of third in the ranking of

highest rates of infant mortality in the Borough with 185.4 per 1000 births (down 8.6 on the previous year). The rate of infant mortality had also fallen in the Borough (down 7.5) and across London (down 8.4). The changing rates of infant mortality in Somers Town are interesting because, despite overall trends of improving mortality for the borough as a whole and for London generally, local conditions remained to cause pockets of high infant mortality. The fluctuation in rates for specific areas from year to year would suggest the infants in the population were still extremely vulnerable to local conditions and events.

Despite fluctuating rates of infant mortality, the causes of death recorded by the MOH St Pancras remain remarkably consistent in the period 1898 to 1902. Table 4 (Appendix 2) shows the top ten causes of infant mortality for the period. The total number of infant deaths (under 1 year) in St Pancras in the period 1898 to 1902 was 5317. The highest cause of death was diarrhoea and dysentery (759), closely followed by debility, atrophy and inanition (723) and premature birth (664). Bronchitis (513) and enteritis (418) also account for a considerable number of deaths. The remaining five categories in rank order were pneumonia (383), convulsions (288), whooping cough (217), suffocation (192), and measles (112).

Table 5 (Appendix 2) shows causes of death ranked as a percentage of all infant deaths. The causes of death remain consistent during the period but the levels at which they occur fluctuates. Whooping cough, suffocation and measles remain relatively consistent while other categories show marked variation as seen with diarrhoea and dysentery, pneumonia and bronchitis, illnesses that were considered to be susceptible to warm summers and cold winters in a way that the contagious diseases such as measles, were not.

### **Overlaying: suffocation deaths in St Pancras**

Overlaying deaths in St Pancras as elsewhere in England c 1900 were recorded as deaths by suffocation. The annual reports of the MOH for St Pancras, Dr John Sykes, provide an analysis of death by age and cause. The number of infants whose deaths have been attributed to suffocation in the ten year period to 1902 is shown in Table 6 (Appendix 2). As shown in Table 5, suffocation deaths remained relatively consistent as a percentage of all infant deaths under one year in the parish at between 2.8% and 4.3%. Although the number of overlaying deaths in Somers Town alone was not recorded, from Table 5 it can be estimated to be between 5 and 8 deaths per year. Of the deaths that occurred between 1898 and 1902 (192), I have identified twenty-one overlaying deaths as occurring in Somers Town. And based on this estimate, they represent the majority of such deaths and are detailed below. Other deaths from suffocation may also have occurred in Somers Town but due to the scarcity of sources

relating to individual deaths and because coroners' case notes for the district were destroyed during World War 2, it is not possible to identify all suffocation deaths in Somers Town for the period. One issue worth noting at this point is that the recording of infant death in bed was subject to broad variation. Infants may have been found dead in bed and their death certified by a doctor as suffocation or asphyxia from natural causes. The doctor may or may not have suspected overlaying. If the doctor suspected overlaying he was responsible for referring the death to the coroner as an accidental death, but it is possible that this did not always happen. Some deaths would have been referred to the coroner and an inquest may have been held. If it was decided that overlaying had caused the death, then a verdict of accidental death was usually returned by the jury. If a death certificate had already been issued by a doctor, the coroner had the authority to amend the death register. As a consequence, infant death in bed could be recorded as natural or accidental suffocation or asphyxia, as could many other types of infant death caused by disease. It is therefore important to note that suffocation deaths included deaths from causes other than overlaying, although overlaying did provide the majority cause of death in this category. It is not always possible to reconcile the difference in numbers reported by the coroner and those by the MOH. In 1898, for example, the St Pancras coroner reported forty-three deaths by suffocation while the MOH reported forty-two cases. By close examination of the Coroner's Register, the reports of the MOH and newspaper reports of inquests, it has been possible to gather enough information to establish the claim that the majority of deaths by suffocation in infants under one year attributed to suffocation in bed or overlaying for the period 1898-1902 are reported here.

### **Walking the streets: daily life and death in Somers Town**

This section provides an exploration of the streets of Somers Town and the overlaying deaths that occurred there between 1898 and 1902. All points of Somers Town were within a few minutes walk of each other and the neighbourhood was a densely populated area of residential dwellings and industry. The 'walk' locates forty infant (twenty-one from overlaying) deaths in twenty-three separate locations across the area (20 streets, the St Pancras Workhouse, the railway and the canal), occurring over this five year period. The death of infants during this period in Somers Town would have been a commonplace event and it is important to remember that this chapter relates only deaths that have been the subject of an inquest or that have been sufficiently newsworthy to have appeared in the St Pancras Guardian (STPG). When the number of infant deaths in Somers Town for the period 1898-1903 (a total of 1102) is considered, it can be seen that the death of an infant

was something that would have been known to many in the population.

In March 1898, Arnold White, a long time proponent of ideas about national efficiency, gave a public lecture at the Stanley Hall in St Pancras and asked the question ‘Is England’s Navy Inefficient?’ (STPG 11/3/1898). A week earlier, Dr Darley Hartley, a member of the Cape Parliament, had been lecturing on ‘Our relations with South Africa’ (STPG 4/3/1898). National efficiency and Britain’s imperial involvement in South Africa were issues brought to the public’s attention in St Pancras in 1898, the year before the South African War began. On the other side of London, Major Fredrick Maurice was expressing concern about the physical deterioration of recruits at the Woolwich Barracks (Maurice: 1902: 81). In Somers Town, St Pancras, people continued their daily lives in sometimes very difficult conditions. Life in Somers Town was not at all easy.

Some of the worst slum dwellings in Somers Town had been demolished following the Housing Act 1890, but the area had by no means been brought to an acceptable standard of accommodation. By 1898 when the social researcher Charles Booth conducted his survey of the area, overcrowding was still frequently encountered in many parts of the Parish, and Somers Town received some particularly bad reports from Booth (Booth: 2005: B356: p133). By 1898, Somers Town was a well-defined area of St Pancras. Somers Town was positioned between Euston Road in the south, Crowndale Road in the north, Midland Road in the East and Seymour Street (now Eversholt Street) in the west. Members of its population (15,132) were living at a density of 166 to the acre and in some areas Booth recorded that up to 60% were living in poverty (Booth: 1892: 10). Church Way was a notorious slum area in the southern part of Somers Town, running from Euston Road to Drummond Street. Some parts of Church Way were cleared during the 1880s and some of the worst courts, like Christopher Place and Seymour Court, had been demolished to make way for the building of the New Hospital for Women which opened in 1890 (later to be renamed after its founder Elizabeth Garrett Anderson). In 1889 a visitor to Church Way reported:

“Much filth and wretchedness. Two rooms of a cottage were occupied by a man, his wife, and ten children. In the front room of an adjoining cottage were found a young coal carrier out of work, his wife, and five children, the youngest six weeks old and the eldest seven years. All the children were ragged and almost naked, and the eldest was crying with hunger” (The Times: 19/8/1889: 10: C)

At 56 Church Way, George Foote aged 3 months, died on 26 September 1898. The coroner’s verdict was one of accidental death, asphyxia, in bed with his mother. George’s father was a coal porter (STPG 28/9/1898). George Foote’s death was one of twenty-one deaths caused by overlaying which were reported by the St Pancras Coroner’s Court. The coroner, Dr Danford Thomas, remarked “that he held 200 inquests annually on children

suffocated in bed, with their parents” (STPG 22/4/1898), with 500-600 infants suffocated annually in London and some 1500 in Britain. Not everyone perceived such deaths as accidental, although this was usually the official response in the absence of compelling evidence suggesting otherwise:

“The Coroner, in commenting on the frequency of such cases said not long since he received a letter from a lady with regard to the suffocation of infants, in which she urged that in all such cases the mothers should be committed for manslaughter. He (the Coroner) did not think that they would be justified in taking such drastic measures.” (STPG: 22/4/1898)

Booth visited Church Way and its “mainly 2 St[orey] houses” and “very narrow passage” and commented that “it appears to have belied scripture, and having led its denizens to degradation, is now doomed to destruction itself” (Booth: 2005: B 356 p137). The Church Way Improvement Scheme was underway at the time, but had not yet progressed sufficiently to prevent Dr Hamer (Assistant Medical Officer of Health to the London County Council) describing the area as “verminous” (SPV: Vestry of St Pancras Health Department: 1893: 287). Number 56 Church Way, the house where George Foote died in 1898, had been demolished as part of the Church Way Improvement Scheme by the time of the Census in 1901.

Weir’s Passage led from Church Way. At number 1, Thomas Harry Sutton died in November 1899 at the age of 11 weeks. He was found dead in bed with his mother and the coroner returned a verdict of accidental death. At 7 Weir’s Passage, Ellen Elizabeth Ryan was found dead in bed with her parents. The coroner’s verdict was accidental death by suffocation (STPG 28/02/1902). The Ryan household occupied one room in a tenement building. The head of the household (WJ Ryan aged 28 years) is shown on the 1901 Census as living with three sons, Fred (7), Harry (4) and Alfred (1). There is no female figure recorded at the address, but WJ is shown as married rather than widowed, so it is possible that a female member of the household was only temporarily absent at the time of the Census. The birth of Ellen in 1902 would suggest that even if there were no female adult in the household in 1901, this position was not long-standing because Ellen was reported as dying in bed, with “her parents”. There were two other households sharing the house which had four rooms. The average number of occupants per room at number 7 Weir’s Passage was 3.5 (TNA: RG13.145.41.74). Next door at number 8, Elizabeth Morris, a flower seller was charged with wounding Annie Hall, by hitting her in the head with a wooden bucket. Annie Hall was collecting rent for the property (STPG 9/5/1901). At number 9, Henry Denman lived with his mother. Henry was charged with stealing one and a half sovereigns:

“He claimed to have given 1 sovereign to his mother and kept ½ for himself. His mother claimed to have used the money to get clothing out of pawn and spent the change on drink.” (STPG 3/5/1901)

Henry’s mother was remanded and Henry was sent to the workhouse in Pancras Way.

Further along Church Way, to the left, was Wellesley Street, a cul-de-sac of three storey houses. Wellesley Street was part of the Church Way Improvement Scheme and was described by Booth as “one of the worst spots from every point of view in the whole of Somers Town” (Booth: 2005: B 356 p133). Living there in late 1898, at number 2, was the family of Clara Elizabeth Lucy Dovey, who had died on 11 April 1898 at the age of 3 months. The coroner’s verdict was that she had died due to overlaying by her 20-month sibling (STPG 22/4/1898). These houses were soon to be demolished and had gone by the time of the 1901 Census, but not before Booth classified them in one of his lowest categories, dark blue with a black bar, the poorest of “the very poor [...] living from hand to mouth” (Booth: 1967: 191).

The next street to the left along Church Way was Lancing Street where, at number 2, James Boswell, a painter, assaulted his wife Sarah. The *St Pancras Guardian* reported that James had asked Sarah for a clean shirt and that Sarah had in return “used filthy language to him and he struck her” (STPG 22/11/1901). At number 32, James Green was convicted of assaulting, and living off the “immoral earnings”, of Mary Hatton (STPG 18/5/1900). He was jailed for 9 months (6 months for assault and 3 months for living off immoral earnings). At number 11, Albert Henry Millbank stepped on a nail and died of lockjaw (STPG 6/4/1900).

At the north end of Church Way was Drummond Street, where, at number 63, John Hanlon (27) was found dead from intemperance in a coffee shop that rented rooms. Hanlon was accompanied by a “young woman” who found him dead in the morning (STPG 9/3/1900). Coffee shops of this kind were often thought to be the respectable front for the ‘real’ business of room renting and brothel keeping. At 105 Drummond Street, Rose Olive Crockford, the 8 ½ month old daughter of a greengrocer's assistant was found dead in bed. The coroner’s verdict was pneumonia (STPG 4/5/1900). Further along at 169, 6 week old Richard Gould, the son of a caretaker was found dead in bed with his parents and another sibling. The coroner’s verdict was accidental death by suffocation (STPG 25/5/1900). At 195 Drummond Street, the Weats family lived with daughter Violet Ellen. The daughter of a labourer, Violet Ellen was one month old when she was found dead in bed with her parents and another sibling. The headline in the *St Pancras Guardian* was “Four in a Bed” (19/10/1900). The coroner’s verdict was accidental death. In June 1900, Elizabeth Frost aged

39 years was charged with exposing her four children in Drummond Street. The St Pancras Guardian reported on 7 June 1900:

“Elizabeth Frost, 39, married mother of four of no home charged with being drunk, and exposing her four children George 13, Robert 4, Minnie 3, and Violet 20 months in a manner likely to cause them unnecessary suffering at Drummond street, [the] defendant was drunk and sitting on the kerb at midnight, [the] children were in a filthy and neglected condition, the woman’s husband was in regular work earning 50s a week, both were described as ‘addicted to habits of intemperance’ “ (STPG 7/6/1900)

Elizabeth was remanded in custody and her children were sent to the St Pancras workhouse.

Next along Church Way was Drummond Crescent and Little Drummond Street. In December 1901, the abandoned body of a male child was found in the hallway of 36 Drummond Crescent:

“On Monday, Dr Thomas held an inquest on the body of a male child that was found by a lodger wrapped in a parcel in the passage of 36 Drummond Crescent, Somers Town. He called in the police to whom the parcel was handed and their supposition was that someone passing by had deposited it behind the street door unnoticed. The body was wrapped in calico and a carpet bag. They had satisfied themselves that no person living in the house knew anything about the affair. Dr Thompson stated that the body was decomposed and life had been extinct for at least a fortnight. It had been born alive and death had been due to neglect at birth. The Coroner pointed out that the endeavour made at concealment proved the neglect to have been wilful and the jury returned an open verdict.” (STPG 13/12/1901)

In Drummond Crescent, Mrs Rowles was acting as child minder to Albert Sanders when he died aged 4 months. The coroner’s verdict was that Albert’s death had been caused by improper feeding (STPG 28/11/1902). Alfred French, 11, also of Drummond Crescent was charged with stealing condensed milk from 89 Charlton Street (STPG 9/8/1901).

Running between Drummond Street and Drummond Crescent was Little Drummond Street. Booth provides a graphic description of Little Drummond Street:

“A narrow thoroughfare of bad reputation, although even here, Bowles [a local policeman] thought that there was not much crime. It is however the worst spot in the immediate n’hood and a good many prostitutes and amateurish thieves are living here. The houses are small 2 storeyed, and do not look so poor as those of Sidney St. perhaps the gains of vice show themselves, but there is much obvious dark-blue, and this should be the colour of the st[reet] with a black bar in stead of the unrelieved black of the map. The local name for the street is ‘little hell’ and prisoners on being charged, not infrequently describe themselves as living in this byeway of the nether regions.” (Booth: 2005: B 356 p109)

In April 1900, John Davey, 48 years old, described as a “ruffian” and a bootmaker, living in Little Drummond Street, was convicted of assaulting Ada Roberts. Davey was reported as being “kept” by Roberts from her “immoral earnings” but she did not give him enough



money and he beat and “illused” her. Davey was sentenced to nine months imprisonment (STPG 20/4/1900).

To the right was Seymour Street, where at number 134 Sidney James Davies was found dead in bed with his mother. Sidney, who was 3 weeks old, died in November 1901, the verdict was accidental death. His mother was a widow. The Davies household was not recorded at 134 Seymour Street at the time of the 1901 Census. In January 1900, at number 156 Seymour Street, John Sullivan aged 29 was charged with “cutting and wounding” John Sullivan, aged 7 years (STPG 2/2/1900). Along the road at 174 Seymour Street there was another coffee shop reputed to be a brothel (Booth: 2005: B 356 pp111). Further along on the right, Gee Street (now Polygon Road) led into Clarendon Square, the former site of The Polygon, one-time home to Mary Woolstonecraft, author of Vindication of the Rights of Women. She had died there in 1797 following the birth of her daughter, also Mary, author of *Frankenstein* (and many other works) and wife of the poet Shelley. At 5 Gee Street, Emily Marie Bowler, the daughter of a ‘printers labourer’ aged 3½ months was found dead in bed with her mother; the coroner’s verdict was accidental death by suffocation.

Clarendon Square was also the home of John Thomas Finchill who died at the age of 5 months. The son of an electrician, Thomas was “put out to nurse” with Mrs Kirk at 48 Euston Street in April 1900, because his mother had been taken ill and was confined to hospital. Thomas died from ‘fits’ while in the care of Mrs Kirk. The coroner’s verdict was death by natural causes (STPG 27/4/1900). Clarendon Square was also the site of the Clarendon Hall, a local community amenity where philanthropic events regularly took place. In August 1900 the children of Somers Town were taken for a day in the country on a trip organised by the Christian Men’s Union Gospel Mission. The St Pancras Guardian reported:

“Monster Excursion from Somers Town - Slum Children in the Country.  
“700 children and 100 adults [were] taken to Epping Forest by train from St Pancras. Assembled in Clarendon Sq, each child was supplied with large fruit and meat pies.”  
(STPG 24/8/1900)

Other activities at the hall included the provision of meals to children during the winter months:

“Free dinners of stew are distributed to some 500 children twice a week at the Clarendon Hall – this has been done for 40 years during the winter, by the men Christian Men’s Union Gospel Mission. (STPG 7/11/1902)

To the left was Clarendon Street. At number 16 Clarendon Street, Alfred Palmer, the 8 week old son of a coal porter, had been ailing since birth. In May 1901, when Alfred had difficulty breathing, he was taken to the surgery of Dr Cremin, but died on the way (STPG 31/5/1901). A year later, Alfred’s father (also called Alfred) aged 23 years was convicted of

assaulting his wife. Alfred Palmer Senior reportedly hit his wife on the head with a saucepan of boiling water taken from the fire. Palmer's father-in-law was also injured and hospitalised. Palmer's wife asked for leniency from the court and Palmer was sentenced to 14 days imprisonment. Palmer's wife was granted a separation (STPG 9/5/1902). The Palmer household was not shown as living at number 16 Clarendon Street at the time of the 1901 Census. Further along, 32 Clarendon Street was the scene of several infant deaths. Margaret Carter, aged 1 month, was found dead in bed, with her mother on 17 April 1898 (STPG 22/4/1898). The coroner's verdict was accidental death by suffocation. In August 1899, Miranda Ann Eliza Shepherd, daughter of a 'cab washer', was also found dead in bed with her mother and two other children. The verdict of the coroner was accidental death by suffocation. In 1902 number 32 was also the scene of death of three siblings:

*"The Dangers of Improper Feeding*

*"Three children dead in one family. May Webb, 15 months, daughter of a brass finisher, 32 Clarendon Street.[...] Mother stated that she fed child on biscuits bread and cow's milk but it never thrived. It suffered from sickness, diarrhoea and wasting. It died on Sunday. The coroner said that he understood that her other two children were lying dead" (STPG 15/8/1902)*

Medical evidence at the inquest stated that May weighed 8½ lb instead of an expected 28 lbs. Another child, Florence Webb, aged 4½ years, had died the previous night and yet another child, Rose Webb, 4 months, was also dead. The children were reportedly fed on tinned salmon, ice cream and pickles and were dirty and ill-kept (STPG 15/8/1902). The joint funeral of the sisters was held on 18 August 1902 and the following report appeared in the St Pancras Guardian:

*"Funeral of Three Infant Sisters'*

*"On Monday afternoon Clarendon Street was invaded by several hundred women hailing from the adjacent slum district who came to witness and comment upon the uncommon sight of a funeral of three children – sisters – whose deaths so quick upon each other came under the observations of the NSPCC with the result that the coroner inquiry was made into the circumstances attending the death of one of them. May Webb aged 15 months. The evidence of Dr Wall of the north west London hospital was to the effect that the child was greatly emaciated and only weighed 8 1/2lbs instead of 26lb. Another child Florence Webb aged 4 ½ years had died the previous evening and a still younger one, Rose aged 4 months was awaiting burial. It was stated that the children were improperly fed through ignorance and given the same kind of food, as the parents themselves ate, such as meat and potatoes, tinned salmon, bread and cheese, and pickles, ices etc. the cause of death was chronic gastral intestinal catarrh induced and accelerated by injudicious feeding. The combination coaches for the mourners and three tiny white covered coffins comprised the funeral cortège [May's coffin] being by itself in the glass receptacle in the first carriage and the other two in front of the second vehicle. When the mother appeared at the door some threats were uttered, but the presence of one or two constables prevented any unseemly demonstration. The interment took place at the chapel ground of the St Pancras Cemetery Finchley." (STPG 22/8/1902)*

By the time of the 1901 Census, the Carter household had moved on, but the Webb household were still at number 32 Clarendon Street. Number 32 was occupied by seven households (32 people) who shared 12 rooms. The average number of people per room was 2.67. The Webb household had three rooms. Benjamin Webb (29), the head of the household, was a “brass screw cutter” who lived with his wife Florence (27) and children, George (5), Florence (3) and Harriet (1). Rose and May, whose deaths were reported in the St Pancras Guardian in August 1902, had not yet been born (TNA: RG13.13.146.105.17). What had changed in this household between the Census in April 1901 and August 1902 when the children died? George had attained the age of 5 years, Florence was 3 years old. Why, eighteen month later, did Florence, and the as yet unborn May and Rose die within the space of weeks of each other in an emaciated condition?

Left from Clarendon Street was Aldenham Street. At 101 Aldenham Street, Ernest Turner, the 5 week old son of a painter died of pneumonia. The infant was seen by Dr Anklesaurus of Oakley Square (STPG 29/11/1901). The Turner household was not recorded at 101 Aldenham Street at the time of the 1901 Census. A short way along Aldenham Street, to the right, was Little Clarendon Street. Little Clarendon Street was coloured black on Booth’s poverty map, “the lowest grade [...] inhabited by occasional labourers, loafers, and semi-criminals – the elements of disorder” (Booth: 1967: 191). Little Clarendon Street “had been particularly notorious for the number of child prostitutes living there” (Booth: 1898: B22: 60-69) At number 13, Amelia Beatrice Lesson, aged 5 months was found dead in bed, on 9 January 1900. Amelia was described as:

“A delicate child [...] Dr Savoury proved that death was due to exhaustion, from tubercular disease. The jury returned [a] verdict in accordance with the medical evidence.” (STPG 12/1/1900)

The Lesson household no longer lived at 13 Little Clarendon Street at the time of the 1901 Census, but the building was shown as a four room tenement housing two households (14 people). The average number of occupants per room was 3.5 (TNA: RG13.146.77.40). On the same side of the street, at number 21 Little Clarendon Street, William Henry Dole died at the age of 10 weeks. William was found dead in bed with his parents and the verdict was accidental death. William’s father was a costermonger (STPG 21/11/1902). By 1901 the Dole household (4 people) had moved along the street to number 36 Little Clarendon Street, where they occupied one room. Two other households (11 people) shared the four room house. The average number of persons per room was 3.75 (TNA: RG13.146.120.48). Along the street at number 38 Little Clarendon Street, Hannah Bowler lived with her mother. Hannah was found dead in bed with her mother on 27 December 1901 at the age of 10

weeks. The St Pancras Guardian reported the following:

“The Suffocation of Children - a Mother Censured

“On Monday Mr Walter Schroder held an inquest on the body of Hannah Bowler, aged 10 weeks, the daughter of a single woman, living at 38 Little Clarendon Street, Somers Town, who was found dead in bed, on Friday last with its mother. The mother said she went to bed at 10.30 on Thursday and when she woke about 11 on Friday morning she found the child dead on her arm. Asked by the coroner how she accounted for her sleep of twelve hours without waking she said that she had had too much drink. The jury, after some consideration returned a verdict of “accidental death” and censured the mother for taking the baby to bed with her while intoxicated, the Coroner telling her that she very narrowly escaped being sent to prison on a charge of manslaughter.” (STPG 3/1/1902)

The Bowler household was comprised of seven people. Head of household George (57) and Emma (43) his wife lived with children, George (18), Eliza (16), James (14) and Isabelle (26). A grandson, Alfred (3), was also shown. None of the Bowler children were shown as married and Hannah’s mother was reported by the St Pancras Guardian as being single. The order in which the Census return was completed would suggest the Isabelle was the mother of grandson Alfred. It is possible that Isabelle was also the mother of Hannah. George Senior worked as a labourer in a brickfield, daughter Eliza worked as a factory hand, son James worked in a Smith’s Shop and Isabelle worked as an “ironer”. The Census shows the household as occupying one room. This would be unusually high level of overcrowding even for the Somers Town area, especially when the number of incomes (4) the household received is considered. The Bowler household must have lived in very cramped conditions. There were three other households at number 38 Little Clarendon Street (14 people). The average number of people per room was 4.2 (TNA: RG13.146.121.49).

At number 42 Little Clarendon Street, Amelia Florence Mears, aged 8 months, was scalded to death by boiling water which had been poured to wash dishes. Amelia’s father worked as a “carman” (STPG 9/8/1901) or delivery-man. The Mears household did not live at number 42 Little Clarendon Street at the time of the 1901 Census and the building is shown as occupied by the Usher household who had single occupancy of the three rooms in the house (TNA: RG13.146.122.51). On the other side of the road at number 51 Little Clarendon Street, Emily Peters died at the age of 3 weeks. The St Pancras Guardian reported the death as occurring at the mother’s breast (STPG 8/9/1901) and the coroner’s verdict was accidental death. The Peters household was not recorded at 51 Little Clarendon Street at the time of the 1901 Census.

Other occupants of Little Clarendon Street included Amelia Capper, Margaret Parkinson and William Dunn. In January 1900, Amelia Capper was charged with stabbing David Pearce. Amelia claimed that Pearce had “knocked me down and tore my clothes off

and I got a knife and attempted to stab him”, and she was remanded (STPG 19/1/1900). Two months later, Margaret Parkinson was sentenced to twenty-one days for stabbing a police constable with a hatpin when he had prevented her from entering a public house at closing time (STPG 30/3/1900). The following year, William Dunn was charged with assaulting his pregnant wife (STPG 9/5/1902). At number 50, Jane Delaney’s daughter, Sarah Jane, died on 9 August 1898, aged 10 weeks. The coroner’s verdict was “suffocation in bed, with mother, accidental death” (STPG 12/8/1898).

Taking Little Clarendon Street as an example, the 1901 Census shows that on 31 March 1901, 558 people were living in 207 rooms. This is an average of 2.7 people per room but when non-tenement houses (16) in the street are excluded the average increases to 3.1 people per room. Occupancy in non-tenement houses was lower, with 1.7 people to every room. This shows that in 1901, tenement dwellings in Little Clarendon Street had, on average, an additional 1.4 people per room than non-tenement dwellings. The highest occupancy was at number 30, where Walter Slack, a labourer, lived in one room with his wife and six children aged 1 to 13 years. At number 50, where Sarah Jane Delaney died, her mother Jane and brother William aged 4 were living in one room at the time of the 1901 Census. The Delaneys’s house was a tenement and there were four families (11 people) living in the four rooms of the house. Jane worked as a “charwoman” and in 1901 she was 25 years old. She was recorded as the head of the household, there is no husband or other male figure recorded at the address and so it would seem that Jane was raising her son by herself. The average number of people per room at number 50 Little Clarendon Street was 2.75 (TNA: RG13.146.123.54).

At the northern end of Little Clarendon Street was Johnson Street. Number 5 was the home of William Carlisle who, at the age of 13 was remanded to the workhouse following an incident during which he stabbed a young girl in the head (STPG 18/11/1898). Further along Johnson Street was number thirteen, formerly the home of a young Charles Dickens and his family, evicted in 1827 for non-payment of rent (LCC: 1952: 23). Booth also visited Johnson Street and described:

“Towsled haired women, standing at open doors, bare-armed: dirty children, and the houses with too many broken windows, stuffed with temporary mendings. But nothing is charged against the street worse than roughness and drunkenness” (Booth: 2005: B 356 p107)

The ‘open doors’ were taken by Booth as an indication that the houses were tenement buildings. Number 28 Johnson Street was the home of James Thomas Cooper. James, the son of a labourer, died at the age of 2 months and was found dead in bed, with his mother. The coroner’s verdict was accidental death due to suffocation (STPG 13/6/1902). The Cooper

household was comprised of three people in the Census of 1901. Henry (29), wife Margaret (28) and son William, (2) had one room in a six room tenement shared with three other households. The average number of people per room was 2.33 (TNA: RG13.146.68.38). At number 31, Elizabeth Harriet Wood died on 21 October 1900 at the age of 7 weeks. Harriet's death was recorded as occurring from natural causes and was due to wasting. The Wood household are not recorded at 31 Johnson Street at the time of the 1901 Census. At the eastern end of Johnson Street was Stibbington Street. The area bounded by Stibbington Street, Seymour Street, Johnson Street, and Aldenham Street was described by Booth as:

“One of the worst areas remaining in the whole of the subdivision. It has improved somewhat, and the police give it a fair character as regards criminality. But it remains a dark, if not very black corner of London” (Booth: 2005: B 356 p107)

Heading south on Stibbington Street from Johnson Street, Bridgewater Street was the first turning on the right. Samuel Bush, aged 11 years, lived at number 15. Samuel was charged and convicted of stealing 14 lb of coal and was sentenced to attend Drury Lane Industrial Day School. His mother was ordered to pay 1s a week for his support there (STPG 29/3/1901). The Bush household was comprised of eight people and they shared three rooms. Samuel Bush (49) was head of the household. Samuel was married to his second wife Ellen (49). With them lived Samuel's children Bridget (17) who worked as a factory hand, Agnes (15) who worked in a factory packing hair, Jane (13) and Samuel (11). Also living with them was Ellen's daughter from a previous relationship, Ellen Callaghan (16), who also worked in a factory packing hair, and Joseph (4), a son of the marriage. 15 Bridgewater Street also housed two other households (8 people) in three additional rooms. The average number of occupants per room was 2.66 (TNA: RG13.146.77.55).

Next door to the Bush household, at number 17, Matilda Burrage (sometimes spelt Burridge) was 2 hours old when she was found dead in bed, with her mother. The coroner's verdict was accidental death by suffocation (STPG 20/3/1903). The Burrage household (10 people) had three rooms at 17 Bridgewater Street. The house was a tenement shared with two other households (6 people) with one room each. The head of household, Robert (44) was a manual worker. Robert and his wife Sarah (41) lived with their eight children, Alice (17), Annie (15), Margaret (12), Robert (10), Amy (8), Charles (6), Frederick (4) and Alfred (2). Annie worked as an “errand girl”. The average number of occupants per room was 3.2 (TNA: RG13.146.77.55).

Along Stibbington Street, to the south was number 41 where Julia Huggard, aged 30 minutes, the daughter of a railway porter died following her premature birth. Julia's mother had delivered twenty-two children, only two of whom were still living at the time of Julia's

short life (STPG 18/9/1903). The Huggard household occupied three rooms in a seven room house, which housed four households. John (41) a railway porter lived with wife Julia (35) and sons John (14) and Charles (7). The household also comprised a lodger, Charles Lovesay (41) who was a musical instrument maker. The average number of people per room was 2.29 (TNA: RG13.146.63.62). Further along Stibbington Street, at number 53, Florence Margaret Dawson (reported as Frederick Dawson in the St Pancras Guardian), daughter of a labourer, was found dead in bed with her parents the day after she was born (STPG 19/3/1901). The coroner's verdict was accidental death. The Dawson household no longer lived at number 53 Stibbington Street at the time of the 1901 Census. A year later, also at 53 Stibbington Street, George Head, a porter, was convicted of assaulting his wife Annie for refusing to give him a cup of tea in bed:

“He became enraged and punched her about the body. He afterwards kicked her in the back and caused her to fall over a chair. She was now suffering from a partial dislocation of the right hip and very severe bruising of the lower part of the back and other parts of the body. Prisoner was sentenced to nine months imprisonment and the prosecutrix was granted a separation” (STPG 3/1/1902)

George and Annie were recorded as living with their 1 year old son, in two rooms at the time of the 1901 Census (TNA: RG13.146.58.17).

Running parallel with Stibbington Street to the east was Barclay Street. At number 52, Thomas William Harbud, son of a “piano porter”, died in bed, with his mother and another child. The coroner's verdict was accidental death by suffocation (Coroner's Register 27/6/1898). The Harbud household was comprised of five people who shared two rooms. Head of household Joseph (30), wife Edith (29) and sons Joseph (8), Willie (5) and John (2) shared the house with one other household. The average number of people per room was 2 (TNA: RG13.143.138.59). In the next street to the east, Charrington Street, John Duggan, son of a “newspaper printer” died in April 1901, at the age of 6 days. John was found dead in bed with his mother and the verdict was accidental death (STPG 26/4/1901). The Duggan household was the only one recorded at number 65 Charrington Street. George (31) and his wife Emma (26) had two rooms and the average number of people per room was 1 (TNA: RG13.144.10.11).

Platt Street was a turning on the east side of Charrington Street. Henry White aged 2 months died in Platt Street on 12 April 1898. Henry was found dead in bed, next to his mother. The coroner's verdict was death by natural causes, asphyxia due to convulsions (STPG 22/4/1898). To the north, Charrington Street met Werrington Street, where in December 1901 Joseph Wing, aged 7 days, son of a “carman” living at number 45, and Edward Wood, aged 5 months, son of a music hall artist living at number 7, both died of

convulsions (STPG 13/12/1901). In October 1901, at number 28 Werrington Street, Eliza Sibley had died from asphyxiation due to milk in her windpipe (STPG 30/10/1901). The Wing household at number 45 Werrington Street had two rooms in a house shared with seven other households. John (27), and his wife Louisa (26) lived with children Louisa (5), Emily (3) and John (1). Louisa would have been pregnant with Joseph at the time of the Census. The average number of people per room at number 45 Werrington Street was 2.46 (TNA: RG13.146.52.5).

At the east end of Werrington Street, Goldington Crescent led into Pancras Way. There, on the boundary of Somers Town in Pancras Way was the Vestry Hall of St Pancras and the St Pancras Workhouse. It was here that Georgina Brewster ‘abandoned’ her child in the summer of 1898. Georgina’s court appearance was reported in the St Pancras Guardian in early July 1898. Georgina was charged with child desertion, abandoning her child outside the St Pancras Workhouse. Georgina had been evicted from her lodgings and had left her child outside the workhouse, waiting nearby until a police constable found the child. Georgina was also charged with attempted suicide following the abandonment of her child (STPG 8/7/1898). The St Pancras Workhouse was the scene of death for many infants. It is important to remember, however, that although residents of the St Pancras workhouse may have come from Somers Town, they could have also have arrived from elsewhere, both from within and from beyond the Borough. An example of such a death is that of a foundling left in Gordon Square in late October 1901. The infant was taken to the workhouse and died the following day. There is no record of the origins of the child. Other workhouse deaths are more easily identified. Margaret Gilbert aged 8 months also died at the St Pancras Workhouse. Margaret had been sent to the workhouse following the six month imprisonment of her mother for child neglect. The condition of the infant on entry to the workhouse was reported by the St Pancras Guardian as being very poor. The infant was in a “VERY EMACIATED CONDITION” and “THE MOTHER WAS CONTINUALLY THE WORSE FOR DRINK” (STPG 16/2/1900 capitalization in original). Dr Dunlop who was the Medical Superintendent at the St Pancras Workhouse stated that the infant weighed 7 lb instead of the expected 14 lb (STPG 16/2/1900).

Possibly due to its transport connections, St Pancras was a place where infants, both alive and dead, were sometimes abandoned. In consequence, the St Pancras Coroner’s Court dealt with a number of inquests into the deaths of infants whose bodies were found on trains, in railway tunnels and in the Regent’s Canal. The body of an unknown female infant was found in the Regent’s Canal in January 1900:

“Baby found in Canal



“Dr Danford Thomas held an inquest in St Pancras on Saturday on the body of a female child found in a nude condition in the Regent’s Canal. [...] Dr Thomas said that the child had been born alive and died from suffocation. The jury returned an open verdict.” (STPG 19/1/1900)

In February 1900, the body of an unknown female infant was found in the railway tunnels beneath Somers Town. The infant’s body was wrapped in brown paper and it was assumed that it had been thrown from a passing train. There were no marks or anything to identify the infant. The coroner’s verdict was that the infant had been still born (STPG 2/2/1900). In October of the same year, the body of a newborn male child was found in a box on the luggage rack of a train that had arrived from Newcastle. The infant had been dead for eight to ten days. The coroner’s verdict was that the death had been caused by neglect and murder by some person or persons unknown (STPG 19/10/1900). Later, in February 1901, a “castaway” female infant’s body was found floating in the Regent’s canal. It was estimated that the body had been in the canal for two weeks. There was no evidence to suggest that the child had been born alive (STPG 1/3/1901).

Continuing south, Charrington Street became Ossulston Street at the cross roads with Hampden Street. At number 10 Hampden Street, Alice Elizabeth Bonnie aged 2½ months died on 12 April 1898. The coroner’s verdict was accidental death by suffocation (STPG 22/4/1898). The Bonnie household was not recorded at 10 Hampden Street at the time of the 1901 Census.

At number 47 Ossulston Street, 4 year old Alice Jackson died after her clothing was accidentally set alight. Alice was the daughter of a coal porter and the coroner returned a verdict of accidental death (STPG 1/2/1901). The Jacksons lived in two rooms of a seven room house shared by four households. Husband and wife, David (50) and Annie (39) lived with children Thomas (12), Elizabeth (10) and Edward (3). The average number of people per room was 2.71 (TNA: RG13.145.36.64). In the same week, James Jackson, a coal porter, also of Ossulston Street was charged with assaulting Alfred North, a porter. James does not appear to have been part of Alice Jackson’s household. Further along Ossulston Street at number 31, ten month old Edith Kate Gibb, the daughter of a widow, died in October 1902. The coroner commented on the infant’s diet of “condensed milk and arrowroot”. Edith weighed 5 ¾ lb instead of the expected 16 lbs. The coroner’s verdict was death due to natural causes, namely consumption of the intestines (STPG 10/10/1902). Number 31 Ossulston Street was a tenement building housing ten households comprising thirty-one people in fourteen rooms. The average number of people per room was 2.36 (TNA: RG13.145.34.59). At number 109, Ossulston Street, Amelia Watson died in December 1900 at the age of 2½ months. Amelia was found dead in bed, with her mother. The coroner’s verdict was

accidental death by suffocation (Coroner's Register 21/12/1900). There were six people in the Watson household. Husband George (27) and wife Loucy (27) lived with children Charley (9), Loucy (7), Eva (2) and Emily (recorded as 0). George worked as a blacksmith (TNA: RG13.143.45.24).

Leading from Ossulston Street was Ossulston Place where Frederick Charles Smart died in May 1900. Frederick was found dead in bed with his mother and the coroner's verdict was accidental death due to suffocation (STPG 25/5/1900). The Smart household had two rooms and did not share the house with any other households at the time of the Census. Head of household, Joseph (69) lived with his son Joseph (16), a coal porter, daughter Hannah (22) and granddaughter Hannah (5). Frederick may have been the second illegitimate child of Joseph's daughter Hannah. Further along, Ossulston Street met Euston Road to the east of the New Hospital for Women where this 'walk' began. It is still possible to follow much of this route today although most of the housing described above has been demolished and the area, following two world wars, the rebuilding of Euston Station, the new British Library and twentieth century improvement schemes, is now mainly comprised of local authority housing estates. Some of the properties remain, but these have generally been renovated and restored to a condition that was probably unknown at the end of the nineteenth century. The St Pancras Coroner's Court is still located in Camley Street and although extended in the 1950s, the original building where Dr George Danford Thomas held inquests remains.

## **Conclusion**

Infant mortality, overlaying, neglect, abandonment, murder, disease, domestic violence, prostitution, intemperance, poverty and overcrowding were all part of daily life in Somers Town c1900. It was not, however, the presence of such conditions but the concentration at which they were present that is so compelling. In this context, it does not overstate the case to suggest that infant death was an almost daily part of life at a time when infant mortality in Somers Town was higher than in St Pancras as a whole and London generally. From a population of about 15,000 an average of 183 infants died in Somers Town each year between 1898 and 1902 with overlaying being the cause in between five to eight of these.

The overcrowded accommodation in the Borough can be attributed to poverty and the lack of local regulation to prevent it. Tenement buildings and the single room system predominated during the period, but blame for the prevailing living conditions was largely apportioned to the people themselves. This view prevailed despite Booth's estimate that 60% of the population in Somers Town were living in poverty. Intemperance was also an issue in

Somers Town and alcohol features in many of the reports detailed here, but it is not mentioned in relation to overlaying with the exception of one case, that of Hannah Bowler. Despite reports that Hannah's mother was drunk, the jury returned a verdict of accidental death and the coroner was left to admonish the mother. Public outcry about such deaths is not reported in these cases, and it would seem that these deaths generally passed without negative comment or condemnation locally, even from the coroner. But this does not mean that people ignored all cases of infant death. As has already been noted, the death of the Webb children caused a gathering of several hundred women who threatened the mother, and required a police presence on the day of the funeral to control the 'unseemly demonstration'. The death of the Webb children was attributed to 'improper feeding' and 'maternal ignorance', and this reflects the discourse of maternal culpability that dominated discussion of infant mortality at the time.

Bed-sharing was a common practice in the area and this may or may not have occurred as a consequence of overcrowding. Many of the overlain infants were found bed-sharing not only with their mothers but also with their fathers and siblings, but it is notable that others were bed-sharing when overcrowding was not an apparent constraint. Accommodation was also poorly furnished, and the requirement for a cot together with the problem of the cold in winter months undoubtedly combined to make bed-sharing the preferred option for many. But it must be remembered that in addition to the practical benefits of bed-sharing, the practice was routine for many and considered normal. This occurred despite bed-sharing being viewed by some as not only dangerous to infant life but also as damaging to morality and a source of corruption. Nonetheless, in overcrowded tenement houses with occupancy levels of two to three people per room, it would have been extremely difficult to do otherwise. It was the practice of bed-sharing and its prevalence that allowed the diagnosis of overlaying to be made and levelled at mothers as an accusation and indictment of their mothering in terms of maternal ignorance and culpability. This discussion therefore marks out the transformation of a (non) normative discourse around infant care, bed-sharing and the space of the bed(room) and rules of intimacy.

Equally, it must be noted that the judicial system demonstrated a paradox in its treatment of overlaying death and overlaying mothers because, although many inquests were held, only a few women were publicly blamed for the death of their infants with coroners rarely threatening punitive measures; and in general, coroners' juries returned verdicts of accidental death with no admonishment of the mother and no apportionment of blame. Overlaying deaths were considered by juries to be accidental, despite the overwhelming portrayal of overlaying in media sources as a culpable cause of death. This pattern was

repeated elsewhere in London and the frustration of some coroners in the matter is detailed in Chapter Three<sup>9</sup>. In this sense, infant overlaying was constructed as accidental and at the same time attributed to maternal culpability due to maternal ignorance. Bed-sharing was portrayed as an issue of concern by many reporting on conditions in St Pancras but overlaying does not form the overwhelming basis of their concern. Instead the morality of bed-sharing and its power to corrupt took centre stage and this lends support to the claim that the fear of bed-sharing was underpinned by wider social processes that were restructuring the family, intimacy and the space of the bed(room). The subsequent reorganisation of the bed(room) during the twentieth century may have reduced the number of infants found dead while sharing a bed with mothers, fathers and siblings, but this alone cannot be taken as evidence that overlaying deaths were routinely what they were purported to be. This is because such an explanation does not account for the sudden rise in the number of overlaying deaths reported between 1880 and 1906, detailed elsewhere in this thesis, when the conditions in Somers Town were reported over the period as improving rather than remaining consistent or declining.

Overcrowding was undoubtedly an issue in Somers Town but the claim that overlaying was caused primarily by overcrowding combined with intemperance or neglect must be rejected. Such conditions may have been the cause of death for some infants, but the evidence presented here suggests that bed-sharing alone was not the primary cause of these deaths. Instead, it is probable that infants were found dead in bed with their mothers because this is where they routinely slept rather than because mothers had overlaid and suffocated them.

The ordering of both physical and social space forms a central theme in discussion of this chapter. The physical space of Somers Town c1900 was being re-configured in a number of ways. Parts of the Borough were undergoing redevelopment with some thoroughfares being completely demolished. These were areas thought to have the most overcrowding and poorest sanitation. At the same time legislation defined and limited the use of space in terms of commercial, industrial and domestic functions. But there were also changes in the way space was being socially organised. One way that these changes can be understood is through the idea of public and private space. The separation of private and public spaces served to define the conduct of individuals and restricted the use of public space for private purposes. While some practices remained acceptable in public space others did not. And these latter were confined to the private sphere and domestic space. These

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<sup>9</sup> See, for example, pages 91-92 of this thesis, Coroner Althehan Braxton Hicks and the death of Alice Elizabeth Wigden (*The Child's Guardian*: December 1895: 163)

changes represent an increased differentiation of physical and social space. This delimiting of space also represents the control of bodies and domestic space became constituted as the place of the family, intimacy and bodily control. The changed use and social meaning of domestic space also meant that it was being re-configured in terms of its functionality so that household tasks were carried out in designated domestic space, and rooms had clearly defined functions.

The sequestration of experience, as the socialisation and separation of particular experiences from everyday life offers one explanation for the reorganisation of social and physical space. As particular activities became increasingly sequestered and therefore differentiated so too did the space in which they occurred. The socialisation and sequestration of sex, reproduction and infant care in this context can be seen as underpinning the re-configuration of domestic space. The consequence of this was the reorganisation of the bed(room) as a place of sexual intimacy between marital partners. The domestic sphere became the space for the family governed by the morality of the nuclear family. In consequence, failure to organise the home in this way was constructed as a source of physical and moral degeneracy.

The organisation of physical and social space in Somers Town made its re-configuration in these terms difficult for all concerned. Instead, the domestic space in the Borough was overcrowded and many families occupied only one or two rooms. The separation of function and the reconfiguration of domestic space in terms of the nuclear family, intimacy and privacy were generally not possible. The consequence of this was that households living under these conditions, here as elsewhere, were constructed as acting outwith the framework of normativity that was structuring the family. It was in this way that (non) normative discourses around familial relationships, family size and child-rearing can also be seen to inform ideas about what could be defined as (normal) family practice.

This chapter therefore also raises questions about the purported dominance of (non) normative discourses surrounding practices such as bed-sharing and infant care as they operated at the time. As has been noted, bed-sharing was routinely practised in Somers Town c1900, and in this sense routine and regular practice must also be considered as normal for the individuals concerned. This therefore raises questions about what was considered to be normal in terms of infant care, bed-sharing, bed(room) space and intimacy at a time when these practices have been described as being significantly transformed. It also highlights that the 'normality' of household life was anything but uniform.

In Somers Town bed-sharing, infant care and the sudden deaths of infants in bed all breached the normative discourses around these practices and because of this the people of

Somers Town were constructed as both deviant and also as a source of danger and moral corruption. As the principle site of sudden infant death, the bed(room) became significant as a site of control. Overlaying came to represent the outcome of (non) normative practices and provided the focus for public concerns about mothering and infant mortality. In this way, and against the wider background of family restructuring, and the re-configuration of intimacy and bed(room)space, bed-sharing and the possibility of infant overlaying also provided a focus for debate and concern about the physical and moral well-being of the population.

The re-configuration of the bed(room) and the prohibition of bed-sharing between mother and infant is also a means through which ideas of sequestration can be further explored and elaborated. Rules regarding intimacy within the conjugal relationship were repeatedly challenged by the mother / infant relationship and the demands of infant care and breast-feeding. This relationship also became the subject of norms regarding intimacy, and in particular appropriate touch with routine bed-sharing seen as a breach of these. In this sense, excluding the infant from the bed had two purposes: the infant would be protected from possible moral contagion by the conjugal relationship; and the breach of the rules of intimacy constituted in the act of breast-feeding was mitigated by restricting the presence of the infant in the bed(room) to a separate sleep space (the cot). These changes both informed and were also informed by the (non) normative discourse of the nuclear family.

The domestic figuration as the locus of intersection between agent and structure is clearly marked out in this discussion. In particular, the socio-structural influences which shaped the physical and social space of Somers Town are seen in and through the action of mothers in relation to infant care. Some of the influences are apparent in the immediate context of maternal care while others are more distant in space and time. In Somers Town the consequence for many families was overcrowding and poverty. But the ways that these played out in everyday life does not reflect the normative discourses of what should have been.

The separation of public and domestic space was not rigidly defined in Somers Town and the open doors of the tenements served as a warning of this transgression which allowed domestic life to spill out onto the pavements. Drunkenness and prostitution were common sights on the streets and domestic violence also occurred in public spaces. Men were not always seen to act as providers for their families and instead were shown living on the 'immoral' earnings of their female partners with sex forming the commodity of the household economy.

Despite claims that childhood was being marked out as a special and protected phase of life at this time, children in Somers Town are frequently shown as acting in contradiction

to this. Children were not always confined to the 'safe' spaces of home and school. Instead they were seen on the streets at night, sometimes with drunken mothers sometimes alone. Violence by and against children was also recorded as were acts of theft by children whose crimes were portrayed as part of the household economy. Child prostitution is also reported and it can be assumed that this too provided an income for someone other than the child.

Death in Somers Town was also not routinely sequestered and as well as the infants who were found unexpectedly dead in the shared family bed, abandoned infant corpses were also left in public spaces such as canals, trains, and hallways. In this sense, reminders of death and finitude were commonplace. The normative discourse of good infant care was also routinely flouted here not only in the act of bed-sharing but also through improper feeding with infants fed on pickles and ices, bread and cheese. The socio-structural rules and resources employed by the population of Somers Town were therefore different from those suggested by normative discourses surrounding motherhood, intimacy, death, infant care and childhood. These socio-structural influences served in many cases to construct the conditions in which an assumption of overlaying was made possible regardless of the reality of such infant deaths. Overlaying death in this sense can be understood as an outcome of the interrelationship between mothers, wider social structures, and other individuals as they acted out their daily life. What also becomes apparent is that such deaths were constructed as accidental while at the same time they were also attributed to maternal culpability and ignorance and the paradox of this points up the contradictions and imbalance of power that underpins the overlaying discourse as it was played out.

The next chapter goes on to provide intricate detail of the domestic setting of overlaying death. It also shows that when the overlaying discourse was eventually challenged it was not by mothers; but instead the challenge came from medico-legal professionals employing pathology and post-mortem readings of the infant body to support their claims.

## **Chapter Five: A Darker Crest? Freyberger's Cases of Overlaying**

“Can death-wave lift to heaven a darker crest  
Than that which bears the babe upon its breast,  
Crushed, blackened, choked, in helpless agony,  
Beneath a mass of vile maternity?” (Tickle: 1881)

### **Introduction**

This chapter provides a detailed analysis of records of the post-mortem examinations and inquests of twenty-two new born infants from the case records of Dr Ludwig Freyberger. The inquests for these deaths were held by coroner John Troutbeck in Battersea, Lambeth and Wandsworth, south London, between 1908 and 1912. These records were selected for inclusion here because Freyberger himself had annotated his files that the infants had been found ‘dead in bed’ and were therefore candidates for an overlaying categorisation. The case records provide detailed information about both the body of the deceased infant and also the immediate situation of their death taken from the inquest evidence, most probably from the written depositions collected before the inquest was called. This chapter details the way that mothers (and others) were presented in the judicial system and highlights the general ‘absence’ of mothers from the proceedings. It also demonstrates the way in which mothers acted to look after and safeguard their infants and shows that instead of the routine ignorance and neglect with which they were often accredited, many of these women acted to ensure the welfare of their infants, although this was neither always the case nor entirely successful. This chapter, with its detail of bed-sharing practices, outlines the methods that were employed to safeguard infants during bed-sharing and offers a challenge to the assumption that overcrowding and bed-sharing provided an adequate explanation for infant death in bed as overlaying.

Also, throughout this chapter a wealth of detail emerges from Freyberger’s case notes about the day-to-day care of women and infants in the peri-natal period. In the cases detailed below, women received very little professional care in the period leading up to the birth of their infants and were frequently attended by lay practitioners, friends or neighbours at their deliveries. Although midwifery had been professionalised at the time Freyberger was conducting his post-mortems, many of the births detailed here were not attended by a registered midwife and the presence of a doctor was often only in terms of an officiating visit that occurred some hours after the birth. Despite reforms to legislation in the early twentieth century, birth and the immediate peri-natal period were relatively non-medicalised events, in



which women were attended by other women rather than doctors and registered midwives, and husbands were largely absent from the proceedings. The systematic recording of evidence by Freyberger has the effect of casting the birth and brief lives of the infants concerned in routine and regular terms but underlying this were the often spontaneous, sometimes disorganised events surrounding individual births. Women had not always prepared for the impending birth or arranged assistance at the delivery, while the onset of labour then as now was often unpredictable. Sometimes attended by friends and neighbours, the births occurred in the home and monitoring by the state and its agents was minimal. Although by this time it had been made a requirement that a doctor should visit the new born infant and local authority health visitors were notified of new births, ante-natal care was yet to be widely available for pregnant women with its concomitant supervision of pregnancy, birth and subsequent infant care.

The education of women as mothers was viewed by many as a means of preventing infant mortality but thus far, the line had been drawn at direct intervention into the family. In the case of overlaying, this was seen most clearly in the advice that separate sleeping for infants should be practised and that infants should be placed in a cot to sleep rather than sharing the adult bed. Although this may have been recommended, as noted earlier bed-sharing was still widely practised and women were reported as routinely taking their infants into bed with them. That this was in contravention of received wisdom is demonstrated by the references made by women to bed-sharing and the explanations they gave to justify their actions in taking their infants into bed with them. The prevalence of bed-sharing does not, however, indicate a lack of regard by mothers in this respect and women were reported as adopting a range of strategies aimed at ensuring their infants were safe from overlaying. The interaction of physical, human bodies and the proximity and control of maternal and infant bodies therefore underpins discussion of the case notes of Dr Ludwig Freyberger in this chapter.

In addition, the chapter draws on the work of the social theorists discussed earlier in the thesis to analyse the actions of mothers. In particular, it is concerned with the way that mothers enacted motherhood and infant care through their knowledgeability as agents using practical and discursive knowledge (Giddens: 1979; 1984). It also draws on ideas of reflexivity and the internal conversation to explore the actions of mothers as agents in relation to their socio-structural context (Archer: 2000; 2007). Intimacy in relation to bed-sharing is also explored and the idea of the bed(room) as an intimate conjugal space is challenged regarding the routine practice of bed-sharing by mothers, their infants and children with fathers or alternately sometimes with nurses or other birth attendants.

### **Readings of the body: signs, symptoms and meaning**

Central to this chapter and indeed to any discussion of infant overlaying is the idea that the human body has social meaning and that any interpretation of bodily signs is socially constituted. In this sense, the infant body is the central point around which an understanding of overlaying death is constructed. Therefore, in discussing the body, I refer not only to the physical body, but to the social meanings that are attached to the body in life and in death. The body can therefore be understood as taking on meaning beyond its physical aspects to become something that has social meaning and relevance. The physical body functions according to its constitution and is influenced by internal and external factors and in this sense the body may, for example, age or experience disease or trauma. The explanation of these processes is, however, a social process of interpretation and meaning attribution where the physical aspects of the body are subject to interpretation within a social and cultural context. This can be understood in terms of signs and, as with language, the relationship between signifier and signified is not fixed, but variable, changing over time and from place to place according to socio-cultural context. In this way, signs of bodily dysfunction and death are attributed different meanings and open to differing interpretations. The construction of signs, meaning and interpretation occurs within a framework of discourse and the discourse(s) within which the reading of the body is conducted therefore structures the meaning of bodily signs.

The contested nature of bodily signs applies no less within the context of the medical discourse of pathology than within other discourses. Medical symptoms are also signs that are interpreted in a variety of ways; and diagnosis within the discourse of Western medicine usually relies on the aggregation of symptoms and an examination of the body within a broader social context. An example of this is seen currently with the emphasis placed on social factors in the attribution of ‘cot death’ as a diagnosis. As with cot death today, the death of an infant body in London c1900 was interpreted within a series of overlapping discourses. In the case of a death thought to be due to overlaying, interpretation of the death was dependent on juridical and medical discourses, as well as on other discourses that structured understandings of the social context of the death such as those concerning motherhood, child welfare and class. Juridical and medical discourses predominated in the official interpretation of infant overlaying death, but although the dead infant body was examined in terms of a juridical discourse of guilt attribution and a medical discourse of pathology, a discourse of maternal culpability was always present. Within this context, signs on, in, and of the infant body were interpreted through a lens of maternal responsibility for

care of the infant, with the infant body seen as a passive subject that was shielded from, or exposed to, external risks and dangers according to the standard of care, knowledge and attention (or lack thereof) provided by the mother. Signs of health, or illness and death, were read from the infant body ante- and post-mortem. It should, however, be noted that unlike adults who can voice the feelings and responses their bodies have to disease and discomfort, the reading of bodily signs on the infant body took on greater significance in diagnosing the cause of death. The reading of signs on the body, in life and death, was therefore important to constructing the meanings attributed to the death of an infant by overlaying.

Such signs were not always straightforward in their interpretation or uniform in their typology. Signs can be of the body, in the sense that they were marks or changes to the tissue and substance of the body, either internally or externally. Bodily signs could be made both ante- and post-mortem. Bodily signs of this sort could be seen as changes in the colour, texture or temperature of the body and were marked by either their presence or absence and variation from the reference point of what was seen to be a normal condition. The basis of the normal condition or of the usual signs was often referenced, but it is apparent that usual and normal were terms constructed within a context, and greater or lesser congruence with other contexts is apparent. Such signs could also be expected or absent. The meaning attributed to particular signs was more or less contentious. Signs could also be behavioural, that is, enacted by the body, for example, the scream or cry of an infant. Behaviours could also be interpreted in different ways and behavioural as with other signs were interpreted according to the broader context of the death. Bodily signs were not usually read singly, then, but in relationship to other signs and the broader context of the body. This included not only the material and physical, but also the social context of the body. In this way, the reading of bodily signs was conducted with a view to other broader social categories such as social class, poverty, marital status and legitimacy.

The reader of bodily signs must also be mentioned here. Readings of a body were not conducted by a homogeneous group of individuals for a uniform purpose; neither did all individuals have the same access to signs on a body. Individuals read bodily signs within the context of differing discourses and their purpose and perspective varied. A reading of bodily signs could be undertaken, for example, by a mother, a neighbour, a doctor or a forensic pathologist. Each of these individuals would have construed meaning from a sign, but the meaning of a particular sign is likely to have been significantly different for a mother than for a forensic pathologist. Even among professional groups, for example doctors, different meanings were often derived from the same sign. In relation to this chapter, the key point to be made here is that lay and professional readings can demonstrate considerable difference,

as can the readings of proponents and critics of the overlaying thesis.

In relation to the overlaying deaths discussed here, there are also generalities about access to bodily signs that are important to note. The first is that ante-mortem signs were most often seen by the mother or other lay persons; and the second is that medical readings of the body were often conducted after death when access to signs internal to the body through the process of the post-mortem examination were possible. Medical professional readings of the dead infant body during the period of this study relied heavily on the visual aspects of examination. Histology and histopathology, dealing with microscopic inspection of tissue for the identification of disease, are not referenced within the research material explored here, with gross pathological findings tending to be obtained from visualisation of the body, both externally and internally. Needless to say, a post-mortem examination by a forensic pathologist is a highly specialised reading of a body and, as with other specialist discourses, the language used can, at times, be inaccessible to others. Added to this is the issue of distance that is introduced by the re-reading of historical documents, in which analysis is concerned with signs already deemed relevantly interpreted and reproduced for the purpose of reporting, usually to meet some official requirement. In this respect, it is important to note that my intention is not to search for a definitive causal explanation of the deaths discussed here, but instead to examine the way signs in, on and of the body were read and interpreted in context.

The chapter explores the way bodily signs were interpreted to identify states of infant health, illness, death and overlaying. The first section discusses nineteenth century medical opinion on the signs of infant overlaying and suffocation from both proponents and opponents of the overlaying thesis, and demonstrates the lack of a unified medical opinion on the physical signs of suffocation and overlaying. The second section explores in detail twenty-two cases of infants found dead in bed, from the case notes of Dr Ludwig Freyberger.

### **Medical men and the usual signs of overlaying and suffocation**

The reading of signs on the body in an effort to explain death is central to pathology. Post-mortem examinations dissected and explored the dead body in an effort to identify pathology and diagnose the cause of death. Overlaying deaths, however, did not always leave a mark on the body; and on occasions when there were purported signs of suffocation, these did not necessarily indicate that death by overlaying had occurred. This is because a death by overlaying was interpreted as death by mechanical suffocation, but death by mechanical suffocation could also be caused by means other than overlaying. The controversial issue at the centre of the debate about overlaying deaths in the nineteenth and early twentieth

centuries was whether or not overlaying could be detected after death.

Medical practitioners were divided about both the signs of overlaying and those of suffocation. To some, signs of overlaying were readily and frequently seen on the bodies of infants, while for others, overlaying was a rare and unusual cause of death with its pathology difficult to delineate. Suffocation was also problematic to diagnose, and while some practitioners discussed the usual signs of suffocation, others were more circumspect. To further complicate the issue, the term overlaying could refer not only to suffocation by direct pressure of a person laying on top of an infant causing mechanical suffocation, but also to gradual suffocation from lack of air while under the bed clothes, covering by a pillow or covers, or to suffocation from the infant lying face down on the soft surface of a pillow or mattress. Smothering by the breast while on the mother's arm, or by being held too tightly, were also described as causes of overlaying in some texts disclosed earlier in this thesis.

Suffocation and asphyxia were terms frequently used when describing infant deaths from overlaying and some clarification is needed here as to the way that the terms were generally used in such contemporaneous texts. Suffocation generally referred to the limiting of respiration either by compression of the chest or blocking of the airway. Suffocation could occur when the weight of a body overlaid the infant, preventing movement of the chest and limiting the intake of air. This could be the consequence of an accidental or deliberate act and there were frequent (and largely erroneous) references to deliberate overlaying as a means of infanticide. Suffocation could also occur as a consequence of the airway being obstructed, perhaps by being pressed into a pillow and this type of suffocation was often referred to as smothering. Compression of the chest and airway obstruction were both types mechanical suffocation. Suffocation could also be gradual. This usually referred to restricted intake of oxygen because the source of air itself had been restricted. This was thought to occur when infants were left beneath heavy blankets and bed clothes where circulation of air was limited. Gradual suffocation was also referred to as asphyxia. Asphyxia was usually used to refer to an increase in carbon dioxide with a corresponding decrease in oxygen in the blood. Of course, this was the consequence of mechanical and gradual suffocation, and suffocation was also a term used in the event of disease affecting the lungs such as bronchitis or pneumonia. But the term asphyxia was also used to refer to conditions where disease was the underlying cause. Asphyxia deaths included those caused by fits, convulsion and spasms caused by underlying disease and illness or by teething. In practice, suffocation, gradual suffocation and asphyxia were terms used frequently, their meanings were often conflated and they were used interchangeably. The above definitions refer to the general use of the terms, but in practice the specific meaning of each term was governed by the contexts of its

use, as discussion later in the chapter will demonstrate.

In his Principles of Forensic Medicine, Smith (1825) described contemporaneous understanding of the physiological processes that follow suffocation. In cases of suffocation, death was produced immediately by the impeded circulation of blood. As respiration was interrupted, the passage of blood through the lungs was soon arrested, in the mean time, the flow that was maintained conveyed un-oxygenated, 'black blood' to the brain. 'Black blood' was thought to be fatal to life within a short time as more black blood was accumulated in the cavities of the right side of the heart. Because the transit of blood through the lungs was impeded, blood accumulated in the vessels serving this side and the cavities of the left side of the heart were emptied. This process was also the cause of congestion and effusions into the lungs and brain.

The principal morbid appearances of the bodies of those who have died from suffocation were seen by Smith as lungs of a deep blue colour with blood extravasated in the air vessels; the right auricle and ventricle of the heart and the adjoining blood vessels would be full of dark coloured blood. There was also darkness of the countenance and lividity around the surface of the breast and other parts of the body, with turgescence and even rupture of the blood vessels of the brain. When it came to the issue of smothering, Smith states it was, "The mere closure or covering of the mouth and nostrils in whatever way, so as to prevent the transit of air, and thereby induce suffocation" (Smith: 1825: 276). He also states that, with the exception of children, smothering was a rare occurrence while "among them however, it is not only a common accident but often perpetrated upon them as a crime" (Smith: 1825: 276). Smith's account relates to infants who have "maintained existence by action of [their] own organs" (Smith: 1825: 245), that is, had an independent existence, rather than infants smothered during or immediately following birth, a circumstance that was considered to occur more as an accident of birth. According to Smith, overlaying often happened to infants but his description of overlaying does not include the overlaying of a child by another person. Instead, this was in terms of accidental smothering of the child by an inanimate object such as "by a pillow, bolster or bedclothes being accidentally laid against the child's face in such a manner that its own struggle cannot disengage it, while either no one is at hand, or nobody is aware of the circumstances till too late" (Smith: 1825: 246).

For Smith, circumstantial evidence, in the absence of eye witnesses, was the only means of ascertaining whether the death had been caused as a consequence of accident or infanticide. Smothering could also occur as a result of restricting, by external means, the movement of the thorax and, although this may have occurred as a consequence of overlaying, Smith relates it only to incidents such as being buried under falling earth.

However, for some contemporaneous medical practitioners, there appears to be a definite conviction that overlaying left signs on the body that could be discovered post-mortem. For others, overlaying was seen to have few if any definitive signs. What must be remembered, however, is that even for those who appear to view overlaying as an unproblematic diagnosis, the signs of overlaying were still disputed.

Despite the apparent ambiguity of meanings, practitioners still referred to the usual signs associated with overlaying, suffocation or asphyxia, leading the reader to assume that overlaying, suffocation and asphyxia in infants was regular, and readily identifiable with normal and indeed usual signs. That this is not so becomes apparent when comparisons are made, not only between proponents and critics of the overlaying thesis, but also between signs described by practitioners who are in agreement about overlaying as a cause of death and those who are not. What then becomes apparent is that, although a diagnosis of overlaying may be accepted, the signs of overlaying were still disputed.

The coroner for the North East London district, Wynn Westcott, a proponent of the overlaying thesis, suggested that overlaying deaths could leave definite signs on the body that were detectable after death. In his 1903 article The Overlaying of Infants, Westcott clearly frames his discussion in terms of overlaying and states that “It cannot be doubted that a considerable number of infants are overlain by parents” (Westcott: 1903: 1208). But following his brief mention of signs of overlaying, this article develops gradually into a discussion of the signs of suffocation and asphyxia with the effect that signs of overlaying were conflated with the more general signs of suffocation and asphyxia. Westcott states that infant bodies could show marks of overlaying, but he is also open to the possibility that overlaying might have left no direct signs, “Some overlain bodies show undoubted marks of pressure upon the body or face for example, a flattened nose is often seen.” (Westcott: 1903: 1208). Despite the title of his article, this is Westcott’s only reference to a sign directly related to overlaying. It must be noted, however, that pressure marks on a body can be caused post mortem, and the possibility of an already dead infant being overlaid by another person was not addressed by Westcott. Westcott moved from the more tenuous signs of overlaying to the more general signs of suffocation, for overlaying deaths were expected to demonstrate signs of suffocation whether or not direct signs of overlaying were absent, so that “Apart from any definite marks of overlaying, the dead infants I refer to present the well-known signs of death by suffocation.” (Westcott: 1903, 1208). This would suggest that, for him, there were ‘well known signs’ of death by suffocation that could be seen externally on the body, such as:

“There are bluish lips, a livid complexion (which may soon pass off), flexion of the legs and arms, clenched hands and frothy mucous often blood-stained, in the nostrils

and mouth. In some cases the tongue is protruded and discoloured; the neck and face turgid, the nails blue, the whites of the eyes reddened, and punctiform marks on the conjunctivae and eyelids.” (Westcott: 1903, 1208)

The signs of mechanical suffocation and asphyxia due to disease were not, however, distinct in their manifestation, and asphyxia could also be caused by a range of conditions or diseases. On this, Westcott states:

“Many of the external signs may be due to asphyxia resulting from a spasm of the glottis, or from convulsions due to dentition, or to disease of the brain and its membranes” (Westcott: 1903, 1208)

Suffocation death could also be caused by a range of other environmental factors and Westcott outlines some possibilities:

“Such as the pressure of the mother’s breast or arm, or to compression of the chest from being actually lain upon, or to a simple excess of clothes covering over the nose and mouth. I have found occasionally that one child in bed has moved in its restlessness and had lain over another; or, again, an infant may roll over and hide its own mouth and nose in a pillow, causing death. I have also had 3 cases in which a baby has been overlain by the domestic cat.” (Westcott: 1903, 1208)

In these scenarios, Westcott describes possible causes of mechanical suffocation, gradual suffocation, and smothering, and this passage provides a good example of the way the terms suffocation and overlaying are conflated within his discussion.

Post-mortem examination of the internal aspects of the body did not provide any further means of identifying the possible cause of suffocation deaths. Westcott states that the internal signs were the same for suffocation, gradual suffocation or asphyxia:

“I may say that the appearances of the heart, lungs, and the brain will be much the same whether the suffocation has been due to spasm or the convulsions of natural disease, or to deprivation of air by clothing or by actual pressure on mouth or nose.” (Westcott: 1903, 1209)

For Westcott, then, the diagnosis of overlaying was dependent on an external examination of the body, with the internal post-mortem examination adding nothing other than possible confirmation of suffocation. Importantly, towards the end of his article, Westcott refers frequently to suffocation in bed rather than overlaying when discussing the interior of the body and the usual signs of suffocation:

“The most common appearances found by a post-mortem examination of an infant who has died from suffocation in bed are an unusually dark-coloured fluid state of the blood, the lungs engorged with blood, and sometime oedematous, the brain and membranes congested, and showing minute red points, the heart’s right side containing soft clot, and the left side empty; the pleurae and pericardium showing minute ecchymoses, and the mucous lining of the windpipe reddened of a curious cinnabar colour.” (Westcott: 1903, 1209)

But these signs of suffocation could not necessarily be taken as *prima facie* evidence of



suffocation or overlaying, as can be seen from a report from Cripps Lawrence, physician, describing the post-mortem findings on an infant ‘presumed overlaid’:

“The brain-substance was unusually soft, and presented numerous puncta vasculosa. The pericardium was congested, and exhibited several distinct patches of ecchymoses; while its cavity contained two or three drachms of straw-coloured turbid serum.” (Cripps Lawrence: 1870: 276)

Cripps Lawrence later attributed the “real cause of death” to interuterine pericarditis (Cripps Lawrence 1870: 276) and states that there was an absence of symptoms of suffocation in the circulatory and pulmonary organs of the infant. ‘Puncta vasculosa’ or minute red points, and ecchymoses on the pericardium were not, for Cripps Lawrence, necessarily symptoms of suffocation. Despite Westcott’s apparent acceptance of the overlaying thesis, his discussion concentrated on the signs of suffocation and asphyxia, and the dearth of signs relating directly to overlaying was passed over. Even Westcott’s claim to the ‘well known signs of death by suffocation’ is cast into doubt when he acknowledges that understanding of the broader context of the death may be necessary for a diagnosis of suffocation:

“In the case of a death by suffocation many years ago Christison remarked “that the common conviction that a medical man should always be able to detect death from suffocation simply by an inspection of the body, and without a knowledge of collateral circumstances is erroneous”. (Westcott: 1903, 1209)

In the face of such ambiguities, Westcott’s adherence to the overlaying thesis seems rooted in his affiliation with the Temperance Movement. Westcott became a member of the Society for the Study of Inebriety in 1899 (Society for the Study of Inebriety: 1899: 15). The purpose of the society as outlined at the First Colonial and International Congress on Inebriety, held in London in July 1887, was to study the history, causes, prevention and cure of inebriety, supporting temperance and prohibition work (Society for the Study and Cure of Inebriety: 1887: 1). Westcott presented a number of papers to the society and also travelled to the United States delivering his lectures. He became president of the Society in 1899 following the death of its incumbent, Dr Norman Kerr (Society for the Study of Inebriety: 1900: 15).

Templeman (1892), also a proponent of the overlaying thesis, writing in Aberdeen a decade earlier than Westcott, drew different conclusions about the signs of overlaying, which for him seemed notable by their absence:

“The external appearances presented by the body are chiefly negative in character. There are no marks of violence to be observed. As a rule there is no flattening of the nose and face from pressure. Post-mortem lividity comes on early, and is specially well marked on that side of the body on which the infant has been lying; the face is placid and calm; the eyes sometimes slightly congested, but not staring; the lips are livid, and the tongue not protruded. Frothy mucus, often tinged with blood, is generally seen about the mouth and nostrils. The hands are sometime tightly clenched.” (Templeman: 1892, 323)

There was some agreement between Templeman and Westcott, namely, the marked lividity, blood tinged mucous and clenched hands, but other signs such as the protruding tongue were disputed. The most notable disagreement between the Templeman and Westcott regarding the 'usual signs' of overlaying is seen in the reference to pressure marks on the body, where Westcott claims that some infants show pressure marks and stated "a flattened nose is often seen" while Templeman claims "As a rule there is no flattening of the nose and face from pressure" (Templeman: 1892: 323). Internal signs of suffocation, however, provided more ground for agreement between Westcott and Templeman. Templeman states that internal investigation of the body, post-mortem, would reveal:

"The usual appearances found in cases of death by asphyxia, viz a varying degree of congestion of the cerebral membranes – more or less engorgement of the internal organs, especially the lungs and kidneys, and the large thoracic veins, a fluid condition of the blood, which was dark in colour; and generally a distended condition of the right side of the heart. While the left was nearly or altogether empty and contracted (in one case both sides of the heart were completely empty). In about half the cases examined small punctiform haemorrhages were observed beneath the pleura and pericardium. The larynx, trachea, and bronchi were, as a rule congested, and contained some frothy, often blood-stained mucus" (Templeman: 1892: 323)

In this regard, reference to the 'usual signs' of suffocation and asphyxia did provide some ground for agreement between Westcott and Templeman, namely the fluid condition of the blood, the condition of the heart, the blood stained frothy mucous and the punctiform haemorrhages. But as has been seen, these opinions were in keeping with Smith's (1824) earlier work on forensic medicine and reflected the accepted view of the physiology of suffocation that prevailed at the time.

Writing in the mid nineteenth century, coroner Thomas Wakely had raised doubts about overlaying as a cause of death. Wakely was not a supporter of the overlaying thesis and, as discussed elsewhere in the thesis, was progressive in his approach to such deaths, and called for an epidemiological study of infants found dead in bed. Wakely expected very definite signs to be evident on the bodies of infants on the rare occasions when overlaying did occur:

"Equally true is it that out of hundreds of examples of infants found dead in bed, only two instances have been seen in which the proof was conclusive that the little creature, had been destroyed by the pressure of persons who had been lying with them in bed. Even in one of those cases the question might have been fairly raised, whether the signs of pressure visible on the body had not resulted from contact after death with the person who had slept with the deceased infants. (Wakely: 1855: 103)

The signs of overlaying for Wakely were the mechanical signs of pressure on the body, such as the flattening of the nose, or impressions on the skin made by bedding or another body.

Impressions of bedding were to be found on the underside of the body, while impressions made by another body would be found on the uppermost side. This suggests that Wakely used the term 'overlying' in the narrowest sense, excluding the wider causes of suffocation and asphyxia, and limiting his discussion to infants that were actually killed by being laid on by another person with resulting suffocation. Interestingly, Wakely was alert to the possibility that marks could be impressed on the body after death.

The broader social context of the infant death also played an important role in diagnosis and Cripps Lawrence, writing in the British Medical Journal touched on what he saw as an important aspect of the overlying verdict in the cases he discussed:

“The mothers were single women; and lest, in these or any similar instances, imputation of neglect of their offspring, or wilful intent to destroy life, should be attributed to them, these cases in which the real causes death, without autopsies, could never have been arrived at, indicate the necessity and value of pathological investigations in all cases of sudden death of infants.” (Cripps Lawrence: 1870: 276)

The fact that the mothers were single women and the infants illegitimate was considered by some to be motive enough to account for the deaths. The obvious implication was that such infants would be murdered by their mothers with overlying seen as an obvious method of infanticide. Cripps Lawrence undoubtedly recognised the role of social context in cause attribution and diagnosis, and his warnings point toward the need for a diagnosis of death rooted in pathology of the body and a reading of bodily signs.

### **“Found Dead in Bed” - The death of newborn infants**

Unnamed Baby Swains was found dead at 4am on 20 July 1909; he was 4 weeks old. He had been lying asleep on his mother's right arm; they were in bed. On the other side of the bed, his father lay asleep. At first, Ellen Swains did not realise that her baby was dead; she noticed only that his arms were cold. She later said that his colour was normal, that his mouth and nose were clear, and that his clothing was not too tight. The child, who was Ellen's first, had been born at full term and Dr Hartley had been in attendance at the birth. Baby Swains had been breast fed since birth, and had had no cold. He had been taken out two days earlier, on Monday 18 July 1909. Ellen Swains last saw her baby alive at midnight when he had been lying on her arm. He had been a bit cold, but not enough to make her anxious. Ellen had no idea what had caused her baby's death. She said only that his breath had been “hard”. Ellen woke her husband at 4am. Mr Swains said it looked as if the child had just died.

In his evidence, Dr Hartley of 20 Albert Square, London SW, said that he had last seen Baby Swains alive on 13 July 1909. Mr and Mrs Swains had brought the baby to his

surgery because they were concerned about his breathing. The child did not have a fever and his colour was normal. Dr Hartley thought that perhaps the child's lungs were not fully developed; he had asked the Swains to bring the baby back to see him in a week's time, but he did not see the child alive again. Dr Hartley had thought that Ellen's confinement, the birth and labour had all been quite normal. Dr Hartley next saw Baby Swains on Wednesday 20 July, following the infant's death. The child was laid fairly well up on a pillow and Dr Hartley noted that the body had been disturbed since its death. This was not surprising as the child had died some hours earlier, and had been lying on Ellen's Swains arm at the time of his death. The child's finger and toe nails were livid. When he was told that the child had been found dead on his mother's arm, Dr Hartley thought that the child may have been suffocated but he was not quite sure if this was by external means (such as overlaying) or from actelectasis<sup>10</sup>, a condition of the lungs that could restrict breathing.

Ludwig Freyberger's post-mortem examination found that the child's lips were livid dark blue and that there were no external marks of violence and no internal injuries. The heart was congenitally malformed with the left ventricle and atrium being small and the foramen ovale patent (or open), also the lungs were collapsed, blue and spongy in texture. The major organs were cyanotic. Freyberger concluded that death was due to failure of the child's heart from patent septum foramen ovale and partial actelectasis of the lungs. He also noted that Dr Hartley's initial diagnosis included the possibility of suffocation by external means and wrote in his notes "F[ound] in bed between parents Dr thought overlaid". Following Freyberger's post-mortem examination of the body, Dr Hartley revised his opinion and concluded that the child had died from actelectasis and congenital malformation of the heart. The jury returned a verdict of death by natural causes (Wellcome: GC140/3/140).

Taken from Ludwig Freyberger's post-mortem case notes, this case is quite typical of an infant found dead in bed. The parents had had some concerns about the health of the child – they had, after all, taken him to Dr Hartley's surgery because of his 'hard breathing' – but their concerns were not enough to make them anxious for the life of the child, and they did not expect his death. In fact, Ellen had not, on first sight, even realised that the child was dead. For Ellen Swains, the signs of her child's impending death were absent. For Dr Hartley, the absence of signs of illness ('hard breath' notwithstanding) was sufficient for him to consider overlaying as a cause of death. This was a consideration despite Ellen's description of the circumstances of the child's death. Baby Swains could have been overlaid,

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<sup>10</sup> The spelling 'actelectasis' is taken from Dr Freyberger's case notes and was a commonly used at the time. Current medical texts refer to 'atelectasis'.

but if this had been the case, either the overlaying had occurred without Ellen's knowledge or she had been mistaken about events.

Signs of health and illness were frequently referred to in Freyberger's notes. The signs were related by the witnesses and can be interpreted as indicators of the expectations and assumptions they made about the well-being of the child concerned. In the Swains' case, the doctor saw no external signs that the child was ill. Breathing difficulties in newborns were not exceptional. The child had been breast fed (a positive sign of maternal care) and weighed 9 lb at the time of death, a good weight for a 4 week old infant. The child had been 'taken out', which was seen as a risk factor for the newborn, but the outing had been some days before and he had not developed any sign of a cold. The witnesses reported no signs of illness that could explain the death of the child and, as was often the case, lack of definitive pathology led the investigation to include other explanations of death including suffocation or overlaying by the mother

Until the post-mortem was conducted, with no external signs of illness, the witnesses observed no pathology that would account for the death. This was often the way that a suspicion of overlaying entered the proceedings, following the absence of signs indicating a 'natural' cause of death. As in the case of Ellen Swains, suspicion of overlaying occurred whether or not the mother made a claim to the contrary. In this way, the overlaying of an infant was presented as an event that could occur without the knowledge of the adults who were present at the death. In effect, it was assumed that the mother could overlay her infant and know absolutely nothing about it. This possibility may, in part, be due to the very broad definition of overlaying used by some practitioners, which includes being covered by bed clothes, bolsters or pillows. Alternatively, it might also have been believed that a witness had deliberately misled the inquest. Freyberger's post-mortem examination of the Swains infant did, however, identify significant congenital heart abnormalities, and following this any speculation about possible overlaying would have been dismissed by the coroner. It is in these circumstances that the involvement of Ludwig Freyberger became a deciding factor in the way deaths were diagnosed. It is no small fact that, during the three year period of Freyberger's case notes, no infant death was attributed to overlaying.

Ludwig Freyberger made systematic and meticulous records of the post-mortem examinations he conducted. The case notes were recorded in leather bound ledger books, each case having a unique page reference and with cases routinely indexed. Freyberger recorded his notes to a prescribed format with regard to the organs of the body and signs of health and illness. This reflected the procedure of evidence gathered at the inquest, the order in which witnesses were called, and the routine nature of the questions that were asked of

them. Freyberger also included detailed notes of the witness depositions and in some cases retained copies of the depositions sent to him by John Troutbeck. Although the full procedure for English inquests is not reported in what follows, it is nonetheless important to have an understanding of the way that the inquest process shaped Ludwig Freyberger's case notes and his presentation of information.

### **Troutbeck requests a post-mortem**

Freyberger recorded witness information in the same order that witnesses appeared and gave evidence before the court. This began with the witness who identified the body and moved on through the witnesses as they entered the case chronologically. The details of the post-mortem examination followed the format outlined in the 'Request for Post Mortem Examination' issued by the coroner. As with all inquests in England at the time, the starting point of the investigation was the body and its formal identification. In the case of overlain infants, identification was usually undertaken by the father, sometimes the mother (usually an indication that the father was absent from the household), sometimes by another relative, or (rarely) by a neighbour or professional such as a policeman. The child's body would be present in the 'viewing room' of the court during the inquest proceedings. Once the identity, age, and sex of the child were established, it was usual (in young infants) for the circumstances of the labour and birth to be outlined along with information about the child's position in the family and the number of siblings still living (for example, child number 5, 3 living, meaning that the subject of the inquest and one other child were deceased). It was usual only in the case of newborn infants that the birth and labour were mentioned as a central part of the inquest evidence. This was rarely the case with the death of an older child unless the circumstances of the birth had a direct bearing on his or her death.

The main points of interest discussed regarding the birth and labour related to the normality of the labour, the development of the foetus / infant (did the child seem premature?), whether the child cried or not, and whether or not there was medical or other assistance at the birth. Other ante-mortem factors that were considered relevant related to the post-partum health of the infant: How had the child "got on"? Was there any illness? And was the child expected to live or not? Also, the child's demeanour was referred to; whether the child cried a lot or moaned, whether the child seemed delicate, or was cross or expressed hunger to excess. Whether or not the child had been 'taken out' was also seen as relevant and in this regard chest infections, coughs and colds were also taken as relevant information. It must be noted that being 'taken out' carried more significance to the infant's death at that time than it would today. Beliefs about the harm done to a child by being outside reflected

earlier views on 'miasma' as well as the poor air quality in London at the time before the Clean Air Acts, and at a time when London had considerable industry and pollution.

Post-mortem factors considered relevant to the inquest proceedings included the position and location of the body when found (for example, in bed, on the mother's arm or on a pillow), and also the condition of the body when found, including information relating to colour, temperature or rigidity, whether or not the face was covered, whether there was vomit, blood or mucous, and whether the hands were clenched or the toes flexed. In addition, the witnesses' assumptions and explanations about the cause of death were considered, and this might have included whether or not the witness thought the child was overlaid or if the child appeared to have had a fit or convulsion.

In recording such information in his case notes, Ludwig Freyberger produced a catalogue of bodily signs which together point toward some of the underlying assumptions surrounding cases of sudden infant death where the infant was found dead in bed with parents or siblings. The spectre of overlaying was nearly always present, at the centre of the case, refuted by the mother, suspected by the doctor, or lingering on the periphery, a possibility to be ruled out during the process of the investigation. Despite its every-ready presence in many case notes, the suspicion of overlaying was always allayed by Freyberger. Freyberger identified underlying pathology within each body that he examined, and in each case death by natural causes was his conclusion. That overlaying was always present is shown by the annotations which can be seen added to case notes ('found dead in bed') which can also be seen in the Coroners' Registers of the day. An infant found dead in bed caused suspicion and in some jurisdictions resulted in an almost routinely arrived at verdict of accidental death by overlaying.

The story of an infant's health and well-being began with its mother and maternal culpability and extended from pre-conception until an as yet undefined point sometime in the offspring's later life. The issue of mother blame was wide-reaching; suffice to say Freyberger's case notes, for instance, contain references to the actions of mothers (both ante-and post-natal) which have been compiled in an effort to explain the death of their infants. In the period that Freyberger was working, the health and welfare of mothers (and fathers) in the preconception period was considered important to the general well-being of the next generation; but at the level of the individual, infant health and welfare was an issue discussed in relation to the mother and her pregnancy. Although knowledge about the effects of maternal disease and nutrition was widespread, these were not discussed in the case notes. Instead, the behaviour of the mother (to be) provides the setting for ante-natal indicators of the possible causes of infant disease and death and there were many references to the

activities of mothers during their pregnancies. In order to understand the relevance of some of the references within the case notes, it is important to have an understanding of the behaviour expected of pregnant women.

The primary responsibility of a pregnant woman was to have a husband (although many did not) because illegitimacy was seen as a significant factor in infant mortality, with infant mortality higher for illegitimate than legitimate infants, and suspicion of infanticide or neglect appears to have fallen more readily on the single woman with her first child. Beyond this, a pregnant woman was considered to have a responsibility to prepare for her labour and the safe delivery of her child. This included consulting a doctor or midwife and arranging for their attendance at her confinement, preparing clothes and bedding for the expected child, and generally acting in a way thought conducive to the delivery of a healthy infant. She was also expected to be open about the pregnancy, sharing information about when the delivery was expected. Expectant mothers should have raised no suspicion that their infant was not wanted or would not survive birth. As with overlaying, issues of pregnancy, labour and birth were, in the main, raised when there was an absence of visible indicators pointing to illness or pathology as the cause of death. Evidence about the death of a newborn infant frequently referred to these issues and raised the question of whether or not the woman expected her pregnancy to end in the birth of a full-term healthy child that she expected to rear. Occasionally women were asked if they had 'taken anything' (perhaps to bring on a miscarriage), but this occurred only infrequently and generally the subject was alluded to but talked 'around' to a large extent. The possibility of an induced miscarriage is seen underlying the references made in some case notes, and as with overlaying, the context of the event was of great importance. In the case of a newborn infant found dead in bed, the pregnancy, labour and birth were explored more thoroughly than with older infants and although the post-mortem was given considerable weight, the social context of the pregnancy and birth were also considered important.

It should be noted that in the absence of a post-mortem conducted by a forensic pathologist, the social context of the death formed a greater part of the evidence. Where a general practitioner (GP) provided the medical evidence a full post-mortem examination may not have been conducted. Many GPs relied on visual examination of the external body, sometimes in-situ, but this often occurred some hours after death and frequently the body had already been 'laid out' by the family. Even in the event that a full post-mortem examination of the body was conducted by a GP, their forensic skills may not have been sufficient to uncover the finer points of the underlying pathology. It should not be considered as coincidence that Freyberger found no cases of overlaying in the three years covered by the



case notes, while GPs working in other jurisdictions for other coroners routinely reported overlaying deaths.

Post-mortem examinations were usually conducted by the local or attending GP and the post-mortem examination and witness fee was a considerable source of income for some GPs. In a move to bring specialist forensic knowledge to the inquest process, the London County Council compiled a list of forensic pathologists who could be called upon by coroners in cases where it was felt specialist knowledge was required. The unusual professional relationship that developed between Troutbeck and Freyberger led to a very high number of infant deaths being investigated by Freyberger. This was a source of antagonism between coroner Troutbeck and pathologist Freyberger on the one hand, and local GPs on the other, and often resulted in challenges being made to post-mortem findings and disputes about the qualifications of the professionals involved. This argument raged for a number of years and was the subject of a long running series of articles in the medical journals, frequently under the heading of 'The Coroner, The Pathologist and the Medical Man'. It is against this background of controversy that analysis of the following sudden infant deaths in bed is set.

### **Brief lives: Twenty-two infant deaths**

There were twenty-two newborn infants (including the Swains child) found dead in bed recorded in Freyberger's case notes. Of these cases, thirteen were male and nine were female. The ages at death ranged from 10 hours to 4 weeks; seven were less than 24 hours old; six were between 1 and 7 days; the remainder were between 1 and 4 weeks. Twelve of the infants were born prematurely; the premature births were between 6 and 2 weeks pre term; one child, recorded as 6 weeks pre term, weighed 6 lb at birth and was 20" in length (it is unlikely that this child was in fact premature by any significant amount of time). The smallest child weighed 3 lb 10 oz and was 16" in length and was recorded as being born in the seventh month. Death was expected in only one of the cases. Nine of the children were born to primiparous mothers, one was a second child, and nine were born to mothers having their fifth or subsequent child. There were no children born as third or fourth deliveries recorded in the group. One child was the fifteenth delivery for the mother. Where the number of living siblings is recorded (eight cases), the families had lost a total of twenty-five children; for one family, their sixth child was the first they had lost; one mother had lost six children, two had lost three children, three had lost two children and one mother had lost one other child.

Where the circumstances of the birth are mentioned (fifteen cases), four had a

midwife present, six had a doctor, one had a nurse, one delivery was assisted by a grandmother, one by a sister and a neighbour, and three others by a neighbour. One birth was recorded as having had no assistance. Of the twenty-two cases, there was mention of some illness (cough, cold or sniffles) in six cases, while four of the children were referred to as being 'blue' or having 'blueness', which was usually taken as a sign of disease of the cardio-respiratory organs. In the remaining twelve, there was no mention of ante-mortem illness. All of the infants were found dead in bed, four were on their mother's arm and one was lying on a bolster. Sixteen of the infants were discovered dead by their mothers. A nurse, a grandmother, an aunt or a father each found one infant dead. In all cases the infant was in bed with its mother at the time of its death. Exploration of Freyberger's case notes now continues through examination of the remaining twenty-one cases of newborn infants, in addition to Baby Swains found dead in bed.

Leslie Chester was 24 hours old when he died; he had been born at 7.30am on Saturday 17 December 1910. Leslie was the first child of the family and his father thought Leslie to be healthy at his birth. At the inquest Leslie's body was identified by his father. Eliza Poole, grandmother to Leslie was present at the birth. She said that it was not a difficult birth and that the labour had lasted not quite three hours. Eliza too thought that Leslie was a healthy baby. Leslie was born before a nurse or doctor arrived at the home. Dr Barclay attended Leslie and his mother (who remains nameless in the case note) and stated that it was a normal confinement, that the baby was small and that delivery was quick for a first delivery. These last two factors are perhaps related, with the small size of the child permitting a speedier delivery.

Eliza Poole last saw her grandchild alive in bed with his mother at 2am on Sunday morning and he was "all right then". At 7.15am on Sunday morning, Leslie's mother said to Eliza "How strange baby looks I don't think it is alive". Eliza found that Leslie was dead, "cold in face and hands", but his feet were still warm. Neither Eliza nor Leslie's mother could explain the death and Dr Barclay was called at 9am. When Dr Barclay arrived, he found Leslie "quite dead and cold – no stiffening, no marks of overlay but slight marks on bed clothes. Nothing suspicious, d[eceased] face was away from mother. No marks on face or mouth". It must be remembered in reading Dr Barclay's evidence that he did not arrive at the home until approximately two hours after the death had been discovered and he probably relayed only what he had been told, rather than reporting his direct observations made at the scene. Although possible, it is unlikely that Leslie's mother had remained in-situ with the dead child during the intervening period. From Barclay's comments, it must be assumed that overlaying was considered as a possible cause of death, although it was later discounted. It is

unclear what significance Barclay placed on the “slight marks on bedclothes”. Bedclothes were thought to sometimes leave an impression on the body of a dead infant, and it was believed that overlaying could leave the imprint of bedding materials on the underside of the body post-mortem, but marks on the bedding material are not normally referred to in these cases.

In his post-mortem examination, Freyberger found vernix caseosa in Leslie’s lungs, probably inhaled during birth. He diagnosed that this had led to acute broncho-pneumonia and subsequent suffocation and convulsion. Leslie weighed 7 lb at his post-mortem examination. The jury returned a verdict of natural causes (Wellcome: GC141/5/49). Leslie’s father, mother and Eliza all considered Leslie to be a healthy child. They did not expect his death and could not explain it. Dr Barclay had included the possibility of overlaying in his consideration of the death, along with the possibility of something suspicious having occurred. External indicators of the child’s impending death had been absent.

This case indicates that with the death of an infant, despite high infant mortality, causes other than natural causes and underlying pathology were usually considered. Suspicious situations, circumstances or marks were considered even if they were later ruled out. Premature births were also subject to this scrutiny if the child died shortly following its birth. An example of a premature newborn infant found dead in bed with its mother was the child of Mary Hudson.

Mary Hudson did not expect her child to be born until the end of March 1910. On 18 February 1910, Mary was out during the evening and thought that she may have “hurt herself a little”, bringing on labour pains at midnight. There is no information as to why she thought she had hurt herself. Mary’s sister, a married nurse, was staying with Mary because she was currently “out of a situation” (unemployed). Mrs Lillian Pepper, the landlady, was also present. No doctor could be obtained to attend the birth, but a police constable was contacted and he recommended a nursing home to them. Mary’s child was born at sometime between midnight and 3.35am. Mary’s sister was not present when the child was born but she saw him afterward and said he was a fine baby who “cried well”.

Nurse Owen, a student nurse, visited from the nursing home. She had previously attended ten births during her training. She arrived at the Hudson household at about 3.35am by which time the child had been born. Nurse Owen “delivered the mother” (delivered the placenta). She thought that the child may have been premature due to his “blueness” although his nails were “natural”. Nurse Owen did think that perhaps the child’s lungs were not properly expanded. Mary’s sister had promised to pay Nurse Owen’s fee. The landlady, Mrs Pepper, said that she had thought that the child was due at the end of March, more than a

month away. She knew nothing about Mary injuring herself, but said that the child was a little dark in colour and very small. The child was recorded as weighing 6 lb and being 20” in length which is within the normal range for a full term infant. At about 11 am the child was given sugar and water but had no food other than this. He became sleepy and died at 1pm. He was in bed with his mother.

Ludwig Freyberger concluded from his post-mortem examination that the child had died due to a coma following compression of the brain and intra-meningeal haemorrhage caused by pressure exerted on the head during the act of birth. Freyberger found moderate caput succedaneum (swelling of the presenting part of the head during birth) and both parietal bones were freely moveable against one another; there were no fissures or fractures. The jury returned a verdict of natural causes (Wellcome: GC140/4/43).

This case was unusual because neither the child’s mother nor father is referred to as giving evidence at the inquest. In the case of newborns, the mother was often absent, it is assumed because of her confinement and the custom of ‘lying in’ for several days following the birth. The father, on the other hand, was nearly always present at the inquest, taking on the key role of identifying the body whether or not the mother was present to give evidence. The absence of a father at the inquest quite often indicated his absence from the household. Whether or not Mary Hudson was married and whether the father of Mary’s child was present in the household is unknown. It is interesting that Mary’s sister, who was recorded as a “married nurse”, was not actually present at the birth although she was there immediately before and after. There was no reason given as to why this was the case. The term ‘married’ was often used as a euphemism to indicate that a woman had knowledge of childbirth and sexual matters. This was also seen with reference to “Mrs Lillian Pepper married landlady”. Nurse Owen took the child’s “blueness” as an indication that the child may have been premature but contrasts this with the correct development of the child’s finger / toe nails which were taken as a sign of full gestation.

It is unusual that Mary’s marital status was not referred to in the case note. In cases where it was not apparent, for example when no husband gave evidence, it was normally recorded that the mother was single or estranged from her husband (perhaps for an amount of time that makes the child’s illegitimacy apparent) or ‘walking out’ with someone. Ludwig Freyberger does not refer directly to (il)legitimacy in the notes relating to infants found in dead in bed. It is strange that, in a house where two other women were present, one claiming to be a nurse, no one was with Mary Hudson when she delivered her child.

The weight (6 lb) and length (20”) of the child (post-mortem) suggests that he was not born prematurely and Freyberger noted only that the child was “moderately nourished”.

There was no information that would explain why the child was not expected until the end of March (six weeks hence). The child had significant injuries to the head and Freyberger attributed the child's death to a "birth injury".

The case of William Tuckey, also found dead in bed, was one where there was also some uncertainty about the circumstances of the child's birth and subsequent death. The body of William was identified by his father, James. William was the seventh child of the family and five of his siblings were still living at the time of the inquest. If William's mother gave evidence at the inquest, it has not been recorded in Freyberger's case notes, but it is likely that she was still 'confined'. William was born on Wednesday 2 December 1908 and he weighed 4 lb 15 ½ oz. Jane Adams (recorded as sister-in-law) thought that the child was expected after Christmas. She said that William's mother had been "taken bad" at 3pm on Wednesday and that William was born between 5 and 6pm. Jane said that she was not present at the birth and that no doctor had been called but that William was "all right". James Tuckey had been called home between 5.00 and 5.20pm on the Wednesday evening, by which time the child had been born; after his arrival home, "he was sent to fetch a good lady". James said that at this time William was "all right" but "moaning". It is not clear who had sent for James Tuckey.

Annie Porter, "a monthly nurse" for years "only going out under a doctor or certified midwife", was fetched between 6 and 7pm. When she arrived, she thought that William must have been born perhaps two or three hours earlier. William was still attached to his mother via the umbilical cord and placenta. Annie cut and tied the cord and "saw to" the afterbirth but stated that this was "not quite a nurse's work". Annie then sent for a doctor but it was "too late". When Annie left William and his mother, William was crying but not in a very "satisfactory" way, although she qualified this by adding "but sometimes they moan". Annie Porter said that no arrangements had been made for the birth and she was still visiting William's mother but she didn't know if she would be paid for her attendance. The mother had not told her when the birth had been expected but Annie did not think William was a full term child and that he had perhaps been born one month prematurely. James said that his sister, Jane Adams, had told him that Annie was a midwife but he did not know whether this was true. At her previous confinements, Mrs Tuckey had been attended by both a doctor and midwife. James said that his wife had made no arrangements for the birth and he did not know why she had started her labour pains. James also stated that his wife was all right at 8am on 2 December when he left for work. James was not in regular work and earned between 10s and £1 per week. The following morning, 3 December, James left for work sometime before 6.20am. William had been in bed between James and William's mother.

When James left for work, William was still alive.

Jane Adams said that William had been found dead in bed by his mother's side, at 10am on 3 December 1908. Jane said that William's mother told her that baby William had been crying all night but had then gone to sleep. William's mother had not realised that William was dead beside her. William had not taken the breast. The family lived in three rooms and no preparations had been made for the birth. Freyberger thought that William had been born approximately two weeks prematurely, "probably half suffocated", and that there had been no attempt made to clear the child's airway. Freyberger suggested that if medical assistance had been sought more promptly, the child may have lived, being "otherwise healthy". The post-mortem notes show that there was a quantity of thick, frothy, brown mucous in the child's airway and that the lungs were dark purple-red, with no ecchymoses. On conducting the hydrostatic test, the lungs floated below the surface of the water.

The hydrostatic test was used to ascertain whether the body of an infant found dead had been born alive (where taking a breath was considered evidence of life), or else had been stillborn. The test was based on the assumption that the condition of the lungs is changed by respiration. In his lecture to medical students at the University of London in 1834, Professor A.T. Thomson (1835: 804) described the procedure for performing the hydrostatic test. A visual inspection of the lungs should first be made; if the child had never breathed, there would be little blood in the pulmonary arteries, the lungs themselves would be small, scarcely filling the cavities of the thorax, and they would be dense, compact and dark red. If the substance of the lung was cut, no blood would be exuded. A child that had breathed would have larger lungs (inflated by air), the lungs would be pale in colour and elastic in texture, on incision, the lung would exude bloody fluid and the crackling of air (crepitation) would be heard. To conduct the test, the lungs were first removed from the thoracic cavity and wiped dry. Ligatures were placed around the major blood vessels and the trachea, and the organs placed into a vessel 12" deep of fresh soft water. If the lungs sank, it was assumed that the child did not breathe and was stillborn. If the lungs floated, it was assumed that the child had taken at least one breath. In his lecture, Thomson (1835: 804) described additional aspects of the test which included observations about the position at which the lungs floated or sank and whether floatation was even or partial. Thomson also recommended 'sinking the lungs below the surface by applying pressure with the hand, and measuring the displacement of water. Thomson concludes, however, that evidence the child never breathed was not evidence that the child was born dead. This is an interesting qualification to the belief that breath equals life and one that allows that infanticide can occur between the beginning of the child's expulsion from the womb and its first breath. Thomson wrote that by the time of his

lecture in 1834, the test was not seen as completely reliable because under certain circumstances, such as when decomposition has occurred (with putrefaction producing gas in the lungs), the lungs floated despite the infant being stillborn. There were other criticisms made of the hydrostatic test throughout the nineteenth century, but despite this Freyberger referred to conducting the hydrostatic test during post-mortem examinations on more than one occasion (Wellcome: GC/140/1/149; GC/140/2/66; GC/140/4/286). Sometimes he conducted the test when there were witness statements that the child was born alive and took a breath. Freyberger's purpose in such circumstances is unknown as the test would appear redundant. In the case of William Tuckey, the issue of stillbirth is not raised or recorded in the case note, and Freyberger's use of the hydrostatic test is unexplained. At William Tuckey's inquest the jury returned a verdict of natural causes, but comment was made that James Tuckey, as father, should have taken more care of his "wife's interests" and the nurse should have gone sooner to get a doctor (Wellcome: GC140/2/54).

Mrs Tuckey was reported as commencing labour at 3pm, but no assistance was called at this time. James Tuckey was called home between 5.00 and 5.20pm, by which time the child was already born. Who had called James at this time? Why was a midwife or doctor not called? Having returned home and found the child born, it would seem that James had not attempted to cut and tie the cord or clear the child's airway. Evidence from other cases suggests that such intervention from a lay person was not unusual (Wellcome: GC140/5/210) and James's failure to intervene was not explained. Instead, James went to fetch assistance, not from a midwife, but from a "good lady". James's choice of words is interesting, but can be explained by the conditions set out in the Midwives Act (1902).

The Midwives Act (1902) became effective on 1 April 1905. The Act was intended "to secure the better training of midwives and regulate their practice" (2 Edw. 7 c.17). Under the Act a woman could not call herself or practise as a midwife without training and registration. Ambiguity in the Act did, however, allow women to attend confinements for monetary gain as long as they did not call themselves 'midwives'. This loophole was closed in 1910, when an amendment made it illegal for a woman to habitually attend or receive financial reward for assisting at a birth unless working under the direction of a doctor or registered midwife. Certified or registered midwives were not permitted to take charge of "abnormal cases or diseases connected to parturition, when a doctor should be called" (Stevens: 2002: 371). Practising midwifery without certification was a criminal offence. A general defence against charges under this Act was, however, that anyone could assist at a birth in an emergency.

Working as a 'monthly nurse' under supervision of a doctor or registered midwife

provided an alternative for women who worked in the role of unofficial midwife, but who for one reason or another were not certified. In 1905 Board certification entailed a fee £1.1.0 to be paid by the midwife, but there were other barriers to certification, including failure to pass the Board's examination or possession of a criminal record. The criminalisation of women practising unregistered midwifery may be an explanation for the references that are made to the attendance of a "good lady" or a "monthly nurse" seen frequently in the case notes. There are cases such as the Tuckey case where assistance was not given and this resulted in the death of an infant, but the Midwives Act should not be construed as explaining inaction on the part of individuals present at such births because of the general defence of acting in an emergency. Indeed, before the 1910 amendment there would have been no grounds for prosecution of friends, neighbours, mothers or sisters routinely assisting at a birth.

For a monthly nurse, the term 'working at the direction of a doctor or midwife' seems to have been practised in a very loose sense, and rather than working under specific direction assistance was called for only when needed. There is no evidence that the doctor or midwife had necessarily seen the mother during the confinement, or been in attendance in the recent past. In a practical sense, this would enable a 'monthly nurse' to conduct her business freely and save a doctor or midwife the task of attending every confinement that they 'directed'.

Evidence from other cases supports this (Wellcome: GC140/5/149) and shows that in practice it was not routine to have a doctor or midwife at every birth. In the case of William Tuckey, the arrangements seem to have operated quite clearly in this way. No arrangements had been made for the birth and Annie Porter had not therefore prearranged with a doctor to attend the confinement, nor had she informed anyone that she would be working under their direction at Mrs Tuckey's confinement. In 1908 when William's death occurred, Annie Porter was not committing any crime under the Midwives Act<sup>11</sup> but neither was she working within the meaning of the Act.

In evidence, Annie Porter said that she was sent for between 6 and 7 pm and that by that time the child had been born some two to three hours but was still attached to the mother via the umbilical cord. This situation raises a number of questions. Where was James at this stage, had he returned to the house? Mrs Tuckey had delivered her seventh child, and it is assumed that she was familiar with the process of childbirth, so why had she not attended to the child herself? Was she incapacitated by the delivery? The two to three hours elapsed time would perhaps suggest a certain degree of recovery on her part. There was some suspicion introduced by this inaction on the part of James and his wife because, as Smith states "A child may be lost by remaining in a posture unfavourable to respiration – by being suffered

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11 Midwives Act 1902. 2 Edw. 7 (BPP: 1902: c.17)



to lie in the discharges that accompany the birth” (1824: 75). And it is perhaps evidence of this that Freyberger sought by conducting the hydrostatic test. Apart from such suspicions, this case was unusual in the way that some blame for the child’s death was placed on James Tuckey. Usually the father’s responsibility was constructed, within the inquest process, around providing financially for his family while matters relating to pregnancy, labour and child care were generally seen as the responsibility of the mother and other women. Therefore criticism of James for failure to obtain medical assistance is unusual. Although James was not in regular work, he was earning a wage, albeit a limited one. That the family had three rooms is quite surprising considering their limited income and perhaps Jane Adams, Tuckey’s sister, also lived with them. Even if this was not the case, the Tuckeys (two adults and five children) shared the three rooms but this level of occupancy was by no means unusual for the time. Despite this, there was no direct reference made to the somewhat suspicious circumstances that surround the death of William Tuckey.

The following case provides an example of the way that the sudden death of an infant in bed was linked to overlaying as the cause of death. The newborn child of Gerald Hoaker was 25 hours old when he died. Identified by an unnamed neighbour, the infant was described as a small child, the son of Harry, a “carman” living apart from his wife. The child had been born near midnight on Friday 25 June 1909, and a medical student, Sydney Humphrey Owen from St Thomas’ Hospital, was present at the birth. The child did not cry when born. Sydney Owen was a fourth year medical student going through his “midwife’s course”. He had attended between forty and fifty births. He said that labour lasted about 1½ hours and that the weight of the child and its presentation were both normal. Sydney was concerned that the infant did not cry and he had had great difficulty in getting the child to breathe. He gave the child artificial respiration for half an hour until the child began to breathe normally. Sydney saw no reason that the child should not live but did have “some doubts”, and “hence he gave the child castor oil”. At 12.30am, Sunday morning 27 June 1909, the neighbour and the child’s mother were in bed, the child was lying beside his mother and she noticed his mouth was open. The neighbour did not think that the child was dead. Freyberger concluded that the child had died from acteolactasis due to aspiration of uterine contents during, or immediately before, the act of birth, and also that the birth was premature. Freyberger noted that it was impossible to fully expand lungs that are completely acteolactic at birth by employing artificial respiration. The verdict of the jury was death by natural causes (Wellcome: GC140/3/121).

Sydney Owen had been concerned about the child because of his failure to cry properly at birth. This was seen as a serious problem and provides an example where crying

was interpreted as a positive 'sign' of vitality. Sydney Owen also commented in his evidence that being found dead in bed was a “sign” of overlaying. In the absence of other signs or the identification of underlying pathology, overlaying was seen as the only possible explanation for the death of some infants. This belief reflects a view commonly held at the time and is seen in the large number of overlaying deaths reported by coroners across the country, where the evidence presented generally reported an otherwise healthy infant being found dead in bed.

The next case is that of the male child of William Toovey. Born on 29 September 1911, he weighed 5 lb 4 oz. Mrs Toovey had delivered ten children, seven of whom were dead at the time of the inquest. This was a remarkably high rate of mortality even by the standards of 1911. The child's birth was not expected until 29 October and was therefore approximately one month premature. One month earlier, Mrs Toovey had fallen on a “pair of steps” and had been unwell since. On 26 September, three days before the birth, Dr Hardwicke had called to see Mrs Toovey about a lump in her side.

Lucy Grover, a Registered Midwife, attended the birth. She remembered nothing peculiar about it. The child did not seem premature to her and after its birth the child seemed normal and cried well. This was in keeping with the father's view that, although rather small, the child seemed all right. Mr Toovey stated that the child cried all night, but had not taken the breast. He is reported as saying that he last saw the child alive at 1am in bed with his wife and that he said to her “baby looks a little black”, to which his wife replied “Don't disturb him as he has just gone off into a nice sleep”. Ellen Sharpe, a neighbour who went in to see Mrs Toovey while she was ill (perhaps following her fall), said she had last seen Mrs Toovey and the child at 12 noon and that in the morning the child had taken the breast. She had no reason to think the child would die so soon. She left the child apparently “all right”.

The child was found dead by his mother; he was lying away from her on the bed. Mr Toovey sent for Lucy Grover at 2pm. The child was quite stiff and its face was very dark. Lucy said that Mrs Toovey could not give an explanation for the death and reported that the child had had a good drink and a cry in the morning, “so the mother said”.

Freyberger stated the cause of death as suffocation in coma from intermenigeal haemorrhage and premature birth. “Brain well developed [...] bruise over pons, dural caput considerable haemorrhage, blood fluid, dark purple-red. The effusion extending on to cerebellum and down to [...] surface of pons”. He also noted that the lungs were poorly inflated and that the stomach was empty. In addition, the meconium had not been discharged. The stomach being empty is at odds with the claim that the child had been fed shortly before death. Freyberger did not indicate whether he believed the head injury occurred as a

consequence of Mrs Toovey's earlier accident, during the act of birth, or at some time after the birth. The jury returned a verdict of natural causes (Wellcome: GC140/6/77).

Mrs Toovey had had an accident, a fall, but it is unclear whether the "lump in her side" had any consequence for her pregnancy. The child's colour had been unusual, "a little black" according to Mr Toovey, but the midwife had made no comment about this. The child was reported to "cry well" and "take the breast", both positive signs of health. Nevertheless, within one hour the child was dead. Between 12 noon and 2.00pm, the child had gone from being alive and apparently "All right" to being "quite stiff" with its face "very dark". Were Lucy Grover's suspicions raised? This cannot be known for certain but she seems to have had doubts about what she had been told by the mother. Freyberger's report that the stomach was empty and that meconium was still present in the intestine supported her suspicions. Her comment "so the mother said" in relation to the child having had a "good drink and a cry" suggests that Lucy probably was suspicious of the circumstances surrounding the death of the Toovey infant. Interestingly, there was no open discussion of any suspicion about the circumstances of the infant's death in the notes recorded by Freyberger and the jury's verdict of natural causes seems not to have been challenged by anyone.

Prematurity is referred to as a contributory factor in the death of many infants and was seen frequently in Freyberger's case notes. The following case concerns an infant born at 7½ months gestation and shows the routine nature of premature deliveries at the time. Mrs Carlton's fifteenth child, David was born on Tuesday 4 April 1911 and lived for 13 hours. Mrs Carlton had lost two children previously. Alfred Carlton, the child's father, stated that the child was not expected until June and so it was approximately 1½ months premature. One week earlier, Mrs Carlton had slipped while hanging up some clothes but Alfred "did not take much notice at that time". He said that his wife had "felt bad" that morning but he had gone out. By the time he returned in the evening, David had been born. Alfred had thought that the child was going to live.

A neighbour, Fanny Gale, a "married woman", had been called at 5am on Tuesday morning, presumably by Mr Carlton. She found Mrs Carlton in pain and sent for Mrs Williams, a Registered Midwife. Mrs Williams said that she had not been engaged for this case but undertook it for the usual payment. When sent for by Fanny Gale, Mrs Williams had been attending another case, but went straight to see Mrs Carlton. She said that she advised Mrs Carlton to rest. Mrs Williams returned to her initial case and asked to be called when Mrs Carlton's "pain started".

David was born at 3.15pm, at which time Fanny Gale came in and "separated mother and child" (cutting and tying the umbilical cord). Fanny sent for Mrs Williams and kept the

child covered up until her arrival at 3.45pm. Mrs Williams said that David was a small child who cried weakly at first, then better. She thought that David would live. She had not seen the child again and did not advise that a doctor be called because it was a “straightforward case”. Fanny Gale said that David cried feebly and that Mrs Williams had instructed her to call a doctor if she noticed any change at all. Mr Carlton went into his wife’s room at 5am on Wednesday morning and found his wife asleep with the child dead by her side, and his daughter was also there. Fanny Gale was also present (although whether present there all night or called at the time was not stated) and said that David was cold but not stiff. Mrs Carlton had fallen asleep, and when she woke she found that the child was dead.

Freyberger thought that the child had died due to suffocation caused by actelectasis of the lungs and patent foramen ovale, and that the child’s prematurity and the mother’s frequent pregnancies (15) were a contributory factor. The child’s face and trunk were deeply livid while the rest of the body was pale. The umbilical cord had been cut and tied. The lungs both sank when the hydrostatic test was conducted, except for the left upper lobe which floated upright and so was not quite airless. The lungs contained blood-tinged frothy serous secretions. The jury returned a verdict of natural causes (Wellcome: GC140/5/210)

David Carlton was a premature child born at approximately 33 weeks gestation. The child was small (4 lb 9 oz and 18” in length) and “cried weakly” at first. The child’s improved crying was taken by Mrs Williams as a sign that the child would live. This improvement was sufficient for Mrs Williams to feel that the attendance of a doctor was not necessary. She did, however, feel that a “change” in the child’s condition would indicate the need for a doctor and further medical assistance. That the child was “cold not stiff” suggests that Fanny believed the child not long dead when he was found at 5am. In stating that she believed the case a “straightforward one”, Mrs Williams can be seen as complying with the conditions of the Midwives Act, where no doctor was required to attend unless the case was abnormal. The claim to the straightforward nature of the case is therefore a legal defence as well as an opinion of the medical status of the confinement. At a gestation period of 33 weeks, the foetus / infant would have been considered viable.

This case provides an example where lay intervention in the delivery of an infant occurred, with Fanny Gale cutting and tying the umbilical cord. Until the Midwives Act, lay attendance at a confinement was common practice and knowledge together with direct practical experience of the labour and birthing process would also be common among many more women than might be the case today. Alfred Carlton is not untypical in absenting himself from the house when his wife went into labour and there are no direct references in Freyberger’s case notes to a father’s attendance at a birth. Fanny Gale’s presence in the home

at 5am was not unusual either and it may have been that she had stayed overnight. This was common practice for a monthly nurse, as noted elsewhere.

The next case is one where a full term, apparently healthy infant, who had received good care and a problem free birth, died unexpectedly. Kate Hoskins died on 9 November 1909, she was 4 days old. Her father, who identified the body, last saw her alive at 7am when he kissed her on the cheek before leaving for work. Kate's father said that Kate was warm and still breathing and that her colour was red. Kate had been born at 10.20pm on the previous Friday. Charlotte, who was at the birth "to see to wife and child", thought that Kate had cried "all right". Charlotte was called from work again on the Tuesday morning between 9 and 9.15am and saw Kate lying dead on the bed. Kate's mother was crying and said "I believe the baby is dead".

Dr Burkefield saw Kate on Monday 8 November at his surgery. He thought that the child was full term, healthy and of average size (Kate weighed 7 lb and was 20" in length at her post-mortem examination which is normal for a full term child). When Dr Burkefield next saw Kate at 10.15am on the morning of Tuesday 9 November, she was "dead and quite cold and stiff". He said that the onset of rigor mortis was dependent on the cooling of the body. He saw no marks of violence on the body and said that the left ear, cheek and temple were white with the "rest of face quite purple". Mrs Hoskins said that the child had been lying on its left side. Dr Burkefield said there was no mottling on the mouth or lips but that the pressure of the child's own weight might produce such mottling anyway. Dr Burkefield said there were no signs that the child had been interfered with. He also stated that the child had been fed at 3am and that the father saw the child at 7am and had reported that "The mother went back to bed immediately with the child lying on her side on the bed". Dr Burkefield thought that the parents were respectable but poor, and noted that there was a fire in the room. Freyberger attributed death to suffocation while suffering from bronchitis and commencing broncho-pneumonia. The jury returned a verdict of natural causes (Wellcome: GC140/3/225).

Doctor Burkefield's evidence is interesting in this case because he is quite obviously relating information passed to him, rather than events that he had directly witnessed. In his evidence, he said that the birth was easy and that Kate cried well and took the breast but it is likely that he was reporting information that had been relayed to him because his actual presence at the birth was not mentioned and it was Charlotte's role to "see to mother & child". This would have been unlikely if a doctor was present. Dr Burkefield had not been at the birth, he was not present at the 3am feed, nor at 7am when Mr Hoskins kissed Kate on the cheek but as is normal in the coroner's court, his 'hearsay' evidence on these events was

taken into account. Kate's mother was the only person present at the birth and death but is also the one person involved who did not give evidence, presumably because she was still 'lying in', it having been only four days since the birth. Why was it that Mrs Hoskins's evidence, as in other cases, was not important enough to warrant a postponement of proceedings? There seems to be no suspicion of foul play, but nonetheless the inquest process and official record would appear incomplete without the mother's contribution, although the evidence of the mother in these cases of newborn infant death is rarely if ever recorded in the case notes.

The reference to Kate's father kissing her cheek before leaving for work was a rare sign of affection between parent and child recorded in the case notes, possibly because such events are not generally considered relevant as evidence. In this case, however, the kiss was a means of knowing that the infant was warm and the witness was close enough to see or feel the child breathing. There is no mention in the evidence of any illness or other indication that Kate would die, although in describing her colour as "red", Kate's father had perhaps identified a sign that the child had a fever or some other pathology. Other signs were positive; the child had taken the breast, was warm, breathing and had cried well.

The mottling on the face would have been due to settling of the blood following death and is usually referred to by Freyberger as livid post-mortem hypostasis. Dr Burkefield, in stating that there could be an innocent explanation for the mottling, namely "pressure of the D[ecase]d own weight", followed by the claim that "no signs D[ecase]d was interfered w[ith]", allows the possibility that suspicions about the death - "no mottling on the mouth or lips" - were raised and discounted and presumably Burkefield had ruled out deliberate suffocation of the infant. Dr Burkefield gave his evidence in terms of an unknown but 'natural' cause of death. Freyberger referred only to lividity in his post-mortem note and made no mention of the "mottling" observed by Dr Burkefield, and it is possible that further settling of the blood post-mortem had altered the baby's appearance.

A case of a very sudden death was that of the newborn son of J. Winter. The child was the fifth child of the family, born on 1 March 1911 in the evening. The child weighed 7 lb. The inquest was held on 3 March 1911 at Battersea Coroner's Court. Mrs Winter was eating bread and cheese when she was "taken bad". Sarah Carter, a married woman living in the same house was present immediately before and after the birth of the child. However, having left to fetch a nurse she missed the actual delivery when Mrs Winter gave birth to the infant after "2 pains" (contractions). Sarah Carter said that the child seemed "all right" and "cried properly". The nurse, Ethel Bassett, a pupil midwife, was called at 11.35pm and attended Mrs Winter at 11.50pm. She thought that the child had been born for about one

hour. The child had not been “divided, [and] was lying as it was born”. Ethel cut the umbilical cord with the help of an assistant nurse. She said the child cried all the time and seemed perfectly happy. Ethel thought that the child might have swallowed something, so she made attempts to clear his mouth. She said it was “supposed to be a regular birth”. Ethel put the child in bed with Mrs Winter and left the house at 1.25am. She saw no reason to believe that the child would die so soon. Sarah Carter also said that the child was all right and “cried properly”. At 7.55am Sarah went upstairs. She said that she had just taken off her boots when she was called by Mrs Winter who said “The baby is dead”. Sarah said that she saw nothing that would account for the death. The child had cried during the night, even during the last hour. When Sarah returned downstairs, she found the child “lying quiet”.

There is no information about what happened immediately before the child’s death and no statement from Mrs Winter. Sarah Carter was recalled to the stand during the inquest, which suggests that some clarification or re-examination was required. Mr Winter, who identified the child, initially stated that Sarah had not been present at the birth, but in her evidence Sarah had said that she was present. When she was recalled, Sarah Carter said that she had been out fetching the midwife at the time the child was born. There does not seem to be anything made of this confusion at the inquest. Evidence was also given by a coroner’s officer to the effect that a doctor was only called to attend a child on the day after its birth and that this was a practice recognised by the Midwives Board. Freyberger concluded that the death was caused by suffocation due to inhalation of uterine fluid during the act of birth, together with actelectasis redux. The jury returned a verdict of natural causes (Wellcome: GC140/5/149). In his evidence, Freyberger said that if a doctor had listened to the child’s chest, they would have heard rattling sounds as an indication of the fluid present in the lungs.

It is unclear whether Mr Winter was present when his wife went into labour. It is likely that he was not, hence Sarah Carter’s trip to fetch the midwife, which left Mrs Winter alone. That the child was born quickly is of no doubt, but by Ethel’s evidence the child was lying “as it was born” at least one hour after the birth. This was despite Sarah’s claim that she cleaned the child’s eyes and mouth.

Ethel Bassett was described as a “pupil midwife” and by 1911 the law was such that she should have been working only under the direction of a registered midwife or doctor which was clearly not the case. This was perhaps the reason that a coroner’s officer also gave evidence at the inquest to the effect that the events were in keeping with normal practice and were recognised as such by the Midwives Board. The divergence between theory and practice highlighted by this example demonstrates how important it is to develop an understanding of practice based on the experience of individuals rather than on knowledge of

the process based on prescribed procedure.

Sarah Carter did not say if she had made any check on the child prior to leaving at 7.55am, so it is possible that the child could have already been dead when she went upstairs, only to be recalled immediately to see the child dead. She did however say that the child had cried during its last hour, presumably at some time between 7 and 7.55am. Death in this case would seem to have been unanticipated by the witnesses. Freyberger had, however, stated that the signs of the child's imminent death were present, that is "rattling sounds" indicating fluid within the lungs, but that an expert reading of the body was required to identify them.

The suspicion of overlaying can again be quite clearly seen in the next case, that of the Jenny infant. William Jenny's daughter was born approximately one month prematurely on 16 July 1908. She weighed approximately 3 lb 10 oz and was 16" long. The child was small even taking her prematurity into account. Mr Jenny said that he knew nothing as to the cause of the premature birth. There was no evidence to indicate how many children Mrs Jenny had previously borne. Registered midwife, Agnes Lubbock, was called to Mrs Jenny but arrived after the birth of the child. William's daughter lived for six days and died on the morning of 22 July. Agnes thought that the child was quiet and not very strong but she did not think that the child would die. Agnes last saw the child on Wednesday afternoon 22 July 1908 and at that time she had thought that the child was getting stronger. The child was being fed with small quantities of brandy and milk as well as the breast "until the mother's milk came".

Mr Jenny last saw the child on 22 July, in bed with her mother. She was by the side of his wife on the outside of the bed. Later, Mr Jenny found the child in bed "on his [sic] side, not on her arm, not covered by bedclothes, nothing to prevent breathing". On discovery of the child's death, Mr Jenny fetched his mother-in-law. He said that his wife had no idea what had caused the child's death. Agnes Lubbock was again sent for following the child's death. Agnes, in turn, sent for a coroner's officer. This was at 1pm and by that time the child was cold and stiff. It was reported that the child had been crying all night. Freyberger concluded that the child had died from heart failure due to a congenital heart defect; the heart was small with patent foramen ovale (split) with actelectasis of the lungs. The child's stomach was empty when she died. The jury returned a verdict of natural causes (Wellcome: GC140/3/145).

Mr Jenny gave evidence to the effect that the child was not "overlaid", implied by his statement that the child was on the outside of the bed, not on his wife's arm (a common assumption being that lying on the arm led to smothering by the breast), and that the child was not covered by the bed clothes or anything else that would prevent her from breathing.



These are statements that refute a suspicion of overlaying even though the allegation had not explicitly been made. This was indicative of the presumption of overlaying that occurred in the absence of pathology, and left the (clearly felt) burden of refutation with the parents.

The next case, that of Alice Amelia Goodyear, provides a case where death was anticipated and in accordance with the reading of bodily signs made by those associated with the child. Alice was 3 weeks old when she died and was the fifth child of Mrs Goodyear, who identified the baby. Alice was Mrs Goodyear's second child in nine months. A midwife, Mrs Jennie Johnson, attended Alice's birth. Alice was described as a very delicate child. She was unable to suckle and breast milk was fed to her on a spoon. Jennie Johnson said that Dr Cowper of the York Road Hospital was called in on Alice's second day. Jennie continued to attend Mrs Goodyear for ten days. She did not think that Alice would live for more than two to three months. Alice's mother also had concerns about the child and did not think that she could live.

At 3am on 25 November 1909, Mrs Goodyear fed Alice at the breast, afterward laying Alice on the bed, away from her and between her and the wall. Mr Goodyear was lying on the other side of the "full size bed". Alice's mother fell asleep and awoke at 7am to find Alice laying on her side, facing her, "her appearance usual". Alice was not covered by the bed clothes. Although Mrs Goodyear expected Alice's death, she did not expect it at that time. Alice had had "sniffles in [her] nose since birth" and Mrs Goodyear thought that perhaps Alice had had a fit. Mrs Goodyear said that she could not afford a doctor and had not thought to apply to the Parish (for assistance). At her death, aged three weeks, Alice weighed 4 lb 12 oz. Freyberger thought that Alice had suffocated due to bronchitis and a congenital heart defect. He also thought that the child was prematurely born. He saw no signs of violence or internal injury of the body. The jury returned a verdict of natural causes (Wellcome: GC140/2/178).

Alice Amelia Goodyear's death had been expected. Jennie Johnson, the midwife, anticipated the death and Mrs Goodyear did not seem optimistic about the child's future. Alice was a very small child, premature, and her mother had experienced multiple pregnancies; Mrs Goodyear had four other children living, the last born nine months before Alice. Strangely, despite her pessimism, Jennie Johnson thought that Alice was "reasonable at birth", although Alice had also had the "sniffles" since birth.

In her evidence, Mrs Goodyear ruled out the issue of overlaying by stating that the bed was full size, that Alice was not covered with the bed clothes and that she was laying away from her, on her side. The way in which the case notes are recorded makes it impossible to tell whether this and similar statements made by other parents were made in

response to questions asked by the coroner about sleeping arrangements and the position of the child at death, or if the parents felt that there was an assumption of overlaying within the inquest process which influenced what they said. In this regard, the regularity with which the issue of sleeping arrangements was addressed along with the order in which information was given in the evidence, would suggest that it was an issue raised by the questioning of witnesses at the inquest, rather than something that was reported independently by each witness in each case. In this sense, the mother of every infant found dead in bed could expect to be questioned about bed-sharing and sleeping arrangements.

The newborn child of L.W.H. Smith was born on Tuesday 3rd October 1911. The child was her mother's ninth child, five of whom were still living while three had been stillborn. A nurse was called just after 7am to attend the birth and on her arrival she immediately sent for a doctor. The child was born between 7.10 and 7.45am. Dr H. Palmer did not arrive until 10.30am, by which time the child had already been born. Dr Palmer thought the child "quite normal" and had no reason to expect its death. A neighbour visited Mrs Smith shortly after the doctor at 11am and reported that Mrs Smith had washed the child but found her to be very cold. The neighbour "could not say if she thought the D[ecease]d was going to live". Dr Palmer saw the child again at 1pm, when the child was crying "naturally". The nurse said that (Mrs) Smith had made preparations for the birth but that it had not been expected so soon. At 9am on 4th October 1911, the nurse again visited but by this time the child's condition had deteriorated and she described the child as "just alive, in bed, w[ith] mother". The mother described the child's cry as weak.

Freyberger reported the cause of death as suffocation while suffering from a congenital diaphragmatic hernia with vertical stomach and hypoplasia of the lung. The jury returned a verdict of natural causes (Wellcome: GC140/6/79). The consequence of the congenital abnormality was that there was no separation between the intestinal and respiratory organs (stomach, intestine etc and heart, lungs etc) in the growing foetus which led to a displacement and distortion in size of the internal organs. The right lung was "perfectly" formed, well inflated but exceedingly small. The left lung, however, was about four times the size of the right and was poorly inflated and congested. This would have had a very limiting effect on the child's breathing. The heart was also partially displaced and partly covered by the left lung, perhaps restricting its action. As well as the displacement of the stomach, large parts of the intestine were displaced into the chest cavity, disrupting the liver which was "almost bisected in the middle by a horizontal furrow. The colon sitting in the chest cavity was full of dark brown meconium" and this was an indication that the child's digestive system was also functioning inadequately. Freyberger noted that the spleen,

kidneys and bladder were normal apart from the consequences of the congenital hernia. The child appeared to be of a normal size and weight and Freyberger made no reference to the prematurity, although the nurse stated that the child was not “expected so soon”.

The doctor, on visiting the child some two hours after its birth, thought it quite normal and saw no reason to expect death, although the “neighbour” an hour later seemed less convinced about the child’s prospects of living. At 1pm, when the doctor called again he thought the child was all right as indicated by his comment that the “D[ecrease]d crying [was] natural”. By 9am the following morning, the nurse described the child as “Just alive”. There were no external signs recorded in the case notes that might have indicated the infant’s condition to Dr Palmer. It would not be unusual for a child with this type of internal congenital abnormality to appear healthy at birth but to deteriorate subsequently, because once independent of maternal support its body could not sustain itself. Therefore, the apparent conflict between the opinion of the nurse and doctor on the child’s health was probably due to its deterioration over the intervening eighteen hour period.

There was no evidence from the mother recorded in the case note and it can be assumed that she was still “confined” as it was only forty-eight hours following the birth. It would seem that the mother was the only person present at the child’s death, with the exact time and situation of the death and its discovery not recorded. This again raises the question of why the proceedings of the inquest could not be postponed until the mother, as key witness, was well enough to attend and suggests that her role in this respect was considered unimportant. In this case, the gross pathology appears to have provided sufficient information.

Margery Bax, the daughter of Frederick Bax, a railway clerk, was born on 23 March 1908. Dr Osborn attended the birth and he said that the child was healthy and born full term. Frederick last saw his daughter alive between 10 and 11pm on 26 March. A monthly nurse (“not a midwife”), Louisa Court, was staying with the family for the first week following the birth and was present when Frederick last saw Margery. Louisa was sharing a bed with Mrs Bax and she said that it was usual for a nurse to sleep in the same bed as the mother. Louisa also said that the doctor was aware of the arrangement: “there was not another bed in the room so she thought the doctor might have known”. Frederick understood that this was usual between a nurse and “wife”, and Dr Osborn said that all over London nurses slept in the bed with the mother.

Margery had taken the breast between 5 and 6 am and had fed well. Louisa Court stated that this was Margery’s first feed. Margery was “apparently all right”, lying on her right side on the bed between Louisa and Mrs Bax and there was nothing over her face. Just

after 7am on 27 March, Louisa came out of the bedroom and said to Frederick to “send for the doctor, I believe the child is dead”. Frederick Bax described Margery as pale with “her little mouth open”. He said that there had been a cot in the room and they should have used it but his wife’s parents thought it best to have the child in their bed for the first week. When Dr Osborn arrived at the Bax home after 9am, Margery’s body was cold and stiff, her mouth was open, and her body was blue and especially marked behind. Her eyes were crossed, she had a blue tongue and there was froth coming from her mouth. Margery’s hands were clenched and her toes were turned downward. Dr Osborn observed no marks of violence or pressure anywhere and thought that Margery’s death was due to some obstruction to her respiration. Ludwig Freyberger found that Margery had suffocated due to general acute bronchitis caused by aspiration of uterine contents (amniotic fluid). The verdict of the jury was natural causes (Wellcome: GC140/1/212).

This is the only case in Freyberger’s case notes explored here where it was explicitly reported that a monthly nurse had stayed with the family and shared a bed with the mother and child, although Dr Osborn said this was common practice in London. Other cases refer to the attendance of a monthly nurse, but generally it would seem that they visited the home on a daily basis rather than ‘living-in’. Frederick Bax, a railway clerk, had a good job and a regular wage; Margery was the family’s first child. It is quite possible that the family had managed to save enough money to pay for the 'live-in' attendance of a monthly nurse. The Bax household does not appear to have been as poor as many of the other households detailed here although they were by no means wealthy. That a cot was available in the room but remained unused suggests that bed-sharing was more than an issue governed by space and overcrowding, and instead should be understood as part of normal routine in the practice of infant care. At three days old, Margery’s first feed was approximately one hour before her death. It might seem problematic that a three day old infant had not yet suckled, although it was not unusual to see recorded in the case notes that an infant had fed shortly before being found dead. Frederick’s remark about the presence of a cot in the room is also significant and hints at a suspicion of overlaying on his part with his comment that they “should have used it”. This case, although regarding an infant found dead in bed, was not annotated as such in Freyberger’s header notes and it is possible that, as the header notes were recorded at a later date, this case was accidentally omitted by Freyberger. But it should also be considered that conditions in the Bax household and their relative affluence would have diminished the suspicion of overlaying as a cause of death, and this could also have been the reason Freyberger had not included Margery Bax in the category 'found dead in bed'

The next case provides an example where medical and parental opinion was opposed

with regard to an infant's expectation of life. The body of 4 week old Frederick Babbs was identified by his father. Frederick had been a full term baby, Mrs Babbs's first child, and Dr James Hall attended the confinement. Mrs Babbs thought that Frederick was "hardly full term" but also thought that she would be able to raise him. On the other hand, Dr Hall thought that Frederick would not live as he had had "trouble getting him to breathe at all".

On Christmas evening at 8pm, the Babbs (including Frederick) went to a wedding party and returned home at 1am. Their walk home took about thirty minutes. Mr Babbs said that Frederick had been "cross all day", and he last saw Frederick alive at 1.20am on Christmas morning, when he, Mrs Babbs and Frederick were in bed. Frederick was on Mrs Babbs's left side next to the wall, lying on her pillow. Mrs Babbs fed Frederick at 5am, but he took the breast "badly". Mrs Babbs took Frederick away from the breast and laid him at her side. At 12 noon Mr Babbs awoke and saw Frederick on Mrs Babbs's left side, next to the wall, lying on her pillow. Frederick was "a funny colour, blue and red on the side where [he] had been lying". Frederick was dead. Mr Babbs said that Frederick could not have been suffocated, his face was quite clear. The couple were sleeping in a full size double bed and were "staunch tee-totallers". Mrs Babbs did not know what had caused Frederick's death but she said that he seemed to sneeze and cough a little. Dr Hall was called on Christmas day at about 1.30pm. At that time, Frederick was still warm. Dr Hall said that there were no marks on the child but that the body was discoloured "due to the position of [the] body after death". Dr Hall saw no signs of pneumonia but thought the Babbs had been foolish to take Frederick out at night. Dr Hall also said that Frederick was a delicate baby and reported that his parents "say [they were] fond of d[ecease]d". Freyberger found the cause of death to be suffocation from general bronchitis and broncho-pneumonia. The jury returned a verdict of natural causes (Wellcome: GC140/3/288).

Again, overlaying was an unspoken but possible explanation for Frederick's death. Having been to a wedding party, the possibility was raised that the parents had been drinking alcohol (they did sleep from approximately 1.20am until noon, a trait often associated with those who had been drinking). However, Mr Babbs said they were "staunch tee-totallers", therefore ruling out the possibility of the child being overlain by a parent in a drunken stupor. He also said that the bed was "full size" and that Frederick "could not have been suffocated" as his "face was quite clear", again tacitly addressing the possibility of overlaying.

Expectations about Frederick's life chances were, however, mixed. His parents thought Frederick would live, while Dr Hall thought that he would not. Mrs Babbs thought that Frederick's sneeze and cough did not have any serious consequences and they took Frederick to a party, and walked home with him at 1am. Dr Hall thought the parents were

“foolish” in taking Frederick out at night because he was a delicate child. Dr Hall had had concerns about Frederick’s breathing at his birth. It is not recorded whether Dr Hall saw Frederick in the intervening four weeks between his birth and death, and it is probable that his assessment was based on his contact with Frederick when newborn. Mr and Mrs Babbs did not appear to have shared the doctor's concerns. Dr Hall’s statement that “parents say fond of D[eceas]d” is unusual in conveying information about the emotional aspect of a case. In other cases when this was done, it had the purpose of casting light on the circumstances of death. In this case, perhaps Dr Hall was also saying something that he thought relevant to interpreting the death.

The case of 14 day old Percy White is one where there was a very definite suspicion of overlaying. Percy White was born on 28 September 1910. He was a full term baby and Dr Parker attended the birth. Percy was breast fed and his father described him as very healthy. Percy was the second child of the family (the first having died of measles at the age of 5 months) and he had not been taken out. Percy died on 11 October 1909. Percy’s body was identified by his father who last saw Percy alive at about 12.30am on 11 October. Percy was asleep between his parents in their double bed. Hettie White, mother of Percy, last fed him at about 9.45pm on the night of 10 October. She went to bed at about 10.20pm, taking Percy with her. Percy was lying on the pillow between his parents. Hettie said that the infant was not on her arm. When Hettie woke at 12.30am, Percy was still alive. Hettie woke again at 7.40am. She said that she was “half lying on her stomach” and “partly lying on [Percy]” with “her r[igh]t breast lying over [Percy’s] face”. Hettie had a cramped feeling in her arm. Percy’s nose was not flattened but his mouth was “drawn”. Hettie thought that she must have been lying on Percy because of his colour, his drawn mouth and the pains in her arm. Hettie said that she was a heavy sleeper. Mr White had got up at 7.40am. Percy was lying close to his mother, half on his back. Percy looked very black but there was no blood anywhere. Mr White thought that Percy had suffocated because his colour was “dusky”. When Mr White got up, his wife was no longer lying on Percy, “she had shifted”. The Whites said they had not yet bought a cot for Percy because Mrs White had not wanted to take him out.

The White’s landlady sent for Dr Parker, who saw Percy seven hours after his death. Dr Parker had attended Percy at birth and although he was called to see him four days before his death (for flatulence), he had not attended. The doctor said Hettie thought she had overlain the child, although he could see no signs of it, “No sign of overlaying or pressure on face”, but it could be a possibility. Dr Parker described the Whites as “quite sober, respectable”. He stated that he had not attended their first child, but had no reason to anticipate Percy’s death. In his post-mortem examination, Freyberger attributed death to

suffocation due to broncho-pneumonia and acute bronchitis. The jury returned a verdict of natural causes (Wellcome: GC140/4/286).

When Hettie woke at 7.40am, she found herself partially lying on Percy, with her right breast lying on Percy's face. Hettie's assumption was that she had overlaid Percy and killed him. Why did she make this assumption? We are told that Hettie was a heavy sleeper, that she had cramp in her arm from the way she had been laying, that Percy's colour was unusual (very black – 'dusky' – according to Mr White), and Percy's mouth was drawn. But, Hettie also stated that Percy's nose was not flattened. Mr White thought that Percy had been suffocated, because of his colour, but had not seen his wife overlaying the child. Dr Parker did not, however, agree with the White's assumption of overlaying because he could see no signs of pressure on Percy's face, nor any other sign of overlaying, but it must be remembered that Dr Parker did not see Percy until seven hours after his death. Flattening of the nose in overlaying cases was one of the signs much disputed by medical professionals and the colour of pressure marks and post-mortem lividity can change during this period. Parker dismissed overlaying as a cause because there was no flattening of the nose. Mrs White also mentioned Percy's nose although other factors seem to convince her that she had overlaid Percy. If Dr Parker's view and the evidence of Freyberger are accepted, then Percy must have been dead when Mrs White laid on him, or at least, the overlaying did not contribute to Percy's death. Interestingly, Parker and Freyberger appear to agree on this point, but discussion, if any, they had on the issue is unknown. Mr and Mrs White both appear to be of the opinion that Percy was overlaid and killed by Mrs White. Reference was made to the purchase of a cot, but as reported in other cases a cot had not been obtained because the mother had been lying in or had not wanted to take the child out. It is probable that the mother had no alternative care for the child and so could not go out herself unless she took the child with her, an action that was seen as posing a considerable risk to the child. Alternatively, such reasons could have been given as justification for the parents' failure to purchase a cot when this was portrayed by some as the responsible and correct thing to do.

There is very little information in the case notes for Mabel Knights, but it is interesting nonetheless because of the confusion around the position of Mabel's body when she was found dead by her mother. Mabel was born prematurely on 23 September 1911. She was described as a "7 month child", meaning that she was born approximately two months prematurely. Mrs Cox, a registered midwife, attended the birth and said that Mabel was small but that her development was ordinary. Mabel was fed on a milk and water mixture (3:1) until "her mother's milk came". Mabel took the mixture well and began to thrive. Mrs Cox did not think that Mabel would die. Mabel's grandmother identified the body. She thought

that Mabel had been getting on well for a few days and she thought that Mabel would live.

At 12.20am, 27 September, Mabel had a good feed. She “got bad” in the middle of the night and at 6.20am Mabel’s mother found her dead. Mabel’s position at this time is unclear as she was variously reported as being “by her [mother’s] side”, “dead on her mother’s arm” and “pressed to her [mother’s] side”. Mabel’s mother was reported as being frightened. Mrs Cox said that she had been told by Mabel’s mother that there had been enough room for the child to breathe. No doctor had been called to see Mabel until after her death. Mabel was 5 days old. Freyberger found that Mabel had died from heart failure caused by her premature birth; he described her body as wizened and icteric (yellow). Mabel was 17” in length and weighed 3 lb 9 oz and this was in keeping with her prematurity. The jury returned a verdict of natural causes (Wellcome: GC140/6/71)

There is no information about Mabel’s father and it is likely that he was absent from the household. It is not stated whether Mabel’s mother was married. It would seem that Mabel’s grandmother was the senior person present, because she had the task of identifying the body at the inquest. Any suspicion raised by the confusion surrounding the position of Mabel’s body could have been ill-founded because it is possible that Mabel was on her mother’s arm, at her side and pressed to her mother’s side simultaneously, and in fact, if information about the infant’s position is aggregated in this way, her position does make sense. Mabel was premature and very small. Although her grandmother might have expected Mabel to live, her physical appearance must have been unhealthy because she was small, wizened and yellow, and perhaps the circumstances of her death looked unsurprising to the doctor called to see her dead body. In this sense, the obvious visible pathology of Mabel’s condition countered any suspicion that might have surrounded the death of an infant born to a (probably) single mother.

The case of Frank Mussell’s son provides another case where the body of the child was found partially overlaid by the mother. The unnamed son of Frank Mussell was born full term on 1 November 1911, with Nurse Rossi attending the confinement. The child was breast fed. Frank last saw his son alive at 2am on 17 November, in bed with the child’s mother. Frank was working and had just popped in to see that everything was all right. His wife was in their double bed and the child was “partly awake and partly asleep”. When Frank returned at 6pm, he went to the bedroom and found his wife asleep, lying on her right side, in the middle of the bed. The child was lying to her right “off her arm, under r[igh]t arm with head, D[ecase]d half on side and half on face, half turned toward her, elbow right across face”. Frank picked up the child but he was dead. The child was warm but stiff. Frank saw no marks on the child but his face was very dark. Frank woke his wife. Mrs Mussell had fed the



child at 9am. She last remembered that she fed the child on her right side, not on her arm. The child was lying about 6" from her. She was sleeping, elbow bent, with her right hand on her cheek. When Frank woke his wife, he noticed that she awoke as if from a faint rather than as from sleep. Frank thought his wife must have fainted and had had faints before.

Mrs Sergeant, maternal grandmother, saw her daughter at 6.20am on the morning of the infant's death. She said that her daughter had told her on the morning of the death that she had felt "faint and giddy" and had got up to get a drink of water. Mrs Mussell had gone back to bed and remembered no more after that. Nurse Rossi attended mother and child for ten days. She thought that Mrs Mussell was a very good mother "for a first baby's mother". A police constable was called to the house following the baby's death, by which time the child had been placed in an armchair in the kitchen. He described the child as black around the mouth, face and left arm while the face was white. He said that Mrs Mussell was much distressed.

Freyberger found the cause of death to be suffocation while suffering from bronchitis and congenital malformation of the heart. The child's nostrils were blocked with "greyish white mucous". He also found patent foramen ovale (hole in the heart) and ecchymoses (blood spots) in the thymus, lungs and heart. Unusually, the condition of the infant's ribs is described in the post-mortem details, stating that there were no breaks or fractures of the ribs. The jury returned a verdict of natural death (Wellcome: GC140/6/114).

There is a suggestion that Mrs Mussell overlaid her child when in a faint. Frank stated that she awoke as if from a faint and Mrs Sergeant reported her daughter complaining of feeling faint and giddy. Mrs Mussell did not remember anything after feeding her child at 9am until her husband roused her at 6pm. This is a very long period of time (9 hours) for Mrs Mussell to be unconscious and for the infant to be unattended, although her husband's ability to rouse her would suggest that at that time she was sleeping. It would seem that the infant could have been dead for some while because rigor mortis had commenced.

The position of the infant's body when Mr Mussell came home was described as being "half on side and half on face", with Mrs Mussell's elbow across the infant's face. This position might have caused suffocation if the weight of the arm restricted the airway or pushed the infant's face into the bedding or mattress, but contact between their bodies would seem to have been minimal. The infant died at some time during the day while Mrs Mussell lay asleep or unconscious, but it is impossible to say whether these events were connected. Freyberger's description of the infant's ribs is interesting because it was unusual and one reading could interpret it as Freyberger looking for broken ribs subsequent to compression of the child chest following overlaying.

Harriet Cresswell was 4 weeks old when she died on 11 December 1911, the first child of the family. Harriet had had a slight cold and her mother, Alice Cresswell, rubbed her chest with camphor oil. However, the child had been taken out the previous week and Harriet's parents were not anxious about her. Harriet's father got up for work at 6.30am and thought that Harriet was much better. She seemed all right and was asleep. Mr Cresswell went off to work. Alice Cresswell breast fed the child at 6.30am. Alice gave Harriet the breast every two hours because she thought she was thirsty. Alice put the child in bed beside her. At 9.15am, she picked Harriet up and found she was dead. Alice did not know what had caused Harriet's death. Freyberger conducted a post-mortem examination and found that Harriet had died from acute broncho-pneumonia and general bronchitis. The jury returned a verdict of natural causes (Wellcome: GC140/6/147).

The next case concerns Lily Goldsmith who was born at full term and described as a "strong child". Lily was the fifth child of the family and at the time of the inquest two of her siblings were already dead, "one with consumptive bowel" and one "D&V"<sup>12</sup>. Lily was one month old and her body was identified by her mother. Lily had "had a little cold, no cough" and her mother "first noticed anything on Monday when d[eceased] had a little wind". Lily's mother went to bed at 9.20pm, taking Lily with her. They were in a full size bed. At 4.30am Mrs Goldsmith wanted to feed Lily, who was laying on the bolster, facing her mother, her face quite pale. She touched Lily and found her dead. Lily's mother called Dr Thyme, who confirmed that the child was dead. Dr Thyme knew the child "quite well" and he said that Lily's mother had been very badly off lately. Lily had been vaccinated ten days previously by Dr Thyme. He had inspected her arm a week later and it was quite normal and Lily was "doing nicely". Dr Thyme had been called from a confinement on Tuesday morning, 17 December, at 4am. The child was already dead, her face was livid but there were "no signs of injury about the child". Lily was lying in bed with her face outward. Her body had been moved. Freyberger conducted his post-mortem examination of the body and found death to have been caused by suffocation from acute bronchitis. The child's lungs were found to be extensively collapsed. The jury returned a verdict of natural causes (Wellcome: GC140/6/249).

Thomas Alfred Smith was 3 weeks old when he died on 7 February 1909. Thomas was the ninth child of the family and only five of his siblings were living at the time of the inquest. Although Thomas was premature (he was a "7 month child"), his father described him as "not weak at birth". Thomas was breast fed at first but "then [the] breast went off" and he was fed on cow's milk and barley water; his diet was agreed with the doctor. Thomas

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12 Diarrhoea and vomiting

had had a cold, but he had not been seen by a doctor and his parents did not expect his death. On Saturday 6 February 1909, the Smiths moved lodgings from one street to another. This was the first time that Thomas had been taken out. Mrs Smith said that Thomas's cold did not get worse. He had been outside for about seven minutes between 4 and 5pm. Mr Smith last saw Thomas alive at 1am on Sunday morning (7 February). Thomas was in bed with his parents, lying between his mother and the wall on Mrs Smith's arm. Mrs Smith awoke at 8am on Sunday morning; Thomas was still on her arm with his face against her shoulder. Thomas's father said that Thomas looked "very bad" and he thought that Thomas was dead. Thomas's body was still warm, there was blood on the pillow and a blood-stained discharge was coming from Thomas's nose and there was also blood on Mrs Smith's nightdress. Mrs Smith was asked at the inquest, if her shoulder might have prevented Thomas from breathing and she said that it might have done so. Mr Smith said that Thomas might have been suffocated but he did not think so. Mrs Smith said that Thomas's hands were slightly bent, although Mr Smith did not notice the position of Thomas's hands. Neither of Thomas's parents could explain his death, they said that Thomas was not insured, they had not been to any public house and that there was no other child in the bed. The post-mortem conducted by Freyberger found that Thomas's death was due to failure of the heart accelerated by broncho-pneumonia, pulmonary stenosis and weakness due to premature birth. At his death, Thomas's body was 17" in length and weighed 4 lb. The jury returned a verdict of natural causes (Wellcome: GC140/2/152).

Again, there are suggestions in this case that the parents were acting to refute the suggestion of overlaying. Unusually, the suspicion that overlaying of the infant might have caused the death was addressed directly, presumably by the coroner, and although Mrs Smith denied the suggestion she was also open to the possibility that it was so. Blood-staining on the mother's night clothes was taken as evidence of overlaying in other cases but despite this, and in the presence of the pathology identified by Freyberger, a verdict of natural cause was returned. It was in cases such as this (in the absence of a post-mortem examination by forensic pathologist) that the assumption of overlaying was usually made and a verdict of accidental death was returned. This case therefore serves to illustrate the important role that Freyberger played in constituting such deaths as due to natural causes rather than as due to maternal culpability, ignorance and neglect, and also indicates Freyberger's role in challenging the overlaying thesis.

The unnamed male child of John Wesley Lyth died at 3am on 14 December 1908, and was 26 hours old. The child was the seventh of the family and only four of his siblings were still living at the time of his death. The child was born prematurely; his birth was not

expected until 27 December. Dr Gilbert Cope attended the confinement and said that the birth was “quite normal”. The child's father thought him healthy and last saw him alive in bed with his wife at about 6.15am. John noted that when the child was dressed by the nurse (presumably shortly after birth) he had had “continual motions” and “several napkins had to be used”. The nurse had dressed the child because she said his arms and legs were cold. At about 11.20am, the child was found dead in bed by his maternal grandmother. Mrs Lyth had asked her mother if the child was all right. The child was lying on his right side with his hands raised to his face and “his hands were cold and clenched”. At that time, there was no sign of any discharge coming from the child. Afterwards, John saw “a great deal of blood coming apparently from his mouth”. The child was lying at his wife's side, not on her arm. John thought that “something wh[ich] caused flow of blood killed [the child].” John said that his son could not have been suffocated because he had gone into the room several times and seen the child's face. Dr Cope said that he had been called at about 1pm by which time the child had been dead some hours. He said the child's hands were clenched and very pale, that there was venous congestion of the right side of the face and nose and also that there was a considerable amount of blood-stained serum on the child's right shoulder and in both nostrils. Dr Cope thought that the cause of death was “doubtful”. Mrs Lyth had told him that the child had been lying on the right side of his face and the parents could not account for the death. The child had cried “heartily” at birth. Freyberger found death to be caused by suffocation from actelectasis redux and aspiration of uterine contents during the act of birth. The jury returned a verdict of natural causes (Wellcome: GC140/2/66).

Although Dr Cope might have had suspicions about the circumstances of this infant's death, these must have been taken as less significant than Freyberger's post-mortem examination evidence. The series of symptoms described by the parents suggests that the infant was experiencing problems immediately following its birth and that in the circumstances suspicion about the infant's death was misplaced. Strangely, with the amount of blood reportedly lost by the infant, there is no mention of blood on the mother or her night clothes.

The record of Eva Harrison's death is brief. The case notes contain little information but do make a direct reference to a mother's views on bed-sharing and provide evidence that bed-sharing was considered normal practice. Eva Harrison was the sixth child of the Harrison family. Her five siblings were all alive at the time of her death. Eva's body was identified by her mother. Eva had been “a little cross on Saturday [and had] a slight cough”. She was taken to bed on Saturday night (6 February 1912) at about 11.20pm by her mother. She was lying on her mother's arm, outside of the covers. Eva was given the breast between

2 and 3am (7th February). Eva's mother said that she had taken "all her babies in bed w[ith] her; this [was the] first she lost". When she woke between 5 and 5.20am, Eva was still lying on her arm, lying on her back with nothing covering her face. Eva's body felt cold and when her mother picked her up Eva did not wake. Eva's mother sent for a doctor at once. She did not think that Eva was suffocated and she could not account for Eva's death. Eva had never been taken out. [Mrs] Harrison said that her rooms were "rather cold". Freyberger conducted his post-mortem examination and found that Eva had died due to failure of the heart, disseminated broncho-pneumonia and bronchitis. He said that the body was "fairly nourished" weighing 7 lb 12 oz (length 19"). The jury returned a verdict of natural causes (Wellcome: GC140/6/218)

Eva Harrison's case notes do not contain much information. The infant was asleep on her mother's arm in bed where she was found dead. Eva had shown some signs of illness (a slight cough) but there were no signs that made her mother anxious about Eva. The doctor was called "at once" when Eva's death was discovered and it is assumed that her mother would have sought medical attention for Eva if her health had been poor or worrying. The child was small for her age (her length and weight being that of a new born infant). There was no suggestion of suffocation or overlaying recorded in the case notes. Mrs Harrison did, however, make a direct statement regarding bed-sharing, and this case provides evidence that bed-sharing was considered, by some, to be normal and routine practice. Unlike other mothers whose infants had been found dead in bed, Mrs Harrison states that this was her regular practice and that having previously raised five children (presumably successfully) she saw no problem with taking the infant Eva into bed with her. There is, however, a sense of defiance in her statement and this raises the possibility that, in the circumstance, Mrs Harrison felt that her behaviour was being challenged by the court and it had been implied she had had a role in Eva's death.

## **Conclusion**

This chapter details twenty-two cases of newborn infants who were found dead in bed. Dr Ludwig Freyberger and Coroner John Troutbeck, in whose court the inquests were held, provided a direct challenge to the dominant overlaying thesis that prevailed at the time-period of these cases. Both the overlaying thesis – seen in the evidence of GPs – and the myth of overlaying - seen in the evidence of lay witnesses – pervade the case notes and it was only by repeated recourse to forensic pathology that this was overcome. It is for this reason alone that the verdicts in Troutbeck's court are routinely returned as due to natural causes, while in other cases in other districts of London the verdicts in very similar

circumstances (but without forensic post-mortem examination) were returned as being due to accidental death by overlaying.

In Freyberger's case notes bed-sharing is portrayed as a normalised behaviour and practice that was being routinely challenged by official discourses around infant care, domestic space and intimacy. Relatedly, inquest witnesses were routinely questioned about bed-sharing and sleep arrangements within the household. In these circumstances it is reasonable to presume that bed-sharing was construed as having had a possible role in the sudden death of infants in bed. That bed-sharing was seen as a normal practice is also demonstrated when infants were taken into the maternal bed even when other sleep arrangements were possible. Although bed-sharing was routine, it had distinct features associated with gender and age. Fathers were often reported as not sharing the bed in the immediate period following the birth, but this is not to suggest that bed-sharing at this time was completely prohibited, because it is usually only the father who was excluded. Others, such as the monthly nurse, neighbours (presumably but not always female) and other children, are frequently reported as being present in the bed at the time of the infant's death. This clearly marks out interesting but previously unrecognised ideas about intimacy and bed-sharing in the context of birth and the immediate post-natal period. At these times the conjugal bed was constructed as a space for mothers, infants, other children and (female) nurses, but not the (male) father. This could be explained in one of two ways. Firstly, in the immediate post-natal period the bed was not considered to be a conjugal space and therefore was also constructed as a non-intimate space. Secondly, it was constructed as a space of intimacy between women, their birth attendants and their children. As has already been stated, during the time-period explored in this thesis, the bed(room) was being re-organised and there were situations in which bed-sharing was not yet considered to be an intimate interaction. This is seen, for example, with the sharing of beds and bedrooms by employees (servants or shop staff) employed in what were considered to be 'live-in' positions. Ultimately, it is most likely that a combination of these provided the reality of the way the bed(room) was organised in relation to intimacy in the cases detailed above, so that during the immediate post-natal period women were considered sexually unavailable, the bed was not considered to be a space of purely conjugal intimacy at any time, and the sharing of the bed by the mother, attendant and other children, was not necessarily construed as an intimate act.

Common practices around pregnancy, labour and birth in relation to midwifery, monthly nurses and lay birth attendants are also highlighted in this chapter, and there was a marked distinction between the actual behaviours of people at and around the time of birth

and the practices prescribed by legal and official discourses. These provide an important reminder of the methodological issues around accepting legal statute and professional or official instruction as a proxy or indicator of practice.

The role of poverty in the cases discussed is also relevant in as much as it was within poorer households that the suspicion of overlaying was most readily seen. In these cases, reference was frequently made to payment for medical attendance and assistance at the birth. In at least one case, the mother said she had not called a doctor because she could not afford the fee. In some cases the poverty of the household was reported directly, in others it was referred to obliquely. But poverty and overcrowding do not provide the explanation for bed-sharing, because its occurrence was also reported in cases where there was space and provision for the infant to sleep separately from its parents and siblings. Instead, bed-sharing especially with newborn infants was considered by many of the women and their families as the preferred way to care for their infants. Although this was sometimes challenged, the evidence suggests overwhelming that the women detailed here took their infants into bed with them because they thought it was the correct thing to do. It is not that the women were unaware of the risk posed to their children by overlaying. The evidence suggests that they were neither ignorant nor careless and neglectful in this regard. Instead, in most of the cases the women described various strategies that they adopted to ensure the safety of their infants while bed-sharing – placing the infant on a pillow, on top of the covers, away from others – and as such they were acting as both responsible and knowledgeable in relation to risk and infant welfare. With regard to intemperance, alcohol would seem to be of little or no relevance to these cases; and although parents were sometimes referred to as abstemious generally, discussion of their habits in relation to alcohol does not appear to be an issue here.

One remarkable feature of these cases is the absence of the mother from the inquest proceedings. Often the mother was the only witness to either (or both) the birth or death of the infants concerned, and as such they were the only people who could have provided eye-witness testimony. The practice of 'lying-in' after a birth might have meant, in the death of infants in the first week or so of life, that the mother was considered unable to attend court - but should this have been justification enough for their absence? It would seem that if the inquest properly fulfilled its purpose, then the testimony of the key witness should have been included. It is unclear whether the testimony of mothers was seen as unnecessary, or whether the business of the inquest was so pressing that no postponement could be made. In either case, the evidence appears strangely incomplete without the testimony of mothers regarding the deaths of their children.

On the few occasions when the circumstances of an infant's death might have

appeared suspicious (for example, the Toovey, Hudson, and Tuckey infants) the situation did not always raise interest or stimulate direct comment. When signs of suffocation were raised as a possibility, they were always subsequently rejected by the pathologist and coroner's jury. The pathology of overlaying and suffocation was not straightforward, yet within Troutbeck's jurisdiction and with the assistance of Freyberger, the discourse of overlaying operated to the exclusion of both the myth and thesis of overlaying, so that infants were never (finally) considered to have been killed by being overlaid.

The detailed information recorded in these cases concerns the immediate context of sudden and unexpected infant death in bed and the medico-legal proceedings that followed. In sociological terms these provide the opportunity for exploring overlaying death as a socio-structural event grounded in the experience of individual women. The discussion that follows sets out the socio-structural conditions of overlaying as they unfolded in relation to mothers (and others) as agents. In particular it analyses the discourse of overlaying as it is shown to have influenced the conditions in which the women acted out their mothering both before and after the death of their infants. Central to this discussion is the way that women employed the overlaying discourse in conjunction with other influences to make sense of, and interpret the deaths of their infants.

Many of the mothers who found their infants dead reported they did not expect the death nor indeed did they recognise that their infant was dead in the first instance. This testifies to the unexpected nature of overlaying as a death event. Many mothers reported their infants as looking 'normal' when they were discovered dead. Such deaths, unexpected and without signs of violence generally connoted overlaying. But overlaying as the cause of death was not necessarily the assumption made by mothers in the first instance. Instead, mothers usually reported that they did not know what had caused the death of their infants. How then did the idea of overlaying enter into the explanation of infant death in these circumstances?

In cases where the mother was the first person to find the infant dead they reported the health and behaviour of the infant in the period immediate preceding death. Usually, this was by reference to the last time they were awake with the infant, and they often reported breast feeding and positioning the infant prior to sleep. The appearance of the baby and its interaction with the mother, in the first instance led the mother to consider the infant's sudden and unexpected death as non-sensical; she did not know, and could not explain, why the infant had died. Reports from the mother regarding positioning the infant, for example, on a pillow suggest that she was aware that the sleep position of the infant in relation to herself or others was relevant in this context. Mothers also reported the position of the infant in relation



to bedclothes and pillows. The positioning of the infant was an issue raised during the inquest, but the actions reportedly taken by mothers before their infant's death show that this was already something that was meaningful to them in their practice of mothering and bed-sharing. It also formed part of their sense-making narrative of events at the time. The practice of positioning the infant in a particular sleep position suggests awareness that sleep position was significant and was probably understood in terms of infant welfare as well as practicality or comfort. Many of the women detailed in these cases were therefore acting in relation to the overlaying discourse before the death of their infants occurred. It is reasonable to assume that the potential risk of overlaying informed the way these mothers practised bed-sharing and acted to minimise the risk of overlay. As these events unfolded, how then was the potential risk of overlay transformed into the overlaying death?

It appears, in most cases, that women did not in the first instance assume that overlaying was the cause of their infant's death. This is interesting because although they were shown as acting to safeguard their infants from overlaying, mothers did not immediately assume that they had failed in this respect. Instead, they looked first for other causes. The explanation for this can only be located in the immediate context, and the experience and knowledge of the women in relation to the infant. For these women there was nothing to suggest that they had killed their infants. The most that was claimed was that a breast or arm had partially covered the infant's face. The experience of these women bed-sharing with their infants, sleeping and breast-feeding them may have provided experience enough for them to know categorically that they did not overlay the infant.

Discussion of the different ways in which the infant body was portrayed during this time-period becomes important in this respect. Throughout the discourse of overlaying, infant bodies were constructed as passive and compliant and this is in contradiction to discourses around intimacy, the family and the bed(room) where infant bodies were constructed as unruly, unsocialised, disruptive and as actively transgressive of normative boundaries. The infant body was both the passive victim of overlaying and the compliant subject of the post-mortem examination offering its pathology in explanation of its death. But at the same time it was the unruly and active body that breached social norms and was consequently sequestered. What this suggests is that while the dead infant body was indeed amenable to the role of passive victim essential to the overlaying discourse, the living infant body was active and would make known its needs without regard to its social context. It must be remembered that the mothers described here, who woke to find their infants dead, had until that point experienced them as active, noisy, demanding, messy and in all ways as individuals with whom they had interaction. These infants were not perceived by their

mothers to be passive victims who died without a struggle, lying quietly as if asleep. It is not surprising then that mothers did not readily accept overlaying as an explanation of their infant's death.

These cases show that an analytical distinction must be made between mothers who acted to prevent overlaying and those who either considered or assumed that overlaying had caused the death of their infant or those who did not. In this respect, mothers might have acted to reduce the possibility of overlay yet not considered it in the first instance as a cause of their infant's death. This raises the question of when (or if) overlay entered into the sense-making narratives of mothers subsequent to the discovery of their infants death?

The suspicion of overlaying was reported in some cases before the involvement of others from beyond the immediate household or family context. When infants died in these circumstances an explanation of death was sought in the immediate aftermath by the mother or father. Upon finding their infant dead, the mother looked first to the health and behaviour of the infant in the period immediate preceding the death. Usually this was by reference to the last time she was awake with the infant and mothers often referred to breast feeding and positioning the infant prior to sleep. Some women reported that they awoke to find a part of their body laying over the infant, for example, an arm or breast. In these cases, although the mothers acknowledged the possibility of overlaying they generally did not report it as more than this and no mother claimed at an inquest that she had overlaid and killed her infant. The mothers who had expressed concern that they had overlaid their infants and had suggested this as a possible cause were subsequently convinced otherwise. Fathers were often the first or second person (after the mother) to discover the death of an infant. In cases where they were first to discover the death it was usually because of the appearance of the infant and in these case the infants were often described as looking 'strange' or 'dark'. It is in this context, and on discovery of such a death that overlaying was reported as a possibility in the first instance. It is these cases (and the case of William Wheeler from Chapter Two) that suggests infant overlaying death was within the knowledgeability of the mothers and fathers whose accounts are reported here. Can it be claimed, however, that this knowledge was present before they had experienced the death of their own infant and thus formed part of their sense-making narrative in interpretation of the event. It is within the immediate context of the infant death that mothers sometimes acknowledged but subsequently rejected overlaying as a casual explanation of death. Fathers, although they referred to overlaying as a possible cause of death more frequently than did mothers, also subsequently rejected it as an explanation of death. It was in this way that the situation was first assessed by those immediately involved in terms of what they knew of the context and recent past in relation to

the infant and overlaying as a possible cause of infant death. In these terms, knowledge of overlaying was one aspect of the socio-structural conditions in which the deaths occurred; that is, the rules and resources as conditions of action for the individuals concerned, their knowledgeability and agency as manifest in their action. The practices of mothers were influenced by the possibility of overlaying before the death of their own infant occurred. This raises important question about, why in light of this knowledge did women continue to bed-share with their infants? One possible reason was that the risk of overlaying appeared to be remote when compared to the benefits that bed-sharing offered. A second reason is that that women were constrained to bed-share by their material circumstances, although, as already noted the decision to bed-share was also made when conditions allowed other possible arrangements. Another reason (and one to which I will return) is that women's direct experience of mothering and bed-sharing could have played a greater part in their practice than did the more remote and impersonal discourse of overlaying.

The presence of others, both family and non-family, was also reported at the time of and around discovery of a death. The relationship between those individuals involved at this point was important because while family members did not generally set the death against the background of the household, non-family participants did. This is seen, for example, with references to household conditions, poverty and alcohol use. Immediate family members did not usually comment on the impoverished conditions in which they lived, while others sometimes did. In this way the wider context of the death began to enter into the sense-making reported by witnesses. Grandmothers and the female neighbours either present or called later to the discovery of the death did not usually report a suspicion of overlaying although some (as did mothers and fathers) spoke to refute it. The possibility of overlaying was therefore part of both the external and internal socio-structural conditions that influenced interpretation of these death events.

What becomes apparent through reading these cases is that the relationship of an individual to the event mediated their interpretation of the death. Proximity to the event and relationship to the infant, mother and family served to frame interpretation of the death. It also served to shape the reporting of death in the formal context of the inquest. As people were brought into a relationship with the death their reports became less focused on the infant and more focused on the circumstances and socio-structural conditions. This change was marked most clearly by the doctor called to the scene. The doctor, who might have known the mother and infant in life, reported firstly on the infant and its body and then on its health and his expectations of this. This then might be followed by his report about the circumstances as told to him, the household, their habits and moral character. Often the

doctor's report had little of direct relevance to the immediate circumstances of the death. Usually the body had been moved and 'laid out' and the scene had been re-organised in terms of the death and the infant corpse by the time the doctor visited the household. At this point the possibility of overlaying became apparent if it had not already been raised. The doctor's report also contained his suspicion of overlay or its refutation in terms of his belief or what has been told to him. This was often in terms of the 'character' of the mother and father and the material conditions in which they lived. Poverty, overcrowding and employment informed the reporting of death in this way. Following the doctor, police or coroners' officers sometimes became involved and this constituted the death event as suspicious, and consequently, the coroner also became involved. The discourse of overlaying is supported by these events and in the immediate context of death the myth of overlaying was restated.

It is at this point that the cases detailed in this chapter diverge in their outcome from those detailed elsewhere. When coroner John Troutbeck was notified of a sudden infant death in bed he would send an official message to pathologist Dr Ludwig Freyberger requesting that a post-mortem examination of the body be made. The infant body would then be removed to the mortuary, which in these cases was usually part of the newly built coroner's court where it would remain until after the inquest. It was through the post-mortem examination conducted by Freyberger and the inquest presided over by Troutbeck that suspicion of overlaying was finally allayed. The discourse of overlaying is therefore evident in the cases detailed here from a point before the deaths occurred and remains evident even at the point when a verdict of natural causes is returned by the coroner's jury because the verdict itself served as a refutation of overlaying.

The infant deaths detailed here show that overlaying was constituted through several means, most notably the infant body and its position at death including its presence in a shared bed-space, and its positioning within that space, the attitude of the mother and in particular that she was asleep at the time of death. Overlaying deaths were also constituted by the social positioning of the household and its economic status. Importantly, despite the presence of the (male) father and other siblings, overlaying was always constituted through the action of the mother and her responsibility and was also therefore gendered female.

These cases also raise questions about the agency and practice positions of women in terms of overlaying death as set against the broader social background. Mothers in particular were marginalised within the inquest process. Mothers reported taking action to safeguard their infants and attend to their welfare but the overlaying death ultimately represented their purported failure in this respect. The discourse of overlaying undoubtedly formed part of the general disposition of mothers acquired as knowledge through the myth of overlaying. This

was the understanding that infants died in bed with their mothers as a consequence of overlaying. Individual women may or may not have had direct experience of overlaying, awareness of a specific overlaying death by someone personally known to them, or anecdotal knowledge of overlaying. Alternatively women may have had no idea of overlaying as a possibility, although this would seem unlikely. In all but the last instance, the agency of individual women would have been influenced by overlaying as a socio-structural condition of their actions. It is also possible that even in the event a woman had never encountered the idea of overlaying, the existence of a general discourse surrounding overlaying death would shape the socio-structural conditions of her action beyond her knowledge. It is through these means that all women as (potential) overlaying mothers had their practice as knowledgeable agents shaped by the discourse of overlaying. It is apparent, however, that women at this time were not constrained in their action by the overlaying discourse to the extent that they refrained from bed-sharing. Only that they were aware of overlaying as a possibility and acted to limited its risk. Why was this the case, when to do so would have circumscribed any accusation of failure or culpability that accompanied the death of an overlaid infant? This can be explained in a number of ways. Chief among these was that women's direct experience of bed-sharing and infant care served to undermine the discourse of overlaying in relation to them as individuals. The myth of overlaying in this sense was taken by them to refer to other mothers and their infants. Alternatively, the overlaying thesis, constructed in terms of maternal neglect and ignorance was also construed as something that applied to other mothers. It is also possible that other socio-structural conditions were experienced as greater constraints or enablements than the overlaying discourse. This could be in terms of the material conditions experienced by women, although this has already been noted as unlikely. It is more likely that bed-sharing represented the taken-for-granted practice of infant care for these women at the time, and that subsequent changes in discourses surrounding bed(room) space, intimacy and infant care had not yet become dominant in the lives of these mothers c1900. The (non) normative discourses around these practices, although generally apparent through historical research, were not yet a feature of the way these women carried out their day-to-day activities. What becomes clear, however, is that this also raises questions about the differing position practices of women and others to the overlaying discourse as a socio-structural condition of action in terms of their ability to engage or transform it. It is clear that it was not the actions of the individual mothers in these cases that eventually cast aside the assumption of overlaying. Instead it was Troutbeck and Freyberger through their offices as coroner and pathologist, because there is nothing to indicate that before their intervention these cases differed in any way from those in Somers Town.

## **Chapter Six: 'The Medical Man, the Coroner and the Pathologist': Overlaying and Diagnosis**

### **Introduction**

This chapter explores the long running dispute that occurred between the general medical practitioners (GPs) of south-west London, coroner John Troutbeck and his pathologist Ludwig Freyberger. Much of this dispute centered on the issue of infant overlaying and the role of GPs as expert witnesses in the inquest process. This discussion demonstrates the way divisions about medical knowledge, knowledge claims, status and national identity became crystallized around the issue of infant overlaying, while the overlain infants themselves were marginalized within the debate. It also demonstrates the way that overlaying death became significant in issues to which it was in a sense peripheral, and that overlaying as a diagnosis had become detached from aspects of medicine and pathology in which it was supposedly embedded. Building on the detailed case notes explored in the last chapter, the material that follows also provides important information about the way that coroner Troutbeck and pathologist Freyberger became involved in the deaths of supposedly overlain infants. It therefore provides an insight into the official processes that were initiated by an overlaying death and casts light on the way overlaying was discussed by medico-legal professionals at the time. Importantly, this chapter also serves as an account of the ways that individuals engaged with the discourse of overlaying as socio-structural conditions of action (in terms of rules and resources) in their situated practice, drawing on it to support their roles and actions.

The period between 1902 and 1906 was marked by Troutbeck's attempts to reform the coronership of the South West London District despite vociferous opposition from the local GPs. The reforms (driven by demands from Troutbeck's employers, the London County Council (LCC)) were seen firstly in Troutbeck's insistence that post-mortem examinations be conducted by a skilled pathologist; and secondly through his employment of Freyberger as specialist pathologist in this role. Throughout the period of his appointment to the South West London District, Troutbeck employed Freyberger's skills in forensic pathology in what appears to be the majority of cases in which he felt a post-mortem examination was required. Freyberger undoubtedly made significant financial gain from this employment but his services were never really employed by coroners in other districts and the work for Troutbeck appears to have been the mainstay of his practice. It is therefore no coincidence, that following Troutbeck's death in 1912, Freyberger disappeared from reports of inquests in the London press and returned to his previous obscurity.

Beyond the personal stories of these men and their encounters were changes in broader medical, social and legal attitudes relating to sudden death and its investigation already discussed in the thesis. In the sphere of medicine, scientific methods brought new understanding of physiology and death of the human body (Behlmer: 2003; Weatherall: 1996). Alongside this, specialisation within the medical profession was reshaping the role of the general medical practitioner and this saw GPs taking on the more routine role of dealing with day-to-day health issues, while complex cases were increasingly referred to specialist practitioners (Littlejohn: 1903; Smith: 1825). Against this background (and detailed in this chapter) the claim that GPs were adequately trained to conduct post-mortem examinations gave way to the role of the specialist pathologist and forensic pathology (Burney: 2000; Cummin: 1837). Cause of death was now to be determined according to pathology manifest in the body (Armstrong: 1986; Prior: 1989). As part of this, deaths that were previously attributed to ‘acts of God’ were reinterpreted in terms of accident, industrial injury or disease (Strange: 2003). In its turn, medical scientific knowledge and understanding of the body was also influencing lay perceptions of health, with environmental factors such as nutrition, working conditions and poverty increasingly construed as influences on the body (BPP: 1885: C4402). In a broader sense, understandings of class and gender were also developing in a way that linked both of these social categories to an individual’s quality of life (Booth: 1898; Ross: 1994). These influences were therefore also being interpreted as factors that could impact the body for both good and ill.

There were also significant changes in the way that the infant body and infant death were perceived (Armstrong: 1986; Pelling: 1988; Pooley: 2010). Infant bodies, vulnerable and dependent, were susceptible to a host of misfortunes but the interpretation of infant death was being re-configured and the previously ‘natural’ event expected within each family was being transformed into a death attributed to accident or illness that could and should have been prevented (Lewis: 1980). The infant body was becoming the subject of scrutiny in a way that had not previously been possible. Infant bodies were seen to be susceptible to a range of maladies that could now be identified as rooted in the environment. Nutritional diarrhoea, poor hygiene and even maternal ill-health during pregnancy were all seen as factors that could cause infant disease and death (Ferguson: 2004; Newman: 1906). In addition, poor and sickly infants were also seen as the origin of an adult population that was unfit to serve the nation (Maurice: 1902; Newman: 1906). If the adult population was to be literally fighting fit, it was necessary to produce strong healthy infants and children, and the responsibility for this task belonged to the mothers of the nation (Newman: 1906; Searle: 1971). But as will be demonstrated, responsibility for this carried with it the risk of maternal

culpability, with mothers seen as culpable for the death and illness of their infants (Garrett et al: 2006). In this sense, it is the dependency and vulnerability of the infant body that clearly creates its corollary of maternal culpability. This is not to claim that women were not previously blamed for the death or ill-health of their children; indeed they were, but the range of their perceived responsibilities was being re-configured and increased at this time. There were many reasons for this, but improved understanding of disease, nutrition and feeding on the one hand, and the poor living and working conditions of women in an increasingly urbanised society on the other, combined to increase the demands of maternal care while diminishing the conditions and resources in and by which women mothered their infants. It was during the latter part of the nineteenth century that infant welfare really became a social concern and the sense emerged that, if only women were to take better care of their infants, then infant mortality would be greatly reduced (Lewis: 1980; McLeary: 1933; Newman: 1906). It was also at this time that infants were construed as dying from preventable causes. In this way, improper feeding and accidents such as overlaying, replaced act of God as the cause of infant deaths.

Amid these changes, the role of the State was also evolving; this included an expanding bureaucratic framework able to monitor the population to an extent never before seen in the UK (Giddens: 1990). This involved not only the registration of births and deaths but also a growing legislative framework which increasingly encroached on the day-to-day lives of individuals in birth, illness and death (Armstrong: 1986). In this, practices around pregnancy, child birth, disease control, death and burial supplemented the gathering of statistical information about the population, and legislation was introduced to prescribe the role of midwives, the recording of births, the notification of contagious disease and the registration and certification of death. Alongside this there was a strengthening of the British state and the notion of 'Britishness' or 'Englishness' entered into proceedings. In this way, the Austrian Dr Freyberger, labelled by many as foreign, was seen as doing things in a 'foreign', rather than British, way and as such he brought with him ideas and practices that were foreign to south-west London.

Exploring the relationship between medical practitioners on the one hand and the coroner and pathologist on the other, points up the way in which overlaying was considered by GPs to be one of the routine and common causes of death in infants, and also shows how medical practitioners responded when their authority and income were threatened. The response of GPs when challenged by coroner Troutbeck was to withdraw cooperation from the inquest process and to agitate against Troutbeck and Freyberger. The consequence was that overlaying became the issue around which lines of argument hardened and the diagnosis



of infant death in bed as overlaying became a point against which the practice of Troutbeck, Freyberger and the GPs was measured. A situation arose in which the actions of Troutbeck and Freyberger became aligned with refutation of overlaying as a routine cause of infant death, while the GPs continued to support the overlaying thesis. Having adopted this position, it became difficult for the GPs involved subsequently to accept Freyberger's diagnoses without undermining their own position.

In simple terms, in order to maintain their role as post-mortem examiners, GPs had to continue to claim overlaying as the cause of infant death in bed; to do otherwise was to accept the claim that Freyberger's specialist knowledge was superior to their own. There is no doubt that the prevalence of the overlaying verdict during this period was in large part due to the way in which GPs and coroners accepted overlaying as a routine risk of infancy and bed-sharing and subsequent suffocation or asphyxia as a natural or accidental death with the verdict delivered according to the particular coroner or jury. But it is also apparent that, by definition, acceptance of the overlaying thesis necessitated rejection of Freyberger and other explanations of such deaths.

Overlaying death in this way became the contested area over which the dispute raged. Freyberger challenged the overlaying thesis and Troutbeck (regardless of any personal opinion) used Freyberger's evidence to challenge the GPs. The action of Troutbeck and Freyberger in their challenge to the overlaying thesis raises a number of issues. Then as now death by overlaying could not be demonstrated by post-mortem examination in the mortuary (Mitchell, Krause and Byard: 2002: 133). And so it was against this empty vista of medical pathology that claims for and against the overlaying thesis were made. The social constitution of overlaying was dependent on a scenario whereby mothers were constructed as responsible for the death of their infants by carelessness, neglect or accident; and in the accounts that follow, these are situations presented by GPs in and around the inquest setting. The main focus of these accounts, however, was neither the inquest nor the corpse. Instead it was the process of the inquest that was at issue. Consequently, lay witnesses - especially mothers - were not represented and death attribution took second place to arguments about the right to attribute cause of death. It was the intangibility of overlaying and its secondary role within the dispute between coroner, pathologist and medical men that allowed overlaying to become a means to an end rather than an end in itself.

The issue of fees was central to the GP's case, and although this was frequently and vociferously denied by the medical practitioners, there is no doubt that self-employed GPs, out of pocket when called to the scene of a death, were reluctant to give up their right to the two guinea medical witness fee. This income was considered 'bread and butter' to GPs

working in poor areas, where the fees they could expect to charge patients were limited; and consequently medical witness fees represented an important part of their income.

Significantly in these circumstances, status and authority were also at issue for the medical practitioners, and the disputed territory of death and cause attribution was central during a time when the epistemological space of the inquest was being reshaped and death itself sequestered.

Throughout the exchanges recounted here, the mother and infant are silent. The infant body, present at the inquest, was represented in the accounts of the body given by Freyberger and the medical practitioners, but it has no other representation. The mother was entirely absent, mentioned only in reference to the dead infant when she was often portrayed as complicit in its death, with her role seen in terms of acts of ignorance or neglect.

### **The role of the coroner and the inquest procedure**

The proceedings of the inquest and its role in the English justice system during the nineteenth century are central to discussion of the conflict between Troutbeck, Freyberger and the GPs of South West London. The inquest can be understood as:

“An open tribunal whose verdict rested with a lay jury and whose proceedings were supervised by an elected official, the nineteenth-century inquest could be cast as a traditional check on authority by an active and watchful citizenry.” (Burney: 2000: 2)

The inquest system was intended to provide a safeguard against wrongful deaths (particularly in prisons), and so was organised as a contingent process dictated by the circumstances of a death rather than by strict adherence to legal form (Burney: 2000: 7). Until the Coroners' Act 1888 (BPP: 1888: c.41), coroners had been elected as life-time officials to their role and usually did not retire but died in post. They could be removed from their position by the Lord Chancellor but this was only in exceptional circumstances, for example, where they had committed a crime. Candidates for election to coronerships were usually solicitors local to the area and, once elected, served for life without the need to seek re-election. The Local Government Act (BPP: 1888: c.41) abolished the election of coroners, who instead were to be appointed by the local authority. The Act also empowered local authorities to set a compulsory retirement date for coroners. As a consequence of this, in London, there operated alongside each other coroners elected for life to their role and LCC appointed coroners who had agreed to certain terms and conditions as part of their contract. This was a situation which led to a lack of coherence across the coronerships in the London districts and some coroners who had been elected to their post felt they had a greater

mandate than those who had been appointed by the LCC. Three parliamentary Acts<sup>13</sup> shaped the authority of the coroner and the role and remuneration of the medical witness, and formed the basis of the legal argument between the coroner, the pathologist and the GPs. It was also against this background that the LCC sought reform of the legislation relating to the inquest process. Underlying calls for reform, the LCC, which had become responsible for inquest costs, wanted value for money when it made payment to medical witnesses for post-mortem examinations and evidence.

The body and its post-mortem examination have a central role in the inquest process. Until 1926, the body played a visible role during the inquest because of the legal requirement that the body should be 'viewed' by the coroner and jurors. This entailed that the body remained physically present throughout the inquest<sup>14</sup>. The centrality of the body and its 'view' by the coroner and jurors was a cornerstone of the inquest process, but during the period explored here a gradual change in practice was taking place. Although legislation to abolish the jury 'view' was not enacted until 1926, by the time of Troutbeck's coronership the emphasis had shifted from the 'view' conducted by coroners and jurymen, to the professional 'view' by the GP or pathologist in their scientific and specialist reading of the body through the post-mortem examination. It was in this way that reading of the body became the central issue around which the argument regarding fees and authority was conducted between the Troutbeck - Freyberger partnership and the GPs of south-west London. This period marked the final stages in the privatisation of the inquest, as it moved from the space of the nineteenth-century public house to the enclosed, official space of the purpose-built coroner's court and mortuary of the twentieth century. This period also marked a transition in the role of the dead body within the inquest process. The exhibition of the body for scrutiny by jury peers, previously central to the process, was relocated to the enclosed mortuary and replaced by the private scrutiny of the specialist pathologist. Control of the body in the inquest process certainly acted to reinforce the position of the coroner and his pathologist, as gradually first the view and then the jury were superseded by the coroner working in conjunction with his officers and a pathologist to determine cause of death.

The development of specialist fields within medicine accompanied an increased medicalisation of the body. In this sense, medicalisation can be understood as the expropriation of health and knowledge of health matters from the public sphere and its

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13 The Medical Witnesses Act 1836 (6 & William IV, C89; The Coroners Act 1888 (51 & 52 Vict. 13, C49; Local Government Act 1888 (51 & 52 Vict., c.41)

14 Traditionally, the inquest was conducted in the presence of the body but by the period covered in this investigation purpose-built coroners' courts with separate viewing and post-mortem rooms were being used in many locations, including the South West District of London.

relocation into the medical professional sphere. Medicalisation of the body influenced the outcome of inquests in cases where infants were found dead in bed; and over time professionalised readings of the body became the dominant voice within the inquest process. At the same time, there was a displacement of the prevailing social understanding of death and illness which allowed medicine to exert control over the body through an expert understanding of disease and physiology (Burney: 2000: 10-11). For Burney, death and disease were restricted within the field of a de-socialised body, which “alienated body processes from the subject’s comprehension, experience and ultimate control” (Burney: 2000: 11). In the case of infant death in bed, the effect of these changes was seen when the common explanation of sudden infant death in bed as overlaying was replaced by a pathological explanation of such deaths rooted in disease. But this transition brought with it (as noted elsewhere in this thesis) the problem that overlaying deaths were thought to leave little or no sign on the body. Therefore, the common-sense explanation of overlaying deaths was replaced with a problematic medicalised explanation that failed to identify concrete pathological evidence in such cases.

The post-mortem process was entirely dependent on the physical presence of the corpse and the interaction of the pathologist with the body and its viscera. The post-mortem examination was, nonetheless, seen by many (including some GPs) as an unacceptable and distasteful “mutilation of the dead” (BMJ: 1904: 2246: 152); and many GPs were unwilling to perform a thorough post-mortem examination because of the distress it might have caused to the families of the deceased (Burney: 2000: 115). Reluctance to perform thorough post-mortem examinations, together with (ante-mortem) clinical knowledge of a patient, led many GPs to perform a targeted investigation of the body by inspecting only the organ(s) they felt were directly responsible for illness, therefore limiting the mutilation of the corpse and possible offence to relatives of the deceased.<sup>15</sup>

Contact with the corpse was also considered to be contaminating (Burney: 2000: 117) and, unsurprisingly, there are recorded cases of pathologists dying through contact with contaminated material during the post-mortem examination (BMJ: 1880: 994:103). Cross-contamination between the living and the dead via the hands of the GP was a well-founded fear. Freyberger himself suffered the physical consequences of repeated contact with the bodies of the dead through the post-mortem examinations he conducted. Despite this, it was expected that the pathologist should have direct physical contact with the body and its

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15 Historically, the distaste and fear felt by many for the practice of the post-mortem examination may have derived from (or is evidenced by) the way in which bodies were originally obtained for post-mortem by the medical schools, from the gallows and the workhouse.

viscera, and on one occasion Freyberger was criticised in court for his use of a mortuary porter to conduct some of the examination tasks. At the inquests into the deaths of two infants, one supposedly overlaid, the other from heart failure, the GP who attended the second child complained “quite properly” that Freyberger had not “touched the body”:

“Dr Freyberger said that he suffered from sore hands and therefore employed the post-mortem porter, paid by the borough council, to open the body. He added that he had done the same in thousands of cases” (Lancet: 1903: 4147: 561)

It is unsurprising that frequent contact with corpses using un-gloved hands, along with the repeated use of astringent antiseptics, would cause damage to the hands of the pathologist.

But, despite this, the Lancet insisted on the need for “*tactus eruditus*” or knowledgeable touch in the post-mortem examination:

“We see no harm in the porter occasionally doing the manual work, of the investigation under Dr Freyberger’s, or preferably under the medical adviser’s eye, but think it unfortunate that Dr Freyberger should not be in a physical condition to touch a corpse. An attendant can not take the place of a skilled pathologist: *tactus eruditus* is required.” (Lancet: 1903: 4147: 561)

The view of the corpse as contaminated and contaminating may have led some GPs to restrict their exploration of, and contact with, the dead body. But regardless of this, many GPs saw the use of specialist pathologists as an infringement on their role.

The nineteenth century inquest was concerned chiefly with accidental, suspicious or violent death, deaths that would generally be termed ‘unnatural’. Unnatural or sudden deaths were not routinely referred to the coroner and could be certified by a GP. Referring such deaths to the coroner was the role of the local Registrar. This left the process open to local interpretation and practice. Henry Harvey Littlejohn, Lecturer on Medical Jurisprudence at the University of Edinburgh, lectured to the Medico-Legal Society of the British Medical Association (BMA) on the issue of when, how and by whom a post-mortem examination should be conducted:

“The law as it at present stands in regard to preliminary investigation of such cases leaves much to be desired. A system which leaves to the Registrar the duty of setting the machinery of investigation going, and an investigation carried out often solely by an official (the coroner’s officer) who has neither legal status nor in many instances the qualifications necessary for the efficient discharge of such an important and responsible task” (Lancet: 1903: 4152: 862)

It was his view that the coroner, rather than an officer, should decide whether there was to be an inquest, whether a medical man should inspect the body and whether a post-mortem examination was necessary to determine the cause of death (Lancet: 1903: 4152: 862). For Littlejohn, practice around the inquest left a large part of the process to chance and was contrary to the principles of public welfare and justice. Littlejohn also referred to the tension

acted out in the disputed territory of the mortuary, where general practitioners and pathologists both claimed superiority in their ability to interrogate the corpse. This issue was at the core of the dispute between GPs and the Troutbeck - Freyberger partnership and forms the central theme of the discussion that follows. It was against this background that the LCC sought to reform the coronerships of London. Their recommendations received a positive response from the BMA, but the Coroner's Society of England and Wales (chaired by George Danford-Thomas, coroner for St Pancras) were hostile to the proposals, which they wholeheartedly rejected (BMJ: 1894: 1744: 1171). The LCC later explained their recommendations for medical investigators and their concern with the procedure as it stood, claiming that post-mortem examinations conducted by unskilled GPs were a waste of money:

“For many years the Public Control Committee have been of the opinion that there had been great waste of public money owing to the fact that *post mortem* examinations are frequently of little value from being performed by inexperienced persons (BMJ: 1902: 2190: 1937)

Their solution to this ‘waste’ was the employment of skilled pathologists to conduct post-mortem examinations in inquest cases. In July 1902, with the appointment of John Troutbeck, the LCC (despite their repeated failure to change legislation) saw an opportunity to implement their policy by modifying the practice of the coroner within the existing legislative framework. On the day Troutbeck was appointed, the Council passed a resolution that:

“All coroners be informed that in the opinion of the Council it is desirable that post mortem examinations in inquest cases of a special nature should be entrusted to a specially skilled pathologist (BMJ: 1902: 2190: 1937)

As a condition of his appointment, Troutbeck agreed to give effect to the LCC's resolution, a move that was later to be attacked by the BMA.

### **Reforming the South West London District**

The appointment of John Troutbeck as coroner to the South West District of London was announced in the British Medical Journal on 5 July 1902 (BMJ: 1902: 2141: 73). From the day of his appointment, John Troutbeck's coronership was shrouded in controversy. Troutbeck's predecessor, Althestan Braxton Hicks, was described as a coroner with a distinguished career, well respected by his colleagues and the medical profession. But despite this, the LCC thought that practices in the district were in urgent need of reform and said as much to Troutbeck when he was appointed (BMJ: 1902: 2166: 72). Troutbeck was

tasked by the LCC to reform the South West District coronership, whose authority they viewed as having been undermined during the Braxton Hicks incumbency. Members of the LCC had been concerned for sometime that inquests in the South West District were being held in order that local GPs could benefit from receipt of medical witness fees when they attended court. Their suspicions were difficult to prove, but when their reforms were imposed through coroner Troutbeck the response of the GPs suggests that the suspicions of the LCC were not without grounds. Until this point, GPs had a well defined role as medical witnesses in inquest proceedings and many, as Littlejohn and the LCC claimed, saw the income from such work as a mainstay of their practice. The cost of inquest proceeding and the income of GPs were therefore pitched against each other as a central point of conflict.

In the same report that announced Troutbeck's appointment, the comments of Mr Cohen of the LCC regarding the role of GPs in performing "necropsies" (post-mortems) were also reported. Cohen was concerned with the waste of money spent on unskilled post-mortem examinations, suggesting that GPs were not best placed to perform this work. The BMA were not happy with Cohen's claim and complained:

"Mr Cohen had hard things to say as to the incompetence of general practitioners in performing necropsies and this charge was also formulated in far too sweeping terms in the committee's report" (BMJ: 1902: 2141: 73).

The Local Government Act 1888 had made the LCC responsible for the administration and costs of all inquests conducted in London and this had set in motion a series of events that would lead to significant changes in the way inquests were conducted, most notably in relation to the employment of coroners and the use of medical witness evidence. Following his appointment and prompted by the LCC, Troutbeck asserted the authority of the coronership to investigate all sudden and unnatural deaths and took it as his responsibility to employ a specialist pathologist to perform post-mortem examinations. These reforms were not well received. Some GPs were affronted by any challenge from the coroner regarding their certification of a death. Others, who had previously been happy to perform post-mortem examinations, began to object now that they were no longer routinely summoned by the coroner to give evidence. The issue of medical witness fees was contested by the GPs, with practice moving toward the employment of a special pathologist so that the GPs could no longer rely on this significant portion of their income.

Freyberger, who the LCC described as an experienced pathologist (having conducted over 4000 post mortem examinations and provided evidence at 1200 inquests), had already been working for the LCC conducting specialist analyses in poisoning cases, and it was suggested that coroners avail themselves of his services "whenever the circumstances

indicate that specialist pathological skill and knowledge are desirable” (BMJ: 1902: 2190: 1937). Freyberger had agreed to provide these ‘specialist’ services for the statutory fee of one guinea for analysis work or post-mortem examination, a point that was to become a bone of contention among his medical colleagues. Dr Ludwig Freyberger had completed his medical training in Vienna where it was usual to conduct post-mortem examinations on all bodies ‘found’ dead. This idea seems to have been taken up by Troutbeck and it appears that he was attempting to bring the practice to south-west London. In this context, Freyberger’s foreignness was later to prove an issue. Within days of his appointment, Troutbeck was presiding over inquests and engaging Freyberger to conduct the post-mortem examinations.

Up until this point, the practice in the South West London District had seemed much the same as elsewhere in London. Significantly, this included Troutbeck’s Westminster District where he had also been sitting as coroner for some years. Following a death, the GP who had attended the deceased would be called to give evidence, and if necessary, perform a post-mortem for a fee of two guineas: one guinea for evidence and one guinea for the post-mortem examination. An inquest would be called either if the GP refused to certify the death as ‘natural’ or, in situations where the GP had already certified death, the coroner was subsequently dissatisfied with the certification. But there appears to have been more to this practice in the South Western District that at first seems apparent. The district occasioned special attention from the LCC and there was the suggestion that the number of both inquests and post-mortem examinations held was higher than necessary.

Troutbeck’s reform was innovative, but whether it was only Troutbeck and Freyberger who worked in this way, or whether similar changes were occurring elsewhere is unclear and correspondence in the medical press focused on these two men with little or no mention of dissent in other districts. Indeed, that Troutbeck was the subject of criticism from his fellow coroners on the issue would suggest that his actions were novel (Lancet: 1905: 4282: 921), and it is clear that not all coroners agreed with Troutbeck’s views on the employment of specialist pathologists. Nonetheless, time has supported Troutbeck’s practice and the post-mortem examination of bodies by Home Office pathologists is now routine practice and a GP would no more be involved in the post-mortem of a patient than they would in performing a complex surgical operation. In this way, it is not only the practice of the inquest that has changed, but also the role of the specialist pathologist and the GP, with the increased specialisation within medicine occurring concurrently around and after 1900. This was by no means the first time that the medical practitioners had crossed swords with the LCC on the issue of the inquest post-mortems, but it was a pivotal point in the battle for fees, territory and authority between the LCC, the GPs, Troutbeck and Freyberger.



Reports of several of Troutbeck's inquests appeared in the national press following his appointment, and the cases appear to be typical of the coroner's fare. The cases were varied, as was Freyberger's involvement. Despite this, unrest was building among the GPs of the South West London District.

### **The 'Medical Man, the Coroner and the Pathologist'**

In November 1902 the first in a long series of articles and letters entitled "The Medical Man, the Coroner and the Pathologist" appeared in the Lancet. The article marked the beginning of a public dispute between the GPs of south-west London – championed by the British Medical Association - and coroner John Troutbeck and pathologist Dr Ludwig Freyberger that was set to rumble on for more than five years. The battle was located in the homes of the dead, the mortuary and coroner's court, and was fought over the bodies of the deceased for the right to attribute cause to a death (and receive payment for doing so).

The article in the Lancet described the case of siblings, a 2 year old boy and a girl of 10 months, who had died after eating mussels. The girl had been taken to the surgery of Dr Bouck in Battersea "in a dying condition" (Lancet: 1902: 4135: 1477). The doctor visited the little boy at home in the caravan where the family lived and found him suffering from enteritis. The little girl died that evening and her brother two days later. Troutbeck ordered an inquest on the bodies and requested that Dr Bouck perform a post-mortem examination on the boy (whom he had treated for two days), and requested that Freyberger perform the post-mortem on the girl.

After giving his evidence, Dr Bouck wanted to know why the post-mortem on the girl had been carried out by Freyberger and challenged Troutbeck from the witness box on this issue. The way in which the story is reported in the Lancet hints at the tone of the argument and shows the level of animosity that had built up between the GPs and Troutbeck in just a few months. There were several issues to which Bouck seems to have taken exception. Bouck thought that the cause of the children's death was apparent, that is, "enteritis following an extremely unsuitable meal". But rather than arguing that the post-mortem was not necessary, he argued that he (Bouck) rather than Freyberger should have been asked to conduct the examination. Bouck was therefore claiming that he should have been requested to perform both post-mortems. Dr Bouck had attended both children in life, albeit for a very short period for the female child. He had recognised their symptoms, made a diagnosis and presumably treated them, although no detail of any treatment was given in the report. As such, Dr Bouck could have signed the death certificates. It was not reported whether Dr Bouck had refused to sign the death certificates or if Troutbeck had ordered the

inquest despite Bourke's certification. As the deaths were sudden, although they were clearly of natural cause, it may have been the case that Troutbeck required an inquest anyway. However, as will be shown, refusal to sign death certificates was a tactic adopted by the GPs of south-west London in a campaign of non-cooperation with the coroner.

Dr Bouck's "natural curiosity" about Freyberger's role was rebuffed by Troutbeck, who asserted his position and authority as coroner with a reminder to Bouck that "coroners hold inquests". The Lancet went on to rebuke Troutbeck, claiming that "the medical evidence is the most important evidence tendered" which clearly discounted Freyberger's evidence from this category. This highlights the distinction that was made at the time between clinical knowledge pertaining to the patient in life, and pathology pertaining only to the body in death, and demonstrates a division in medicine between clinical medicine and pathology. The warning to Troutbeck was also clear – if he did not seek evidence from the medical man attending the patient, then he risked impeding the course of justice.

The issue of fees is relevant here and Freyberger was accused of "taking fees for work which a professional brother was in a fitter position to discharge". Without the employment of a specialist pathologist, the payment to the GP would have been as follows: a small payment for attending the sick child, perhaps one or two shillings; signing death certificates – nil; conducting two post-mortem examinations, two guineas; giving evidence at two inquests, two guineas. As payment of post-mortem and evidence fees were dependent on a summons by the coroner, it was only in the event that an inquest was held that the fees became payable. If Dr Bouck attended the children and signed a death certificate with no inquest, he would receive only the fee for attending the children, perhaps a few shillings. In this case, Dr Bouck would have received an additional payment of two guineas for performing the post-mortem and giving evidence about the male child. Although the issue of fees was important, it was clearly not the only issue and there were other areas of contention. Dr Bouck claimed to know what had caused the death of the children and in his view a pathologist was not needed and no additional information would have been gained by having Freyberger perform a post-mortem. Was Bouck arguing that the post-mortem was unnecessary or that he should have performed it? In the report, Bouck seemed to be hedging and covering both eventualities. Whatever Bouck's argument, the competence of the GP and his authority in identifying the cause of death was being challenged by Troutbeck and in return, the Lancet challenged Troutbeck's authority and competence "reminding" Troutbeck that "medical evidence is the most important". This case points toward what I conjecture was common practice among GPs in such cases (in south-west London at least), that is, the GPs would withhold death certificates in order to receive payment as a medical witness. The

bodies of the children therefore became a disputed territory where knowledge and knowledge-claims (and the attached pecuniary and status benefits) were contested by individuals as members of larger social institutions and extended figurations.

Two weeks later, Dr Leonard S. McManus launched the first of his many attacks on Troutbeck and Freyberger. McManus was a GP in Battersea and also member of the Battersea Vestry. He was well known locally, having initiated a milk depot in Battersea (reported as the first in London) and through this was credited with greatly diminishing the rate of infant mortality in the area. McManus (described as genial and kind) was also Chair of the Battersea Conservative Association (The Times: 28/3/1911: 11: B). Troutbeck had expressed his concern about the standard of post-mortem examinations in south-west London and argued the need for a specialist pathologist:

“He [Troutbeck] said that post mortem examinations were most difficult operations, and he did not know any doctor of weight or experience who would not agree that a medical man with a general practice was not the proper person, or the best fitted, to make such examinations.” (Lancet: 1902: 4138:1720)

Troutbeck was maintaining his claim that specialist skills were needed for post-mortem examinations and it would seem, he was trying to make this claim without discrediting (or alienating) the local GPs. In his response to this report, McManus attacked Troutbeck and Freyberger, challenging both their qualifications and their authority. McManus’s attack on Troutbeck was that Troutbeck as a “layman” was not qualified to judge the ability of a medical practitioner and that Freyberger’s qualifications were “very ordinary” and not at all specialist. The tone of the letter was one of contempt for Troutbeck’s opinion - “he is after all only a layman” (Lancet: 1902: 4138: 1720); and McManus made the claim not only for himself but also for other medical practitioners when he stated “we absolutely deny his right to set himself up as an authority”. Not only was Troutbeck portrayed as exceeding his authority but also that Freyberger had been imposed on the GPs of south-west London and was not “one whom we could accept as an authority on such matters”. McManus’s letter leaves no doubt that he saw Troutbeck and Freyberger as acting outwith their authority, experience and qualifications.

In December 1902 (Lancet: 1902: 4138: 1717) the BMA complained to the LCC about the conduct of Troutbeck's inquests. The LCC, unsurprisingly, supported Troutbeck and Freyberger in their actions and rejected the GPs’ complaint. The only course of action left open to the GPs was to take legal action. It was in this way that the argument became based around the legality of Troutbeck's action, and relied on recourse to the law and interpretation of the Coroner's Act (1887). In this sense, the contingency of the inquest was being undermined by the GPs’ action.

The GPs responded swiftly. A special meeting of the South Western London Medical Society (SWLMS) was called for 2 January 1903, to consider options in regard to the “dispute between the coroner and the medical practitioners in the neighbourhood” (BMJ: 1902: 2191: 1965). The basis of their concern was the way in which the Coroners’ Act was being interpreted by Troutbeck. But they were also worried that Troutbeck’s action was a precursor of new LCC policy, and that the employment of specialist pathologists would become the usual practice in other areas. In which case, more GPs would lose this lucrative source of income. The GPs were also disputing whether the nature of the cases in which Freyberger was involved could be classed as 'special'. Their later comments suggest that the GPs had already conceded that 'special cases' required specialist pathology but they most certainly did not see Freyberger as the man for the job (Lancet: 1903: 4142: 187).

It is likely the Lancet had seen the foolishness of objecting to specialist knowledge being employed in the cause of the public interest, although Freyberger himself was clearly not accepted in this role. This did not, however, stop the debate about which cases should be classed as special. A report of the Special Meeting of the SWLMS appeared in the Lancet on 10 January 1903 (Lancet: 1903: 4141: 126). It noted that there was a marked interest in the subject, with some eighty-three medical men attending from surrounding districts. Troutbeck’s actions were described as 'novel' and in need of consideration. For the SWLMS, the Coroners’ Act (1887) clearly directed the coroner to call on the medical practitioner in attendance at the death and if “that gentleman” was not available then he “should call in some Medical Practitioner in the neighbourhood” (Lancet: 1903: 4141: 126). For the SWLMS, this interpretation of the Act ruled out Freyberger’s involvement in all but special cases.

Counsel for the BMA, Muir MacKenzie concluded that Troutbeck’s actions were not in conformity with the statutory duties imposed on him. The Act did not, however, empower any medical practitioner to bring an action for damages or an injunction to restrain the coroner from acting in this way, and the only legal option available was to apply for a miscarriage of justice in each case with an application to the court to quash the verdict and order a new inquest (Lancet: 1903: 4141: 127).

The discussion that followed Muir MacKenzie’s legal advice gives a flavour of the medical practitioners’ attitude. They felt that the LCC had been acting in the public interest, but that Troutbeck’s interpretation of the LCC’s instructions was unreasonable and “had not been interpreted in the way that any reasonable man would read it” (Lancet: 1903: 4141: 127). McManus was also at the meeting and stated that “Mr Troutbeck had not followed the ordinary ethics of decent society in his dealing with the medical men in that [Battersea]

district” (Lancet: 1903: 4141: 127). Another complained that 41 Regent’s Park Road (Freyberger’s home and office in north London) could not be included in the district of Battersea and therefore Freyberger could not be considered to be in practice in the “neighbourhood”. In addition, “Why, he asked, should they have imposed upon them a gentleman who had practically never been heard before?” (Lancet: 1903: 4141: 127). Dr Myles (who had been the practitioner involved in the case referred to in McManus’s letter to the Lancet (1902: 4138: 1720) seemed to have less time for his colleagues than for the coroner, commenting: “the practitioners had deserved the treatment they had received because they were apathetic and indifferent to their rights” (Lancet: 1903: 4141: 127). Other objections to Troutbeck’s practice expressed concern that if a medical practitioner did not attend at an inquest then his character might be damaged: “The medical man should be present at the post-mortem examination or duly represented there, otherwise he might be landed in a position disastrous to his practice. He had a right to be present at the post-mortem examination and at the inquest” (Lancet: 1903: 4141: 127).

The GPs clearly felt that their reputations were at stake. Troutbeck had not, however, precluded the attendance of any medical practitioner, indeed he claimed to have encouraged their attendance at the post-mortem. The distinction was that a GP invited to attend a post-mortem or inquest (anyone with any relevant information could give evidence to the coroner) did not receive a fee, whereas a GP summoned to attend did receive a fee. The GPs wanted to be 'summoned' not 'invited' and therefore receive payment for their attendance. Troutbeck made this distinction in a letter to the Lord Chancellor (BMJ: 1904 2270: S26: 52) which stated that in these circumstances GPs did not attend post-mortem examinations and he had “given up” the practice of inviting them. The meeting was concluded with the launch of a special fund devoted to the defraying of costs – the GPs had launched a ‘fighting fund’ to take on Troutbeck and Freyberger.

In the same edition of the Lancet (1903: 4141: 110), the editorial also challenged Troutbeck’s actions but the basis of the complaint was slightly different. It was conceded that the LCC and Troutbeck were acting (albeit misguidedly) in the public interest, but Troutbeck’s agreement to give effect to the LCC’s resolution to use a specialist pathologist was cast in a poor light and some impropriety was suggested when it referred to the conditions that the LCC had imposed on Troutbeck's appointment:

“We should hesitate to infer that a coroner about to occupy a judicial position of some importance bargained with the body appointing him as to the manner in which he would carry out duties already defined for him by law. We should certainly question the propriety of any promise ostensibly binding anyone filling such an office to summon a particular witness before him to the exclusion of those who might otherwise be called, more especially should such a promise involve payment

of fees to the nominee of a body holding the position occupied by the London County Council in relation to London coroners.” (Lancet: 1903: 4141: 112)

The propriety of the LCC, Troutbeck and Freyberger were brought into question with this allegation that Troutbeck had received his appointment as a consequence of the bargain he had made and that Freyberger was being favoured (although it was never explained why the LCC would wish to favour Freyberger). The Lancet also challenged the legality of the fees paid to Freyberger by Troutbeck on the basis that the frequency of his work was tantamount to an appointment and as such illegal.

On the same day as the special meeting of the SWLMS, 2 January 1903, McManus also attended after the sudden death of an infant at Speke Road, Battersea:

“I was called at 9.30am to see an infant at 76 Speke Road. On arrival at the house I found that the child had been dead some time, the hands were clenched, the thumbs were turned in, the toes were drawn up, the tongue protruded slightly through the gums, and there was some mucus on the nostrils; the sides of the face were deep purple. The child had been sleeping in bed with the parents who were in very poor circumstances. I sent the usual communication to the Coroner’s office and the only acknowledgement I received from the coroner was a verbal message that Dr Freyberger would let me know when he was going to make a post mortem examination.” (Lancet: 1903: 4142: 201)

McManus had notified the coroner but does not state the grounds for this or whether (or not) he had been willing to sign the death certificate. McManus continues by relaying the case as read by him in the local press.

“I inclose [sic] a report of the case and you will observe that Mr Troutbeck delivered a little homily to the jury in which he pointed out the importance of employing a pathologist of special skill in these cases. Now, I have been making post-mortem examinations in this neighbourhood for 18 years and I have given evidence before all the coroners who have held inquests in south-west London during this time. I have reported scores of similar cases in which the question always arises as to whether the convulsion, if any, which might have caused death arose from partial asphyxia due to overlaying or otherwise, and it stands to reason that the medical man who sees the child lying in the bed and who knows the people and their surroundings is in a far better position to judge of the case than a stranger who does not make a post-mortem examination until three clear days afterwards. I may mention here that the child was washed and laid out after I saw it, thus removing most of the external diagnostic signs, and there was nothing revealed by the post-mortem examination which could not be seen by any medical man who knew his work. In the circumstances I am utterly at a loss to understand the coroner’s remarks, for there was every reason to call in the medical man who first saw it.” (Lancet: 1903: 4142: 201)

The editor of the Lancet agreed with McManus that “the only medical witness who could help the jury in any practical way in such a case as the one detailed was the practitioner who first saw the body”. (Lancet: 1903: 4142: 201)

McManus detailed the physical characteristics of an infant thought to have been

overlaid in bed, but a large part of his assessment was based on the situational factors of the death, namely the “very poor” circumstances of the parents and that the death occurred in bed. McManus was also basing his assessment on his previous experience - “I have reported scores of similar cases” - and was working from the assumption that the child had probably died from a convulsion and that the work of the medical practitioner was to ascertain whether the convulsion was as a result of “partial asphyxia due to overlaying or otherwise”. The evidence of whoever first saw the child and the circumstances of the death in this respect was portrayed as important to the inquest. According to his report, McManus was the first medical practitioner to see the dead child and his evidence was therefore important to the case, but his complaint seems to go further than this. McManus appears slighted by Troutbeck - “the only acknowledgement I received [...] was a verbal message” - and offended by Troutbeck’s actions. Troutbeck’s message had been to let McManus know when the post-mortem was to take place. Maybe McManus did not want to be 'invited' to attend the post-mortem examination and might have felt that he should instead have been 'summoned' to conduct the post-mortem examination and receive payment for his time. Freyberger, “a stranger”, had been summoned to do the work and as such would receive the statutory fee, usurping McManus who had served the community for eighteen years, seen “scores of similar cases”, “who knows the people and their surroundings” and was in “a far better position to judge the case”.

McManus could have chosen to attend the post-mortem and the inquest but he did not. It would seem that to McManus, a post-mortem conducted by Freyberger was an unnecessary exercise because the “external diagnostic signs” had been removed when the child was washed and laid out. In view of McManus’s attitude to such ‘overlaying deaths’, it is not surprising that Troutbeck would require a post-mortem examination conducted independently of McManus, who appeared to have made up his mind on the cause of death based on his external inspection of the body and death scene alone. McManus’s attitude to such deaths was again demonstrated several years later in a letter to The Times (12/06/1908:20: A), when he made reference to the Speke Road case. McManus condemned Troutbeck’s “extraordinary methods” and “the contemptuous manner in which he treats the medical men in the district”, but his later description of the circumstances of the child’s death was notably more graphic in its re-telling than when given in 1903. For McManus, there was no question about the cause of the infant’s death “there was no doubt about it, the child was as flat as a pancake, and the mother admitted to me she had found it under her”. He went on to say “but nothing will persuade me that the great patch of blood and mucus on the back of the mother’s nightdress between the shoulders, and against which the baby’s mouth

and nose must have been closely applied, was in any way conducive to a prolonged existence” (The Times: 12/6/1908: 20: A). If McManus had found the situational evidence so conclusive, why had he not certified the death himself? Did McManus refer the death to the coroner in order to gain the post-mortem work and the accompanying payment? It would seem so, because the ground for his original objection had been Freyberger’s involvement rather than the post-mortem examination itself.

At the time of the Speke Road death, Troutbeck had been in post for six months and had been accused of impropriety, ignorance and arrogance, but he seemed to have brushed off the criticisms and continued to use special pathologists when and where he saw fit. If McManus had had such graphic and relevant evidence to give, why did he not attend the post-mortem and inquest? Had McManus refused to sign the death certificate or had he signed it only to have the cause of death subsequently challenged by Troutbeck. That McManus had “sent the usual communication to the coroner’s officer” would suggest that he had not signed the death certificate, but why not? Was this act part of the GPs’ strategy of withholding their cooperation or was McManus acting in good faith? It would seem that Troutbeck’s faith in the good will of the GPs of the district had been severely limited and, as will be demonstrated, McManus’s actions were in keeping with the customary practice of the GPs in south-west London at the time.

On 9 January 1903, Troutbeck again used an inquest as an opportunity to publicly address the issue of medical evidence. He is reported as saying “a great many medical men in the neighbourhood thought that the law was made for the good of the medical practitioners” (Lancet: 1903: 4142: 187) and that it had been said to him that “Battersea money should be spent on Battersea doctors”. Despite this, Troutbeck would not be swayed: “The only thing that could influence [him] was what was the best evidence to put before the jury to get the best results” (Lancet: 1903: 4142: 187). A Lancet editorial expressed the (probably misplaced) hope that Troutbeck had been misreported. A picture was emerging of local practices which involved GPs routinely refusing to sign death certificates in order to ‘force’ an inquest and in doing so receive payment in the form of medical witness fees. This was, of course, denied wholeheartedly by the BMA and the GPs, but their actions often belied their claim.

The LCC's response to the SWLMS stated that where a coroner was of the opinion that the evidence of the medical attendants was material, then they should be invited to the post-mortem and summoned to give evidence at the inquest even though a pathologist may have been employed. But however important the fee issue may have been for the GPs of south-west London, lack of financial reward was clearly not the only motivation for their



actions. The involvement of a pathologist and the newly appointed coroner's officers<sup>16</sup> were both factors that were displacing the GP from their formerly leading position in the inquest process. Where previously coroners communicated directly with GPs, the intervention of the coroner's officer and pathologist limited the role of the GP and this resulted in a perceived loss of status for GPs, which was the source of obvious irritation:

“We shall hear no more of the coroner's officer being sent to get medical information from the professional adviser. When medical evidence is required it will be given upon subpoena and the witness will, of course, be paid the statutory fee for his evidence” (Lancet: 1903: 4149: 675)

The closing paragraph of the report identified what had only previously been suggested - the GPs were deliberately withholding their cooperation from the inquest process. The Lancet however cast this in a light of vindication for the GPs' action:

“Their action in refusing to give medical evidence save upon subpoena has now been endorsed by the Control Committee of the London County Council and cannot again be impeached by anyone as childish or greedy” (Lancet: 1903: 4149: 675)

This concession by the LCC may have safeguarded Troutbeck in obtaining a specialist pathologist for his post-mortems, but it was hardly a money-saving exercise now that three guineas rather than two could be paid for medical evidence in each inquest case, neither was it the victory that the Lancet would claim for the GPs. As McManus pointed out in another letter in March 1903:

“Their [the LCC] original idea was that there were too many inquests and that the sum paid was excessive, and that by removing what they considered the principle motive for which medical men refused certificates – namely the fee – they would effect an economy of some £20,000; and it was to carry out this policy that Mr Troutbeck was appointed. The fee to be paid to Dr Freyberger was to be two guineas and we are asked to believe that the local man will be called to give evidence as to facts and so swell the cost to three guineas for medical evidence. I do not believe it for a moment; the whole thing is a red herring drawn across the trail; [...] more post-mortem examinations have been given to Dr Freyberger since the deputation to the London County Council than before.” (Lancet: 1903: 4150: 758)

Here the actions of the GPs are clearly spelt out. The LCC claimed that medical practitioners were refusing to sign death certificates (for which they received no fee) in order to force an inquest to be held for which they would receive payment of the medical witness fee. This is an important issue and it belies the claim of the GPs that their argument was about justice and the public interest.

In an effort to assuage the complaints of the GPs, especially with regard to

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16 The LCC had been attempting to professionalise the job of coroner's officer by employing retired policemen who could bring their investigatory skills to the role (Cf BMJ July 5 1902; BMJ Supp July 1904: 57-.58).

Freyberger, the LCC agreed to compile and make available a list of pathologists in the London area willing to undertake post-mortem examinations for the 'usual fee'. To this end, they wrote to the large general hospitals asking their cooperation in the selection of skilled pathologists (Lancet: 1903: 4155: 1114). The response of the hospitals was divided. While a minority agreed to provide the services of pathology experts for the fee of two guineas, the majority clearly held the view expressed by the Medical Committee of Guy's Hospital, that medical experts should not be employed so cheaply. They agreed in principle that the skills of a specialist pathologist were needed in some cases, but proposed that the post-mortem alone could not provide adequate information for an inquest and that the attending GP should always be called. With regard to the fee:

“They are of the opinion that it is impossible to secure the services of pathologists of the required standard for the fee of two guineas” (Lancet: 1903: 4155: 1114)

The Lancet agreed: “The evidence of special pathologists is required in special cases [...] two guineas is a completely inadequate fee” (Lancet: 1903: 4157: 1251). Clearly then, Freyberger's expertise was either not special enough to warrant the increased fee or else by charging the 'usual fee' he was breaching the franchise that specialist consultants had for the specialist knowledge of pathology. In either case, for the committee at Guy's Hospital, Freyberger was acting outwith his professional capacities and was therefore deserving of neither the role nor the fee.

In May 1903 the BMA sent a deputation to the Lord Chancellor. They were particularly concerned that Troutbeck “constantly employed” Freyberger, who did not hold the post of pathologist “to any large London hospital” (BMJ: 1903: 2235:1178) and nor was he known to the Society as a pathologist. Instead, his selection was due to his being “a gentleman willing to for an ordinary fee to make *post mortem* examinations”, an issue that had been raised previously and would be again. Troutbeck on the other hand was accused of “forgetting the dignity and the duty of his office” (BMJ: 1903: 2235: 1178).

Following the deputation to the Lord Chancellor, a letter was sent by him to Troutbeck on the matters raised by the BMA. Troutbeck's response was detailed and lengthy. Troutbeck disagreed with the “narrow” view of the Coroners' Act put forward by the BMA and claimed that their proposals “would establish a peculiar and privileged position for a special class [of medical practitioners] against the general interests of the community” (BMJ: 1904 2270: S26: 53). Troutbeck denied setting aside the clinical evidence in any case and stated that he called all material witnesses when necessary. Troutbeck also said that his practice was to write to the relevant medical practitioner called to the death, “calling his attention to the report to me that he was called in after the death and had expressed his

ignorance as to the cause of death, and asking him, if he was aware of any circumstance bearing on the cause of death, to communicate it to me at once in order to enable me to decide whether or no his evidence would be necessary” (BMJ: 1904 2270: S26: 53).

Troutbeck stated that if, at this point, the practitioner had “nothing to communicate” then he would not be called as witness. Troutbeck made clear the view that if the GP did not know enough of the case to certify death then by the same token he did not know enough to be called as a witness.

With regard to inviting medical practitioners to the post-mortem examination, Troutbeck commented:

“I have given the opportunity to every medical practitioner of attending the *post mortem* examination if he so desires, not because I require him to assist at the *post mortem* examination, but because it was represented by another Deputation that the General Practitioners desired to attend the examination for their own information. I find, however, that it is comparatively rare for any medical practitioner to take advantage of the opportunity so offered, and now the practice may be discontinued” (BMJ: 1904 2270: S26: 53)

Troutbeck dismissed the allegations against him for lack of supporting evidence but his statement regarding his motives, hinting as it does at inappropriate conduct in the South West District, is worth repeating here:

“The view your Lordship [Lord Chancellor] is reported to have expressed with regard to the powers, duties and discretion of the coroner is the view which has been so bitterly opposed by these medical societies, and it is in the endeavour to re-establish this correct practice that I have had a long struggle against the action of these societies. It had been my duty, as I conceive it, to restore in the South Western District the independence and authority of the coroner, and I should add that so far from wishing to derogate from this, the London County Council have constantly given their support to my general attitude of perfect independence, and to the view that it is my duty to exercise in each case a discretion judicially to the best of my ability” (BMJ: 1904 2270: S26: 53)

Troutbeck obviously felt very strongly that something had been amiss in the South Western District coronership and he clearly claimed support of the London County Council and the Lord Chancellor for his attempts to reintroduce “correct practice”. It would seem that Troutbeck was justified in his belief that inquests had been organised according to the principle that GPs were ‘entitled’ to the medical witness fee provided for in the Coroners’ Act (1887), and he challenged the claim of the GPs that it was their “legal, moral and customary right to make post-mortem examinations in every case without exception” (BMJ: 1904 2270: S26: 32).

By July 1904, the BMA had received no more than an acknowledgement of their letter to the Lord Chancellor and their indignation was shown in their resolve to address the matter directly to the Prime Minister, Arthur Balfour. They requested a meeting with Balfour

to make their case and present their evidence to him; their aim was that he should direct the Lord Chancellor to address their concerns about Troutbeck and his coronership. The first letter to the Prime Minister went unanswered and the BMA complained that they had not even received an acknowledgement.

The importance of medical witness fees to the GPs case was shown with a suggestion made at a meeting of the BMA in 1904. It was proposed that as a solution to the fees 'problem' coroners should pay GPs to certify death without calling an inquest. This would have led to the ridiculous situation whereby a GP, upon being called to a death, would refuse to sign the death certificate. He would then inform the coroner about the death and pass on relevant information, at which point payment would be made by the coroner to the GP, who would subsequently sign the death certificate which he had previously withheld. This convoluted practice would circumvent the need for an inquest but still allow the GP to receive a payment for his services (BMJ: 1904: 2275: S29: 117). The Chair supported this extraordinary suggestion, which would have made a mockery of the process, although the idea did not gain the full support of the meeting.

From this point, the campaign of non cooperation became overt on the part of some practitioners and there followed a number of cases reported in the press in which GPs had forced the investigation of a death to a full inquest. One particularly vehement proponent of the tactic was Dr Percy Edmunds, a Divisional Surgeon of Police and Registrar of Death, who was criticised by Troutbeck for failing to give information to his coroner's officer. Dr Edmunds's retort to the officer when asked for information about the death had been that he "should ask Freyberger". Edmunds denied refusing his cooperation but he did not mince his words. For him, Troutbeck was insulting the medical practitioners of the district by challenging "custom and etiquette", and it is clear that the insult was to the GPs' pockets, because Edmunds goes on to outline his solution on to the problem - medical witness fees should not be given into the "pockets" of Dr Freyberger but "diverted" to the local GPs.

By July 1905, the BMA had still not heard from Prime Minister Balfour and at their Annual Representative Meeting, after some discussion, it was proposed that they protest the in-action of the Lord Chancellor and Prime Minister on the grounds of public safety (BMJ, 1905: 2327: S68: 142). Interestingly, this shows that the cause of justice had now been substituted by the cause of "public safety" in the GPs' argument. At the same meeting, McManus also called attention to the request for pronouncement sent by the Wandsworth Division to the Ethical Committee of the BMA. They had asked for a pronouncement on the ethical position of members who were willing to act as pathologists and toxicologists in the coroners' courts, at "a fee authorised for post-mortem examinations made by general

practitioners” (BMJ: 1905: 2327: S68: 142). The Ethical Committee were quite clear in their response; they disapproved of the action of specially skilled pathologists, agreeing to make post-mortem “for the ordinary fee of two guineas” (BMJ: 1905: 2327: S68: 142).

Interestingly, there is no record of the Ethical committee commenting on the ethics of GPs withdrawing their participation from the inquest process.

Following the pronouncement, McManus moved that a meeting be held between the Medical-Political Committee of the BMA, the medical boards of the London teaching hospitals, and the pathologists named on the LCC list, with a view to having the list withdrawn. This resolution was carried, but McManus went on to make a scathing attack on both Troutbeck and Freyberger. McManus, who claimed to be speaking in the “interest of every general practitioner in the United Kingdom”, said that Troutbeck had treated the GPs of south-west London “in a most autocratic and offensive way” and that “his methods had been extremely narrow-minded and bigoted”. After all, Troutbeck was a “layman” who looked at matters from a “layman’s point of view” and he had also exceeded his authority in claiming that general practitioners in south-west London were unfit to make post-mortem examinations:

“But when so-called special pathologists tumbled over each other to accept the post of special pathologists at ordinary fees, they gave some colour to the Coroner’s statement” (BMJ: 1905: 2327: S68: 143)

Later the same year at the inquest of John Waple, Dr McMurtry of Easthill, Wandsworth, was challenged by Troutbeck as to his motivations for forcing an inquest in a case of natural death. Waple, aged 57 years, had been ailing for some months and was suddenly taken very ill. Dr McMurtry was called to see him. McMurtry said that Waple was dying and that nothing could be done for him. He ordered “poultices” and then went home, having stayed with the patient for about two minutes. Troutbeck questioned McMurtry in the witness box and a report of this exchange appears in The Times (7/11/1905:6: E). The exchange between the two men featured Troutbeck’s accusation that McMurtry was wasting public money by forcing the case to an inquest. Troutbeck, in summing up, told the jury that Waple had died from natural causes “The Inquest had been forced before the coroner for the simple reason of ventilating a grievance [...] The jury [...] censured Dr McMurtry for wasting the public money” (The Times: 7/11/1905: 6: E).

The BMJ, sympathetic to McMurtry and the GPs of south-west London, claimed that McMurtry should have been called to perform the post-mortem and that, if there was need for an inquest, there was no need for a post-mortem (BMJ: 1905: 2342: 1323), which was an unusual argument indeed. In the Lancet, this was taken several steps further, not only

supporting McMurtry, but going on to make serious allegations against Troutbeck and Freyberger in their roles as coroner and pathologist:

“An inquiry is being held at this very time into Mr Troutbeck’s behaviour in paying a large sum of public money to Dr Freyberger in the shape of unnecessary fees, or illegal fees, [...] Mr Troutbeck is alleged to have paid Dr Freyberger certain irregular fees, and now that this allegation has been made public by the spirited action of the British Medical Association the ratepayers may be trusted to look closely into the coroner’s disbursements” (Lancet: 1905: 1420)

Put in these terms, that “an inquiry is being held” and that previously “private allegations” had been made by the “spirited action of the BMA”, brought an unnecessary note of melodrama to the report and suggested great impropriety on the part of Troutbeck and Freyberger, a claim that was never substantiated. The Lancet also called into question the role of the coroner’s officer: “medical evidence has to be given in court by a medical man, not retailed in conversation to an uneducated layman” (Lancet: 1905: 4289: 1420). The Lancet was clear in its position on this issue: “what appears to us to have been unnecessary was Dr Freyberger’s presence” (Lancet: 1905: 4289: 1420).

The report of an overlaying case in Lambeth on 23 January 1905 shows the extent to which the issue of medical evidence had spread beyond the attention of those professionals directly concerned, to the wider public. The case was of a two month old child who died “from suffocation whilst sleeping in bed with its parents”. The post-mortem examination had been conducted by Freyberger, who stated the cause of death, and Dr Reed, the GP in attendance, also gave evidence. The BMJ reported the following exchange between a jury-member and Troutbeck.

“Juryman: - I should like to ask, Mr Coroner, why a second doctor was called in this case?

Coroner: - Because I chose

Juryman: - I think it is most unfair.

Coroner: - It has nothing to do with you, Sir.

Juryman: - As a ratepayer, I think it has everything to do with me.

Coroner: - I can’t discuss it. Resume your seat please. It is a question of policy that lies with me.

Jury Foreman: - No doubt some cases you have to deal with require special skill, but this was a perfectly straightforward case, and in this, as in other cases, I think the doctors who devote their lives to the service of the people should be called.

The Jury: - Hear, hear.

The coroner said that certain cases needed careful and skilful examination “(BMJ: 1905: 2300: 223)

The public (as represented by this jury member) were clearly aware of the fees issue and demonstrated sympathy for the GPs and concern for the ratepayers’ pocket. It would also seem that the jury viewed overlaying as an unproblematic diagnosis of such deaths. Later,

this case would figure in legal action taken by the BMA against the LCC.

In 1905, the BMA again challenged the LCC, this time in terms of the legality of fees paid to Freyberger. Mr Bodkin, counsel for the BMA, claimed that in the whole of London, special pathologists were called in 534 cases, and in 514 of these Freyberger was the pathologist called to conduct the examination; in 512 cases this was at the request of Troutbeck, while two cases were for other coroners. Freyberger had received payment of £1098 for this work. These cases were given to Freyberger, referred to by Bodkin as “that gentleman” (BMJ: 1905: 2340: S81: 265), to the exclusion of the general practitioners and the other seventeen special pathologists: “not only to the exclusion of the other special pathologist, but to the exclusion of the rights, the statutory rights, of the medical practitioners in attendance on the deceased, or living in the district in which death occurred” (BMJ: 1905: 265). Bodkin asked the perennial question; why did so many cases in South West London and Westminster Districts necessitate a specialist pathologist, when other areas did not? Bodkin cited a number of cases in which he claimed Troutbeck had caused expense in excess of that necessary to be incurred, and in each case, the monies were paid to Freyberger. One such case was that concerning Dr Galbraith Read who was called in to see the body of an infant found asphyxiated in bed. Bodkin challenged the verdict, claiming that the child’s death “unquestionably came about from asphyxiation” (BMJ: 1905: 2340: S81: 267). He stated that only Read, who had seen the circumstances of the death, was qualified to conduct the post-mortem. He also said that, in paying Freyberger two guineas and Read one guinea, the LCC had expended one guinea more than necessary. This “extra” guinea could have been saved by allowing Read to conduct the post-mortem and give evidence, which would have excluded Freyberger from the process entirely. In their effort to assuage the feelings of the local GPs by allowing Troutbeck to call a specialist as well as the attending GP, the LCC had left themselves open to the “ratepayers” charge of unnecessary expenditure. Bodkin also raised one of McManus’s cases, this time that of a one month old infant found dead after sleeping in a narrow bed between the parents with “all the appearances of being overlaid” (BMJ: 1905: 2340: S81: 270). McManus wrote to the coroner stating that, in this case, he could not certify death without a post-mortem examination. This was a surprising admission by McManus in light of his earlier claim that he could diagnose an overlaying death by simple examination of the body and scene of death. Freyberger was called upon to conduct the post-mortem examination, but “In the meantime the body was washed, [and] the tongue being put back between the lips” (BMJ: 1905: 2340: S81: 270). Freyberger’s opinion was that the child had died from convulsions. Bodkin asked “could there be anything more unsatisfactory than such a case as that? [...] The immediate cause of death was asphyxia [...]

and he [McManus] was the man to speak to that” (BMJ: 1905: 2340: S81: 270). Bodkin wanted the “illegal fees” to be refunded by Freyberger himself (BMJ: 1905: 2340: S81: 264).

The inquiry turned to the issue of “locality” and whether or not Freyberger could be considered as being in practice near the place of a death in south-west London when his practice was across the river Thames in Regent’s Park, north London. It was Ryde’s contention that the Coroners’ Act was designed to compel medical witnesses to attend at inquests and to recompense them for so doing. Acting for the LCC, Ryde’s stated that being in practice in Regent’s Park was considered to be nearby for any death in London because “he can drive there with a horse [in] under an hour” (BMJ: 1905: 2340: S81::264). Bodkin raised the issue as to whether or not Freyberger was in “actual practice”, but this comment undermined his “locality” argument to a large extent. Bodkin asked “whether, with so many *post mortems* a year, he [Freyberger] is able to attend to the ills of the living people I do not know” (BMJ: 1905: 2340: S81: 273). Ryde responded “I had no idea that any attack was to be made on Dr Freyberger”, continuing “I do not know whether he does nothing but attend these *post mortems* – that suggestion took me by surprise – but if he does nothing but these *post mortems* he is in practice in the place where he does do them”. Bodkin had effectively shot himself in the foot with this ill-conceived argument. In summing up, Ryde stated that this was an issue of whether or not the fees paid to Freyberger via coroner Troutbeck were legally paid or not. It was not an issue for the inquiry if some other medical practitioner had a right to be summoned to conduct post-mortems, give evidence and receive payment of medical witness fees.

Local Government Auditor, Thomas Barclay Cockerton, in a letter to the BMA dated 11 January 1906, made his position clear; he rejected the BMA’s challenge and allowed full payment to Freyberger of the amounts challenged (BMJ: 1906: 2351: S92: 16). The BMA asked that Cockerton provide a detailed statement of his reasons and this later appeared in the LCC book of accounts. Cockerton commented that the fees had been paid in conjunction with the legislation (BMJ: 1906: 2378: 205). Although Cockerton expressed sympathy with the position of the GPs of south-west London, he also thought that Troutbeck and the LCC were acting in the public interest in engaging the use of specialist pathologists in ascertaining cause of death at an inquest.

By October 1906, Troutbeck’s tone was notably softened. Although he had always claimed to be sympathetic to the GPs’ cause, his sometimes hard-line approach to the conduct of post-mortems and medical evidence had repeatedly angered the GPs of the neighbourhood. The BMA had also run out of official avenues through which to challenge Troutbeck and Freyberger, but this did not mean that the GPs had given up their campaign of



non-cooperation and agitation. In 1908 the dust had still not completely settled on the dispute. Catherine Alice Eveline Reeves, aged 10 weeks, of Corbbett Street, south Lambeth, was found dead in bed with her parents. Dr Piercy Fox was called to the child at 6.45am on Thursday 30 July 1908. Piercy Fox found that the death had occurred some hours earlier. He examined the bed and the body and “thought he observed signs of pressure on the child’s face” (The Times: 3/8/1908: 6: F). He understood that the child had been lying with its face towards the mother, “but there was no direct evidence of pressure”. Piercy Fox thought that the parents were “perfectly sober, and very much upset”. He concluded that the child had been suffocated because no other cause “could be seen”. Piercy Fox certified death as due to suffocation. “He gave the certificate in order, as he stated in court, that he might be able to give evidence at the inquest” (BMJ: 1908: 2486: 525). Piercy Fox’s report of the death appears in his letter to the BMJ (1908: 2486: 535):

“On Thursday, July 30th at 6.40am, I was called to a house in the neighbourhood, and on arrival, found an infant dead in its mother’s arms. The body was cold, rigor mortis was present, there was some dirty looking frothy fluid exuding from the nose and mouth, the conjunctivae were congested, and a certain degree of lividity of the left side of the head, neck, and shoulders was present. Apart from these signs, I could not detect any marks of violence or pressure. The bed clothes were stained by fluid, similar in appearance to the fluid exuding from the mouth. The father, who was a rag-picker by trade, stated that he went to bed at 12.45am, and woke at about 6.30, when he found the infant (a girl) of ten weeks lying on its left side, towards its mother, “looking funny”, he picked the infant up and found that it was dead” (BMJ: 1908: 2386: 535)

From this, Piercy Fox had come to the conclusion that the child had been accidentally suffocated and signed the death certificate to this effect. He made a formal demand to Troutbeck that he be allowed to attend the post-mortem examination and received word from Troutbeck (written onto his subpoena to give evidence) that Freyberger would notify him of the time of the post-mortem. Freyberger sent Piercy Fox a postcard notifying him of when the examination was to take place. For whatever reason, Piercy Fox did not receive the notification until five minutes before the appointed time. In consequence, he arrived at the mortuary some forty minutes late and was told “Dr Freyberger had waited for fifteen minutes and had then proceeded, so that within twenty-five minutes the examination and the sewing up of the body, had been completed” (BMJ: 1908: 2386: 535). Piercy Fox, not satisfied with this, asked for the body to be reopened for him so that he could examine it for himself. He examined the body and detected “no trace of either bronchitis or pneumonia” but did note some slight ecchymotic patches on the surface of the lungs. In his letter, Piercy Fox also stated that “At the inquest the fact was elicited that the parents were out with their baby as late as 12.30am, and that they had had three drinks apiece” (BMJ: 1908: 2386: 535).

These were points not reported by The Times or the BMJ in their earlier coverage of the case and it is likely that Piercy Fox took this as a point in favour of his overlaying diagnosis. It is, though, unclear how he reconciled the consumption of “three drinks apiece” on the evening before the infant’s death with his earlier claim that the parents were “perfectly sober”. In his post-mortem of the body, Freyberger found that:

“The child was abnormally heavy for its age. [...] death was due to heart failure while the child was suffering from bronchitis and chronic catarrh of the stomach and bowels. All the usual signs of death from suffocation were absent” (The Times: 3/8/1908: 6: F)

A report of Troutbeck’s summation also appears:

“In summing up, the Coroner said the case was an important one. To begin with, this death was certified by a gentleman who admitted that he never saw the patient during life, and it was a most serious thing to certify that death was due to suffocation. It was hardly serious, however, as the extraordinary reason that he had given for doing so. The jury had seen how very inadequate was the reason that he had given. It was a most serious thing, the levity with which judgements of that nature were formed against the poorer classes – that they were capable in so many cases that been alleged of suffocating their children by overlying them. During the last few years he had kept very careful observation on the particular alleged form of death with the result that it had been shown that in that particular district at all events, that the overlying of children did not exist. It was necessary in these cases to be impartial, and not to assume that because a child had been found dead in bed with its parents it had been suffocated. These parents were apparently respectable people, and there was no suggestion of drink. The suggestion that the child had been suffocated was a preposterous one and one that ought never to have been made.” (The Times: 3/8/1908: F)

Far from being the clear-cut case of overlaying that Piercy Fox suggested, Troutbeck saw this diagnosis as extraordinary. More than this, in Troutbeck’s experience overlaying as a diagnosis could not be applied to any cases in the district. Piercy Fox’s claim that the parents had been drinking on the night before the death was at complete odds with Troutbeck’s summation. Troutbeck also claimed that while overlaying did not occur in Lambeth, Freyberger had nevertheless seen many such cases. Troutbeck spoke highly of Freyberger in this respect:

“Dr Freyberger was well known in London as a gentleman who had had great opportunities of forming an opinion in these matters, and he came before them with a different opinion altogether – that all the usual signs of suffocation were absent, and he had seen many such cases.” (The Times: 3/8/1908: F)

The BMJ described Troutbeck’s comments about Piercy Fox as “very caustic criticisms”. They also criticised Freyberger for not making “microscopical sections” of the portions of the intestines that he thought were pathological. For the BMJ, the episode demonstrated the “considerable levity” in the way post-mortem examinations were conducted under

Troutbeck's jurisdiction. Troutbeck's opinion on overlaying also came under attack:

“Mr Troutbeck appears to have a brief for the doctrine that deaths usually attributed to overlying are due to natural causes. In this he is in conflict with the opinion of some of his brother coroners who have long experience to guide them. We do not think that inquiries conducted as was that to which we have referred will help him establish his thesis.” (BMJ: 1908: 526)

From this point on, the correspondence about the “The Medical Man, the Coroner and the Pathologist” and the actions of Troutbeck and Freyberger on the issue of medical witness fees diminished, but only to be replaced with an equally intense dispute between Troutbeck and Freyberger, and local surgeons of the district regarding deaths under anaesthetic, which was to become another of Troutbeck's challenges to established medical practice. With regard to medical witness fees, Troutbeck continued to employ Freyberger to conduct post-mortem examinations until Troutbeck's death in 1912. By the time of the Coroners (Amendment) Act 1926, practice had moved on sufficiently to require legal change. The new Coroners Act (1926) outlined changes in the operational mechanisms of the inquest process which allowed coroners to “forge” a more efficiently bureaucratic system of death inquiry ( Burney: 2000: 165), with the key changes being in regard to the 'view' of the body and the conditions under which a coroner could commission a post-mortem examination. After 1926, the inquest jury were no longer required to view the body and provision was made to hold an inquest in the complete absence of a body, for example, if it had been destroyed by fire. In addition, the coroner could now order a post-mortem examination of the deceased and, most importantly, pay for the service without the need to call an inquest.

This cleared an important stumbling block in the inquest process and was a change that would have provided a resolution in many of the conflicts between Troutbeck and the GPs. The effect was the uncoupling of the post-mortem and inquest from the body, which allowed the “dictates of efficient and accurate interrogation of the body [to take] precedence over both its public display and its connection to place” (Burney: 2000: 166). Burney claims this as a sign of the increased medicalisation of the death inquiry, but although this is the case, by conflating the clinical and pathological medical examination into a single category, whether conducted by a GP or a pathologist, the nuances of these changes are missed in this analysis. In my exploration of the interaction between Troutbeck, Freyberger and the GPs, it is apparent that there was a marked distinction made between the clinical GP and the specialist pathologist, a distinction that cannot be made without recourse to the internal

referents of medical practice as it was organised and transformed at the time.

The consequence of legislative change was to shift the emphasis of the process toward the post-mortem examination, and the number of the post-mortems subsequently increased as a percentage of total cases reported to the coroner, as did the relative number of cases resolved without recourse to a full inquest (Burney: 2000 :167). Despite this change, the level of medical fees remained unchanged and there was no introduction of an increased fee for specialist pathologists. Medical certification remained an unpaid task, and GPs continued to perform the majority of post-mortem examinations on the bodies of those found suddenly dead outside of hospital. Despite the attempts of the LCC and coroner Troutbeck, GPs were still generally viewed as competent to perform post-mortem examinations; it was only much later that the role of the medical practitioner in regard to the post-mortem process became separated from the role of the specialist pathologist, with the Home Office then becoming responsible for the registration of approved forensic pathologists. In the UK, forensic pathologists specialise in the medico-legal investigation of death, particularly the cause and consequence of wounds and injuries, and there is still a clear distinction made between the work of forensic pathology, which is based almost entirely on post-mortem examination, and clinical medicine. This is in contrast with practice in continental Europe, where specialists in forensic medicine are trained in both pathology and clinical forensic medicine (of the living).

With regard to so-called overlaying deaths, as has been shown elsewhere in the thesis, accidental death by overlaying was not a verdict resorted to when Freyberger performed the post-mortem examination of an infant found dead in bed. Indeed, in such cases, and based on extensive examination of Freyberger's case notes, Freyberger always found pathology in the bodies of such infants and identified underlying disease as the cause of death. Did Troutbeck decide for himself that overlaying was in many instances a misnomer, or was it Freyberger's knowledge of pathology that convinced him to reject overlaying as an explanation of infant death? The answer to this is unclear, although other districts had begun to move in this direction, as can be seen with the St Pancras Deputy coroner, Walter Schroeder, who shared Troutbeck's view that overlaying was an infrequent cause of infant death. Although Troutbeck and Freyberger did not bring an end to the ready acceptance of the overlaying diagnosis and verdict, they had mounted a sufficient challenge to the idea and to the practices of GPs and coroners who were routinely accepting overlaying as an explanation of infant death in bed. As a new generation of coroners emerged, the verdict of accidental death by overlaying diminished and overlaying all but disappeared as an issue of public concern.

## Conclusion

This chapter sets out the way infant overlaying death became the focus of a long-running dispute between the medical doctors of south-west London, coroner John Troutbeck and his pathologist Ludwig Freyberger. By presenting an in-depth account of the dispute among the professionals who officiated sudden infant death in bed, this chapter demonstrates the way in which the contested ground of overlaying and the dead infant body became enmeshed in events to which it was in a sense peripheral. The dispute, situated in the local context of the death and inquest of specific infants, was extended as it unfolded and came to encompass an increasing number of people in their roles as officials representing institutions, such as the BMA and the Lord Chancellor's Office. Government and legislation were also challenged when GPs took their argument to the Prime Minister, Arthur Balfour.

The debates between medico-legal professionals detailed here show the overlaying discourse as comprised of complex rules and resources relating to the sudden death of infants while bed-sharing. The positions of the key actors were informed by, among other things, their profession with its related status and economy and their acceptance or rejection of the overlaying thesis. They were also positioned in relation to broader socio-structural features such as the law, local and central government, professional associations and the media. There were also clearly marked out class and gender positions within the debate. In addition, the debates drew on ideas about medicine as a specialised form of knowledge that provided its practitioners with access to information regarding the body, health and illness. Access to medical knowledge was shown as controlled and in consequence individuals participating in the debate were constructed as more or less qualified to take part. Against this, the office of coroner was constructed, by some, as acting in contradiction to the overlaying thesis and medical knowledge. The dispute was set against the background of mortality, population control and the economy. Beyond this, however, the nation provided the context of legitimated knowledge-claims.

There are clear lines of dispute shown in the debate separating Troutbeck, Freyberger and the LCC on one hand, and the GPs, BMA and medical press on the other. The GPs generally supported the overlaying thesis and accepted overlaying as an unproblematic categorisation of death. They were also clearly working from within networks of support and interdependence with others, for example, medical and legal practitioners. At the same time they were enmeshed in networks of conflicting interdependence with the coronership of Troutbeck and the medical pathology of Freyberger. The GPs frequently drew on the discourse of overlaying in two ways. Firstly the discourse informed their (unproblematised)

diagnosis of sudden infant death in bed. Secondly, it served as a resource in their interactions with others to support their claims and positions. The overlaying discourse constructed overlaying as the unproblematic explanation of sudden infant death in bed (in the absence of an expectation of death) while bed-sharing. As such, the discourse also served to define what was considered appropriate action in the event of an overlaying death. This involved the knowledge-claim of the GPs regarding the death and, in the specific context of south-west London, the receipt of medical witness fees.

Coroner Troutbeck and pathologist Freyberger rejected the overlaying thesis which featured maternal culpability as a causal explanation for such deaths, but at the same time their roles and actions were nonetheless influenced by the discourse of overlaying. Troutbeck accepted the possibility of overlaying death but saw it as an infrequent and accidental cause of death. Freyberger appears to have rejected overlaying as a cause of death in all of the cases recorded in his case notes and also those detailed in the dispute with GPs. Both sides in the dispute therefore drew on specific and sometimes different features of the overlaying discourse to support their position-practices. Most notably, the GPs relied on the myth of overlaying as a common-sense explanation of sudden infant death in bed as an accidental risk of bed-sharing. They also drew on ante-mortem clinical knowledge of the infant, the death scene and their knowledge of the household and its social and economic position. Importantly, their diagnosis was usually made at the scene of death, in the bed(room) and the home. Despite the frequent payment of fees for post-mortem examination and medical evidence, there are no reports of post-mortem examination findings by the GPs beyond those that would have been evident from an external examination of the body. It seems unlikely that GPs were carrying out the extensive post-mortem examination of internal aspects of bodies in the way conducted by Freyberger. In this respect, the internal aspects of the dead body were not given priority (or at times even a role) in the explanation of sudden infant death in bed.

In contrast to this, Freyberger relied on pathology and the post-mortem examination for his diagnosis of death and there is no evidence that he visited the scene of a death or discussed it with the witnesses. Instead, Freyberger took the deceased body as his reference point and built his evidence around it. Freyberger would have been given access to the depositions of other witnesses but it appears that these were significant only as background information. Freyberger and the GPs therefore approached the infant death from very different perspectives and began their investigation of such deaths from very different starting points; for the GPs it was the infant's home, and for Freyberger, the mortuary. This shows that the diagnosis of death which had previously taken place in the home, within the

context of family and the household setting was being displaced to the mortuary. In consequence, clinical ante-mortem knowledge of the body and the social context of death were also being displaced. In addition, the role of GP who had previously bridged the separation between family and coroner's court was changed. Instead, the GP became another witness in the proceedings of the inquest with the body and its representation and interpretation mediated by the pathologist. It was this point that marked out the transformation of the body as a subject of interrogation by the inquest. In this sense, the traditional 'view' was rendered redundant as the significant reading became focused on its internal parts and microscopical aspects.

In one sense, overlaying death can be bracketed within the dispute because, although it was the pivotal death event on which the argument hinged, the argument was not otherwise dependent on overlaying. Instead, the argument was concerned with the struggle between individuals associated in networks of interdependence about power / knowledge, status and money. In this sense the overlaying discourse provided the rules and resources which grounded the dispute and therefore legitimated the claims of the GPs. In opposing these claims, however, Troutbeck and Freyberger drew on very different sources.

Troutbeck, who had been coroner in the Westminster District for several years, had, until this point, made no public pronouncements on infant overlaying death and his views on the issue were unstated. Troutbeck had been drawn into the dispute with the GPs because of the conditions set by the LCC on his appointment. It was at this point that the overlaying discourse became apparent in the views Troutbeck expressed as coroner. Troutbeck used his authority as coroner, supported by his employers, the LCC, and the framework of law to impose reformed conditions by which medical witnesses were employed and remunerated. In this way, Troutbeck drew on the overlaying discourse, supported by Freyberger's pathology, to challenge the overlaying thesis. Subsequently, Troutbeck took up the cause of overlaying and entered into debate outside the inquest setting to dispute the overlaying thesis and publicly rejected overlaying as a frequent cause of infant death caused by maternal culpability. In contrast, Freyberger made few, if any, public statements regarding overlaying beyond the evidence he provided in court in relation to individual deaths. It can be assumed that Freyberger rejected the overlaying thesis, as he recorded no cases of overlaying death in his case notes despite his involvement in many cases of sudden infant death in bed. It is important to note that before Troutbeck was appointed coroner of the South West London District, neither he nor Freyberger appeared to have made any public statement in regard to overlaying. Indeed, as previously noted, Troutbeck dated his interest and experience of overlaying to the year in which he also became associated with Freyberger. It is clear that the

dispute in south-west London between the GPs and Troutbeck and Freyberger took the form that it did because Troutbeck and Freyberger were working alongside each other, and this allowed the contested field of overlaying death to become central in the dispute. Without Freyberger's recourse to pathology, it can be assumed that Troutbeck would have 'taken on' the GPs as he was directed by the LCC but that the dispute would probably have found another focus. What this shows is that the discourse of overlaying can only be shown to be significant in relation to the practice of individual agents embedded in networks of interdependence. The influence and impact of the discourse was also mitigated by the socio-structural context and agency of individuals. The discourse was of consequence for those who were its focus, as well as to for those with the capability to draw on it, and in this sense the overlaying discourse had a discursive function beyond the immediate explanation infant death. The dispute detailed in this chapter marked the transformation of the overlaying discourse and the eventual rejection of the overlaying thesis. What becomes apparent is that the relationship between Troutbeck and Freyberger was central in this respect. The effort mounted in opposition to the GPs was largely constructed around the myth of overlaying because this was the ground chosen by the GPs. Having found a position and support from which to reject overlaying as a diagnosis of death, Troutbeck had identified a means of undermining the case presented by the GPs. In this way acceptance of overlaying and the GPs' case became inextricably linked and in a sense, they would stand or fall together.





**Chapter Seven: In Conclusion - From Hettie White to Arthur Balfour: A Grounded Exposition of Overlaying as the Socio-Structural Condition and Outcome of Action.**

“The direct perception of the present does not allow us to suspect its complexity, until it has been revealed to us by historical analysis” (Durkheim: 1972 [1938]: 80)

“Structural transitions should be understood as temporally and culturally situated processes” (Abrams: 1972: 20)

This thesis states that sudden infant death in bed interpreted as overlaying cannot be considered as a straightforward and self-explanatory category of death. Instead, overlaying should be understood as a socio-structural historic event that was constructed through the discourse of overlaying as it intersected other discourses relating to infant death, mothers and mothering, within the context of the home and family as a domestic figuration. It challenges current literature which addresses overlaying and suggests that this either mistakenly accepts the overlaying discourse as an explanation of accidental or deliberate infanticide, or reconstructs overlaying in presentist terms of Sudden Infant Death Syndrome. The thesis also presents the overlaying discourse as both the condition and outcome of action and therefore suggests it as an appropriate context around which to explore and expand ideas about structuration, sequestration and reflexivity. It also provides grounded detail of overlaying events explored through ideas of intimacy, the family, bed(room) space and death. The thesis uses ideas about power / knowledge, the knowledgeability of individuals, and discourse to propose that sudden infant death in bed was interpreted as overlaying in the absence or presence of other explanatory causes and that overlaying death in this respect was a misnomer. Claims to medical knowledge served to both support and challenge the overlaying discourse. Overlaying was constructed as a category of death through the action of individuals acting in extensive networks of interdependence in relation to socio-structural conditions. Overlaying subsequently became detached from the domestic context in which it was purportedly embedded and became significant in discourses to which it was, in one sense, marginal.

The thesis has deployed ideas around discourse to investigate the research materials. The overlaying discourse is defined in broad terms as representing all that can be said or done in regard to overlaying. This includes all practical and discursive knowledge relating to overlaying, including that relating to the body and bodily dispositions, signs, meanings, relationships, actions and interactions. In this sense, the overlaying discourse informs the

definition of overlaying and constitutes its parameters. It also constituted who could be considered as overlaid and by whom or what. In this way, the overlaying discourse served as the socio-structural conditions of overlaying and also constituted it as an outcome of action. The discourse therefore marks out overlaying in terms of its conditions, processes and outcomes and serves as a context of action in this regard. The overlaying discourse provided meaning to the sudden death of infants while bed-sharing, and suggested that mothers overlaid and killed their infants during sleep. The discourse also defined the outcome of overlaying in terms of blame attribution and maternal culpability.

Use of the term overlaying discourse is not, however, intended to suggest that there was a unified discourse of overlaying. Instead, it represents all aspects of overlaying as they were constituted in conjunction (and interdependently) with other relevant discourses surrounding other socio-structural conditions of action, such as those of maternal 'ignorance', temperance and national efficiency. The discourse of overlaying was underpinned by (non) normative discourses particularly those relating to the family, infant care and intimacy. The overlaying discourse also served to configure time and space in terms of when, where and how such deaths occurred and also therefore how such deaths could also be prevented. In this respect, the overlaying discourse represented overlaying as occurring in consequence of moral failure and neglect.

This thesis uncovers the complex relationship between mothers and others in relation to the overlaying discourse as socio-structural conditions of action understood in terms of structuration processes. As has been noted, the discourse itself was a complex of strands that must be teased out in order to show their influence. In this sense, the discourse can never be considered homogeneous, despite the tendency to constitute it in this way when it is referred to as a whole. Instead, the discourse has aspects or strands that represent, for example, its ideological function or signifiatory power. The discourse may serve to influence individuals and from afar it might appear to be the same discourse in all instances; but in practice and in relation to other socio-structural conditions of action faced by individuals, the discourse is like the river into which one cannot step twice. The discourse was continuously being remade as the condition and outcome of action and it is only visible through the action of individuals in interactional contexts. It cannot be seen where it was not deployed, and at the same time it was remade in its deployment. In this sense, the thesis represents the discourse as it was deployed and it is only through the process of historical socio-structural conditions of action that it is witnessed. This shows how the discourse of overlaying served to influence individuals in situations of co-presence as well as individuals located in situations of non-co-presence. It also serves to highlight the transformation of the discourse over the long-

term and therefore details historical social change. Importantly, the thesis provides intricate detail of overlaying death as it was played-out at the time in the space of the home, within the domestic figuration as a network of interdependences. The material is also organised in terms of space and time; and these became important features in defining how material would be arranged, deployed and understood. As a consequence, the thesis has identified many instances of the overlaying discourse as it was represented in public debate about overlaying from the beginning of the nineteenth century to date, from sources such as professional and academic journals including the Lancet and the British Medical Journal, national and local newspapers and periodical including The Times, and the St Pancras Guardian, as well as government and official reports which focused either directly on overlaying or considered it as a peripheral issue. It has also identified all available inquest records relating to Somers Town, St Pancras between 1898 and 1902 which attributed sudden infant death in bed to accidental overlaying. In addition, the thesis includes cases of new born infants who died suddenly in bed as dealt with in the case notes of pathologist Dr Ludwig Freyberger, between 1908 and 1912. These cases featured in inquests in the South West London Coroner's District. They provide detail of the immediate context of infant death including post-mortem examination notes, witness depositions and inquest verdicts. The material presented here also draws on the 1901 Census and the poverty investigations of Charles Booth to provide background detail about life in Somers Town. It draws too on other professional and academic texts produced during the nineteenth and early twentieth centuries, such as Newman (1906) and Westcott (1903), and uses these to explore the ways in which the overlaying discourse intersected with other discourses around infant mortality and temperance. Within the thesis all the above are treated as primary sources. In addition, the thesis draws on nineteenth century texts as secondary sources particularly in relation to medical knowledge, physiology, foetal development, pregnancy and child-birth, housing, overcrowding, poverty and morality as well as sources that link these to the broader context of Britain as a nation state.

Methodological considerations have been dealt with regarding the research material in terms of the following issues; the representative nature of the research materials, the uses made of materials produced and compiled for other purposes, the use of archival sources to investigate past events and the limited voice of women within such materials, especially those of mothers suspected of overlaying. Many of these issues have been addressed by drawing on as wide a range of materials as possible and juxtaposing these to provide comparative and cross-sectional analyses of the events. This is seen, for example, in Chapter Four, where reports from the St Pancras Guardian, the 1901 Census and the Coroners'

Registers for the period have been cross-referenced and further elaborated by information taken from Booth's poverty investigations of the area. The events detailed have also been set against the broader social conditions of action and the views expressed by individuals have been corroborated by the reports of others speaking at different times and places. Individuals identified within the research materials are, therefore, often referenced by others in the same or other sources. This is seen especially in the cross-over between Chapters Five and Six, where Freyberger's case notes and the dispute with GPs in south-west London refer to individuals and events that are detailed in both chapters. This is also seen in Chapters Three, Four and Six, where coroner George Danford Thomas plays a role as coroner for St Pancras and also as Chair of the Coroners' Society. It is through this means that people are shown to be acting through networks of interdependence in local situations of co-presence, as well as in more strategic and institutional roles separated across space and time.

The voices of mothers suspected of overlaying are drawn mainly from the case notes of Dr Freyberger. Here the evidence of women reported at inquests following the death of their infants is taken to cast light on the ways in which women interpreted such deaths. These accounts are analysed in a way that uncovers their reflexive conversations. It is notable that the voices of mothers suspected of overlaying generally remain available only through their involvement in these and other legal proceedings. The sources deployed here were all compiled for purposes other than the thesis. In many cases the language used was that appropriate for the context in which it was deployed, and it is recognised that this will frame the reports in terms of their original purposes. The rationale supporting their use in this sense is that the overlaying discourse was public and often official and these sources are, therefore, the most appropriate of those available. There is also a more general issue raised by investigation of the sources detailed here and subsequently compiling them in order to investigate the past. These are broad epistemological issues for sociology in general, and historical sociology in particular that have been addressed by others and are pointed up by the thesis. The materials presented here offer an historiography of infant overlaying death and the comprehensive range of materials it details provides a valuable opportunity to explore this important issue in relation to its sociological interpretation.

The central methodological problem being referred to here is that associated with using archival sources to construct a sociology of past events. One of the features of this is the 'flattening' of time and space that occurs through the compilation of past interactional events into the present textual context of a thesis. In terms of the theoretical approach taken here, which favours a sociological framework derived from ideas of process, figuration and structuration, overcoming the stasis of 'thesis time' has proved challenging. This is seen most

notably in Chapter Three where the discourse of overlaying is explored in the long-term. This has been overcome by the construction of a typology of overlaying which can identify subtle changes in the discourse over the time-period and bring attention to these against the time-frame. In this way, changes in key features of the discourse, such as attitudes to overlaying mothers, could be marked out to indicate changes in underlying conditions. This is particularly useful in relation to the material detailed in Chapter Three and identified changed ideas about infants, mothers, mothering, sudden infant death and infant mortality. It also serves to cast light on the changing position-practices of individuals as events in the short-term of four to five years. This entails using the reported speech and social practices of people from three short periods. This is seen in Chapters Four (1898 - 1902), Five (1908 - 1912), and Six (1902 – 1906). These chapters analyse the reported speech of people to cast light on the socio-structural conditions of their action and their reflexive internal conversations. This serves to point up the knowledgeability of individuals in relation to their immediate context and broader socio-structural conditions such as the discourse of overlaying. This has proved particularly helpful in regard to inquest evidence detailed in Chapter Five and the ongoing dispute detailed in Chapter Six, showing the ways that agents deployed their knowledge of rules and resources in regard to their social practice. By adopting these methods, the thesis has compiled material in a way that is appropriate to the time-frame under focus.

There are multiple analytical lines of time adopted within the thesis which intersect the idea (and event) of overlaying. In this sense time is used as an organising principle with events presented in relation to their broader temporal networks. The thesis has also usefully pointed up the way that temporal perspective serves to shape the research outcome. Current literature has been deployed to identify the issues associated with the tendency to 'resurrectionism' (Abrams: 1983) and rejects the application of recent epistemologies of sudden infant death to historical events. Material has also been organised in terms of space and time, so that the category of physical space can also be used to counter the teleological tendency of a linear chronology.

This thesis offers an exposition of infant overlaying death as a socio-structural event and points up the conditions and means through which it was constituted. It shows that the simple re-categorisation of infant suffocations in bed served to support the overlaying discourse and its dominant strand, the overlaying thesis, and that this occurred largely without remark or challenge. This change suggested there had been a real increase in the number of overlaying deaths and at the same time obscured the low number of real deaths interpreted as overlaying. The apparent increase in the number of overlaying deaths in

official publications and reports also supported other discourses, but the change in itself did not constitute overlaying.

The thesis also addresses sociological ideas about infants and infancy, mothers and mothering, intimacy, the bed(room), the body, and death, and shows in particular how these can be deployed, expanded or challenged. These ideas are drawn on to explain the discourse of overlaying as a socio-structural condition of action and its transformations over time. Central to this task are the ways of thinking about mothers and infants in the sociological terms set out in Chapters One and Two. These have been deployed to interrogate the research materials and are organised around ideas relating to the differentiation and integration of the mother and infant, the sequestration of infancy, and reflexive motherhood. These ideas have been developed within the thesis and are central to the ways that overlaying has been investigated and analysed, and they comprise a means of explaining key features of the overlaying discourse.

In this respect, high infant mortality was a public issue that represented infant life as precarious. In this way, the social integration of the infant also pointed up the existential challenge posed by infant death. Against a background of high infant mortality, the infant could not be fully integrated into society without the existential protection offered by the sequestration of the infant and infancy itself. In this regard, mothers became the means by which infant life could be sequestered and this required that motherhood itself be reconfigured.

The idea of reflexive motherhood proposed in this thesis addresses these changes and offers a means of understanding motherhood and the practice of mothering in terms of the discourse of overlaying and its transformation over time. Reflexive motherhood also articulates the mother / infant relationship in terms of the transformation of intimacy set out in Chapter Two. In relation to the discourse of overlaying, what must be noted is that despite its apparent focus on overlain infants, mothers were its main subject and the structuring of overlaying death must be understood in these terms. Reflexive motherhood suggests that the practices of mothering must be understood as a reflexive process conditioned by socio-structural influences. Reflexive motherhood also represents the positioning of women as mothers in networks of interdependence, in particular, the domestic figuration. The idea of reflexive motherhood also serves to undermine the overlaying discourse as it was deployed around other discourse relating to maternal ignorance and temperance. It is the idea of motherhood as a reflexive practice that undercuts constructions within these discourses of motherhood as ignorant, feckless and uncaring. Instead mothers are shown to have acted knowledgeably in relation to infant care and are routinely reported as caring for and of their

infants. The discourse of maternal 'ignorance' also suggested its corollary of maternal education, which represents a process that must also be understood in terms of reflexive motherhood.

The idea of reflexive motherhood has been developed to explain changes in practices influenced by the discourse of overlaying and marks the move from pre-modern to modern practices of mothering. As the overlaying discourse moved from its earlier to later form and the overlaying thesis became dominant, so culpability addressed in terms of maternal 'ignorance' became the focus of normative discourses around infant care and mothering that represented the education of women as a means of reducing high rates of infant mortality. Education was construed largely in terms of the practical aspects of mothering such as feeding and sanitation but these were also organised in terms of controlling the infant body. The shift in emphasis was from practical knowledge about mothering as a 'natural' process and experience, to a discursive knowledge of mothering which focused on the practical needs of the infant. Such changes occurred concurrently with developments in medicine, infant nutrition and feeding, welfare and child-protection which brought with it the roles necessary for monitoring mothers. These changes also occurred in a relatively short time-period between about 1880 and 1910, when the demands of reflexive mothering can be seen to be firmly established. The concept of reflexive motherhood can also be used to investigate the 'later' affective developments that others have claimed for the mother / infant relationship. It is likely that not all mothers would have been reflexive in their mothering practices by the end of the time-period detailed in the thesis, but the normative discourses that informed mothering are shown clearly in the research materials discussed in Chapters Four and Five. By the close of the period, mothers were expected to account to others for the way they looked after their children.

Childhood has been discussed in terms of an emergent identity that became significant in the nineteenth century. The relationship between parents and children is often represented in these discussions as being centred on the practical aspects of childcare and welfare until the mid part of the twentieth century, when it is described as becoming more focused on the affective relationship between parents and their children. This has also been suggested in discussions around intimacy. The material detailed and analysed here, however, sets out a very different perspective on the parent / child relationship at the turn of the twentieth century. The research materials show that the relationship between parents and infants and the attitude of others toward children must be understood to have significant affective aspects and that, without recognition of this, these materials cannot be adequately explained. This thesis has discussed examples of practice that can only be fully understood if



it is interpreted as having significant emotional content. For example, mothers were reported to have cried out on discovering their infant dead, they were described as distressed, and they also practised mothering in a way that suggested physical intimacy underpinned by emotion and motivations that were not wholly based in the practicalities of infant care. In this respect women are reported as lying face-to-face with their infants in close proximity, positioning them close to their bodies, and cradling them, all beyond the requirements of breast-feeding. Parents are also reported to have expressed physical affection through kissing their children. They also referred to their infants as having emotions and responded to them emotionally rather than solely in terms of needs and demands.

The affective value that infants represented to their parents was also shown in the way that infant bodies were treated in death. In this regard, infants were described as being 'laid out', washed and dressed subsequent to death and positioned on pillows, cushions, chairs, bolsters and beds. This indicates care of infants beyond that required by the practicalities of death in such cases. Women were also reported to have responded in an emotional way and in public to the deaths of children, and the seemingly 'uncaring' mother was considered as deserving of abuse and condemnation. Beyond this, coroners' juries demonstrated a reluctance to deliver verdicts other than death due to accidental or natural causes, even when challenged by coroners. This suggests that juries were concerned with the social implications of punitive verdicts rather than solely with the practicalities of administering justice in the case of sudden infant death. In these cases, explanation of their actions can be made by recourse to affective rather than practical values around jurors responding to and interpreting such cases in terms of their emotional content. Although the overlaying discourse often refers to the value and cost of lost infant life, beyond the immediate context of interaction it also carries connotations of affection in relation to such deaths. Recourse to emotive rhetoric might sometimes have been motivated by cynicism, but it nonetheless requires analysis in terms of its affective content. In this way, claims that infant care was predominantly a practical issue must be challenged in light of the day-to-day practices of people, especially mothers, in relation to their infants. This is especially significant in view of the official and public sources that have been drawn on here, where issues relating to affection and the emotional motivations of individuals were only of peripheral concern. It is also so in light of the negative and emotive discourse of ignorant mother, as it draws on ideas of overlaying.

There is a similar challenge from the research materials to the ways changes to organisation of bed(room) space have been represented in sociological thinking. In this respect, it has been suggested that by 1900, bed(room) space had been reconfigured in terms

of the conjugal family and intimacy (Crook: 2008). In this way, the parental bed(room) is represented as a place that excluded children and other people as well. This was certainly not the case in the research materials relating to the first decade of the twentieth century which clearly show that bed-sharing was the usual practice for many families and that the bed(room) was routinely shared by mothers, fathers, children and on occasion others. This was the case despite, in some cases, the means of separate sleeping being available. It is therefore necessary to understand the bed(room) at that time in terms other than as a primarily conjugal space. Other family members are regularly reported to be present in the bedroom and sharing the bed space. Neighbours are reported to enter bedrooms while mothers and others are sleeping. 'Monthly nurses' routinely shared bed space with mothers and their new born infants. Conversely, in many cases, fathers seem not to be sleeping in the conjugal bed in and around the peri-natal period. This suggests practices of bed-sharing and organisation of the bed(room) that run counter to many representations of the ways these were reconfigured during the period. The purportedly intimate context of the bed(room) is not demonstrated by the practices described in this thesis. In this sense, current thinking about the bed(room), family and intimacy in terms of its temporal development must be expanded to explain the grounded practices documented here. The sequestration of infancy and reflexive motherhood have, therefore, provided interdependent concepts that can be used to explore wider socio-structural conditions and actions in relation to these themes.

The previously private issue of infant care and welfare became a public issue, but the subsequent protective sequestration of this troubling period of life required social management. In this respect, mothers were made the safe-guarders of both the infant and also of the existential sensibilities of people in the wider social context. Infant life, precarious as it was, could then be made the responsibility of individual mothers. In this way maternal culpability served as protection for the infant through management of its needs and also served as the scapegoat for infant mortality. The threat of finitude represented by infant mortality was socially mitigated in this way.

It becomes apparent through the research materials discussed in the thesis that the discourse of overlaying was taken-up vociferously and in public. It also operated across a range of socio-structural conditions and levels. It was also taken-up by powerful officials and authoritative individuals such as doctors, coroners and social campaigners. Yet despite this, the overlaying discourse at its height could be shown only has having had limited influence on the practices of mothers in relation to infant care on a day-to-day basis, especially with regards to bed-sharing. Its influence, therefore, appears to be limited and remains implicit in the way mothers described positioning their infant for sleep while bed-sharing. It is apparent

in the explanations offered by women following the deaths of their infants and the measures they describe for safeguarding their infant during sleep. It also appears in the reflexive comments made by fathers. Importantly, although some mothers interpreted the death of their infants in terms of overlaying, this was infrequent and instead mothers usually refuted the suggestion of overlaying and often could offer no explanation of such deaths. Despite the prominence of the overlaying discourse and the leniency of any official response following the event, many women rejected the assumption of overlaying as it related to their own experiences of sudden infant death in bed. This particularly points up the role of agency, knowledgeability and local circumstances in the context of such deaths, with others, without personal experience of such deaths, being more accepting of the discourse in the absence of such contextual knowledge.

The role of fathers in the discourse was only peripheral. Fathers were not constructed as responsible for such deaths and their role within the domestic figuration was limited in relation to the infant and infant care. In this respect, the male head of household was subordinated in practice and on occasion displaced from the (conjugal) bed(room) space. These representations of fathers do not support other views of the father's primary role in the household. In relation to their public role, however, men (if present within the household) were shown to take a primary role in the inquest and identified the body and gave evidence despite routinely being only on the margins of the event. Within the research materials discussed, this serves to highlight the absence of mothers' voices in the inquest and supports the suggestion that women were not viewed as being of principal concern in purported infant overlaying. In this sense women, although supposedly instrumental in such death, had only a passive role in its social construction at this point in the process.

In conclusion, this thesis has contributed to knowledge in the following ways: firstly by providing a historiography of overlaying death as it underpins a historical sociology of infant overlaying; secondly by expanding ideas around motherhood, infancy, the family, intimacy and (bed)room space in terms of the explanatory concepts of reflexive motherhood and the sequestration of infancy; thirdly, by providing an empirically grounded exposition of overlaying as it relates to the process and theory of structuration. This thesis addresses Elias's demand for grounded research and Stone's call for research at the level of the ontic to explore the relationship between agents and socio-structural features as the conditions and outcomes of action. The thesis therefore details the discourse of overlaying as it influenced the lives of individual people acting in networks of interdependence from Hettie White, the mother who woke to find her infant dead, to Prime Minister, Arthur Balfour. And therefore also as it shaped practice positions and institutions from mother(s) to England as a nation.

## **Appendix 1: Overlaying, Bed-sharing and Sudden Infant Death Syndrome circa 2010**

In 2007, the latest year for which records are currently available, the total number of neonatal infants (under 28 days) recorded as accidentally suffocated or strangled in bed in Britain was 3 (2 male and 1 female) (ONS: 2009b: 72). In the same year, there were also 264 unexplained infant deaths (ONS: 2009a: 1). These represent 193 deaths identified as sudden infant death syndrome (SIDS) and 71 unexplained deaths (ONS: 2009a: 2). As with historical overlaying, this indicates there is a lack of clarity regarding both the definition and diagnosis of SIDS and other ‘unexplained’ deaths and this remains an ongoing issue (Beckwith: 2003: 286; Carter & Rutty: 2000: 1019; Byard: 1995: 121; Rutty & Sawicka: 2002: 208), with what has been usefully termed a ‘diagnostic drift’ between overlaying, SIDS and unexplained infant death (Collins: 2001: 155). As was the case with historical overlaying, there is discussion and concern about the possible misidentification of infanticide as SIDS (Committee on Child Abuse and Neglect: 2001: 437; Wilczynski: 1994: 61). Many of the features seen in SIDS and unexplained infant death reflect features that were historically attributed to the overlaying deaths, as noted earlier. These include more deaths of boys than girls, more deaths in the winter than the summer, more deaths to single mothers, more deaths of infants with routine, manual working or unemployed fathers, and recognition that other socio-economic factors, such as housing, are also relevant to cases of sudden and unexplained infant death (ONS: 2009a: 3; Schulter et al: 1997: 243).

Arguments about the proper place for an infant to sleep also continue (Scheers: 2003: 883; Wailoo et al: 2004:1082) and there are clear divisions between those who see bed-sharing as a danger (FSID: 2009: 1) or as a benefit to the infant (Heinig: 2000: 189). The role of parental alcohol and drug consumption (Scragg et al: 1993: 1312) plays a part in the discussion of SIDS today as it did for overlaying a hundred years ago, as does the role of over-wrapping (Wigfield et al: 1993: 181), head covering, parental tiredness and fatigue, and infant prematurity. But alongside these recurrent features, there are current-day risk factors identified which were not encountered in overlaying, such as the risk posed by parental smoking (FSID: 2009: 1) and the higher incidence of SIDS associated with particular ethnic backgrounds (Unger et al 2003). Another difference is that unexplained infant death no longer seems to occur predominantly in the parental bed, and instead the cot is frequently the location of an infant’s death, although some studies claim that as many as 70% of sudden or unexplained infant deaths do occur while co-sleeping (Ridson: 2003).

SIDS has over time undergone re-workings in its definition and use and so there has also been a fluctuation in the reported numbers of its incidence. This has been attributed to a diagnostic transfer of certain types of infant death between one category and another, usually based on the ruling out of pathological signs. Another changed feature (far more recent in its recognition) is the acceptance that a mother can lose successive infants to SIDS and that the loss of a second infant does not necessarily indicate a previously 'misdiagnosed' case of infanticide. Until the successful appeals of several women convicted for causing the deaths of their infants, comparisons would have suggested that many women were treated more harshly in 1990s UK than would have been the case in the historic cases detailed in this thesis, where women reported as overlaying two or more infants in succession were represented as examples of extreme carelessness but generally no charges were brought against them.

There are undoubted similarities between historical overlaying and current-day SIDS and unexplained infant deaths, and I note them here to indicate that some features of the landscape remain. I am not, however, attempting in anyway to re-attribute nineteenth and early twentieth century overlaying deaths to SIDS. Others (Hansen: 1979; Kemkes: 2009; Prior: 1989; Savitt: 1979; Williams et al 2001; Zuck: 1995) have in my view mistakenly attempted this. Firstly, historical overlaying and current-day SIDS deaths cannot be compared in any meaningful way with regards to the diagnosis of infant death and its pathology, because there were not and are not any agreed pathological signs associated with either overlaying or SIDS and these diagnoses were and are only ever arrived at by exclusion of readily (in historical context) identifiable pathology. Secondly, a meaningful comparison would necessitate the reconstruction of the nineteenth century epistemic space of overlaying death or a retrospective application of the current epistemic space of SIDS onto nineteenth century situations and neither are defensible methodologically or conceptually. Overlaying and SIDS are not (and can never be) interpreted in terms of each other, and it is not possible to apply the term SIDS retrospectively to earlier cases of overlaying if only because the epistemic space of SIDS did not exist at that time and cannot be applied retrospectively. Certainly each year a small number of infant deaths defy explanation by pathology except by the ruling out of readily identifiable pathological cause, but these are always and necessarily interpreted according to the social and situational features of the deaths in their historic context. The explanation of these deaths can therefore best be explored in terms of their social constitution, the task of my thesis.

There are possible long-term consequences of this regarding investigation of sudden infant death syndrome (SIDS), which may have been delayed for some fifty years until the

incidence of bed-sharing had diminished sufficiently for a significant number of infants to have died unexpectedly in their cots. Many thousands of infant deaths were attributed to overlaying and as a consequence understanding of pathology specific to the infant body did not develop contemporaneously with understanding of the adult body. Also, while overlaying remained the accepted default explanation of infant death in bed, some infants may have been the victims of infanticide. In addition, the form of mothering practices, learned by experience of mothering and being mothered which passed from generation to generation were increasingly replaced with formal instruction and attempts to standardise education for girls and women as mothers-to-be and overlay was presented as an unacceptable risk of bed-sharing.



**Appendix 2: Tables**

**Table 1: Infant Overlaying and Suffocation Deaths, England and Wales, 1880-1890**

<b>Year</b>	<b>Overlaying</b>	<b>Suffocation by Bedclothes</b>	<b>Suffocation in Bed</b>	<b>Total</b>
<b>1880</b>	125	1043		1168
<b>1881</b>	126	1033		1159
<b>1882</b>	156	1103		1259
<b>1883</b>	174	974		1148
<b>1884</b>	202	927		1129
<b>1885</b>	247	863		1110
<b>1886</b>			1232	1232
<b>1887</b>			1246	1246
<b>1888</b>			1367	1367
<b>1889</b>			1388	1388
<b>1890</b>			1517	1517

Source: Compiled from Registrar General Annual Reports of Births, Deaths and Marriages 1880-1890



**Table 2: Annual Deaths from Suffocation by Gender, England and Wales, 1881-1890**

<b>Year</b>	<b>Males</b>	<b>Females</b>	<b>Total</b>	<b>Rate per Million Births</b>
1881	578	571	1149	130
1882	600	560	1160	130
1883	577	571	1148	129
1884	589	541	1130	125
1885	549	561	1110	124
1886	659	573	1232	136
1887	628	624	1252	141
1888	655	712	1367	155
1889	689	697	1386	157
1890	767	750	1517	174
Total 1881-1890	6391	6160	12451	140

Source: Jones: 1894: 40

**Table 3: Infant Mortality (Deaths per 1000 Births), St Pancras and London, 1898-1902**

Area	1898		1899		1900		1901		1902	
	Number of Deaths Under 1 Year	Per 1000 Births	Number of Deaths Under 1 Year	Per 1000 Births	Number of Deaths Under 1 Year	Per 1000 Births	Number of Deaths Under 1 Year	Per 1000 Births	Number of Deaths Under 1 Year	Per 1000 Births
<b>Regents Park</b>	173	178.2	141	148.9	250	183.3	201	147.4	192	133.3
<b>Tottenham Court</b>	139	227.2	124	220.3	99	182.0	85	176.0	88	199.1
<b>Gray's Inn Lane</b>	164	192.6	172	216.4	146	173.0	150	188.5	177	200.7
<b>Camden Town</b>	62	141.2	68	152.5	146	139.2	127	120.9	118	112.5
<b>Kentish Town</b>	451	150.1	479	168.2	228	132.1	229	137.2	192	116.2
<b>Somer's Town</b>	180	183.9	202	197.9	168	182.8	183	194.0	183	185.4
<b>St Pancras Total</b>	1169	170.5	1186	179.2	1037	160.9	975	154.7	950	147.2
<b>London Total</b>	22140	167.2	22289	167.5	20927	160.0	19611	149.4	18722	141

Source: Reports of the Medical Officer of Health, St Pancras, 1898-1902

**Table 4: Number and Causes of Infant Death, , St Pancras, 1898-1902**

<b>CAUSE OF DEATH</b>	<b>1898</b>	<b>1899</b>	<b>1900</b>	<b>1901</b>	<b>1902</b>	<b>Total</b>
<b>Diarrhoea &amp; dysentery</b>	187	189	196	132	55	759
<b>Debility, atrophy &amp; inanition</b>	163	154	128	135	143	723
<b>Premature birth</b>	164	138	118	111	133	664
<b>Bronchitis</b>	131	123	56	124	79	513
<b>Enteritis</b>	116	111	87	65	39	418
<b>Pneumonia</b>	22	96	114	47	104	383
<b>Convulsions</b>	62	68	64	51	43	288
<b>Whooping cough</b>	39	50	41	34	53	217
<b>Suffocation</b>	42	38	38	33	41	192
<b>Measles</b>	26	23	23	16	24	112
<b>Other</b>	217	196	172	227	236	1048
<b>Total</b>	1169	1186	1037	975	950	5317

Source: Reports of the Medical Officer of Health, St Pancras, 1898-1902

**Table 5: Causes of Infant Death %, St Pancras, 1898-1902**

<b>CAUSE OF DEATH</b>	<b>1898</b>	<b>1899</b>	<b>1900</b>	<b>1901</b>	<b>1902</b>	<b>Total</b>
Diarrhoea, dysentery	6.0	15.9	18.9	13.5	5.8	14.3
Debility, atrophy & inanition	13.9	13.0	12.3	13.8	15.1	13.6
Premature birth	14.0	11.6	11.4	11.4	14.0	12.5
Bronchitis	11.2	10.4	5.4	12.7	8.3	9.6
Enteritis	9.9	9.4	8.4	6.7	4.1	7.9
Pneumonia	1.9	8.1	11.0	4.8	10.9	7.2
Convulsions	5.3	5.7	6.2	5.2	4.5	5.4
Whooping cough	3.3	4.2	4.0	3.5	5.6	4.1
Suffocation	3.6	3.2	3.7	3.4	4.3	3.6
Measles	2.2	1.9	2.2	1.6	2.5	2.1
Other	18.6	16.5	16.6	23.3	24.8	19.7
<b>Total</b>	<b>100.0</b>	<b>100.0</b>	<b>100.0</b>	<b>100.0</b>	<b>100.0</b>	<b>100.0</b>

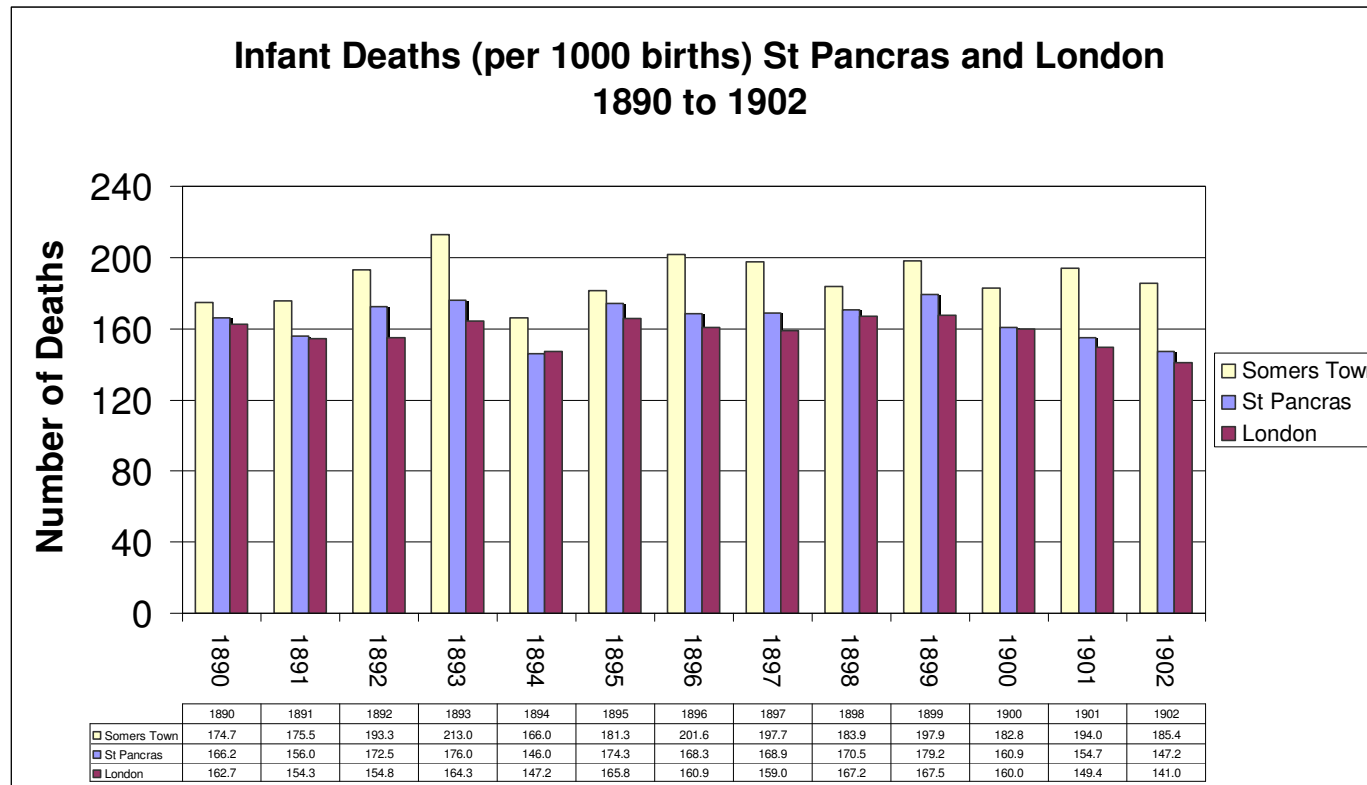
Source: Reports of the Medical Officer of Health, St Pancras, 1898-1902

**Table 6: Suffocation Death % of All Infants Deaths, St Pancras, 1893-1902**

	1893	1894	1895	1896	1897	1898	1899	1900	1901	1902
<b>St Pancras Infant Deaths Under 1 Year</b>	1221	1012	1236	1185	1185	1169	1186	1037	975	950
<b>Suffocation Deaths</b>	47	41	46	38	33	42	38	38	33	41
<b>% Suffocation of All Infant Deaths</b>	3.9	4.1	3.7	3.2	2.8	3.6	3.2	3.7	3.4	4.3

Source: Reports of the Medical Officer of Health, St Pancras, 1893-1902

Figure 1: Infant Mortality (Deaths per 1000 Births), Somers Town, St Pancras and London, 1890-1902



Source: Reports of the Medical Officer of Health, St Pancras, 1898-1902



**Appendix 3: Maps of Somers Town, St Pancras**

**Map of Somers Town St Pancras, London 1870**

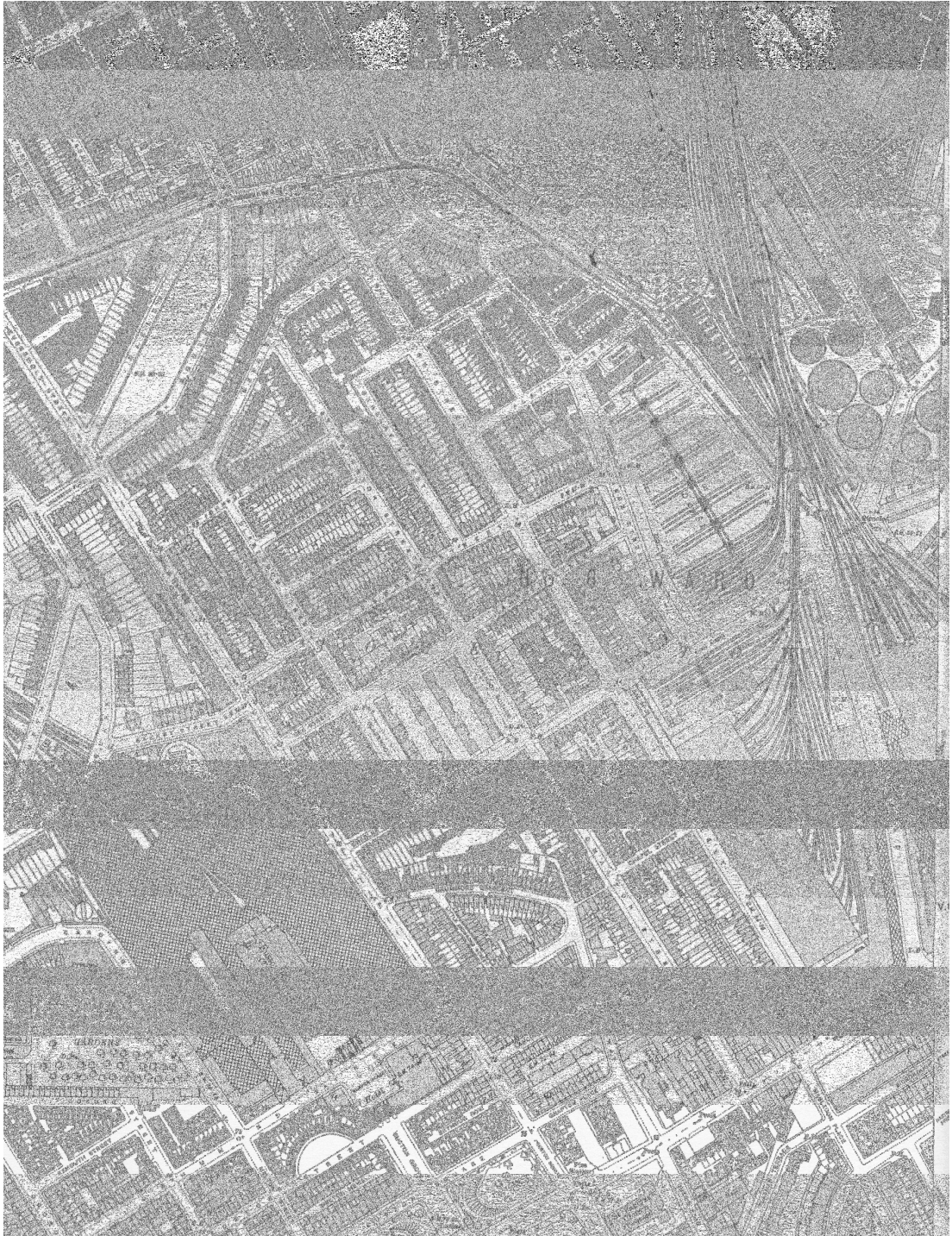




Map of Somers Town St Pancras, London 1896



**Map of Somers Town St Pancras, London 1913**





Appendix 4: Example from Dr Ludwig Freyberger's Case File: The Post-Mortem of Percy White

To be read between joints

Verdict: Natural Causes.

Cause of Death: Infection which  
 supplies from bronchopneumonia  
 and acute bronchitis; patent for some  
 weeks. cyanosis blue splenoidy - acute  
 splenic tumor.

Particulars of Evidence:

Percy White, 16/65, identified by his father  
 of 8<sup>th</sup> St from 24/18 - D<sup>th</sup> took from out of all  
 things D<sup>th</sup> looked in attitude - D<sup>th</sup> very healthy  
 & unimpeded. Last time D<sup>th</sup> alive at 12:30 AM  
 on 11/10/10 - D<sup>th</sup> in bed between parents, double  
 bed - D<sup>th</sup> at awake then, subside to be all right  
 fresh in morning 7:30 or 7:40 AM - D<sup>th</sup> then  
 parents as far as he knew - D<sup>th</sup> then close  
 to its mother, half on its back - D<sup>th</sup> looked  
 very black, as blood cyanosis. D<sup>th</sup>  
 not touch D<sup>th</sup> hand touch, went for D<sup>th</sup> who  
 came only at 2 PM - D<sup>th</sup> was dead when he  
 woke. Mother D<sup>th</sup> was suffocated, as the  
 colour was dusky - When he saw D<sup>th</sup> this  
 wife was lying on it, she had shifted -  
 the wife had not taken out.

Mother White, mother of D<sup>th</sup> other first child, fell  
 from quite healthy, breast-fed, recent taken  
 out - D<sup>th</sup> quite well she thinks. D<sup>th</sup> had last  
 about 9:45 PM on 10/10/10, and after that, she was  
 nursing - went to bed at 10:20 PM  
 D<sup>th</sup> before 10:30 PM, lying below pillow, up  
 on her arm - when was father, it - then  
 went to bed - at 12:30 AM she awakes & D<sup>th</sup>  
 upon - Wake again at 7:40 AM - room pulled  
 lying on D<sup>th</sup>, lying half on her stomach, but  
 the breast lying over D<sup>th</sup> face - within hand  
 cramped feeling on her arm, she used to have  
 been lying on D<sup>th</sup> fully from above - those  
 will flatten, but in mouth (flat) & drops -  
 D<sup>th</sup> quite warm - then thought D<sup>th</sup> was suffocated  
 from father in his arm & drew on mouth of  
 D<sup>th</sup> when a heavy sleeper, as he is - had not  
 got a cot yet, because of D<sup>th</sup> inability to go  
 out.

D<sup>th</sup> Charles Parker, attended with coronial  
 health, D<sup>th</sup> healthy, took breast - was called

Lambeth Coroner's Ct. 14/10/10

0.4/365. 20 in. 67653; fairly young?  
 D<sup>th</sup> from hypostatic; lump, as a tons  
 under of o: alvea; mouth open; D<sup>th</sup> D<sup>th</sup>  
 tongue from; ~~as~~ as conjunctival ecchymosis  
 leaf for Kuller: wall

Brain: meningeal veins full; substance  
 wall.

Upper air food passage: larynx pale  
 swollen dusky, covered by thin  
 of dried present white mucous.  
 Trachea much blood tinged with  
 mucus. Main bronchi ditto - then  
 mucous, swollen.

Lungs: both free, almost ashen, florid  
 submucous, half way down  
~~water~~; dark purple red, in sub-  
 stance of all lobes all deep  
 dark purple tint, more violet ~~pink~~  
 tip of pink head larvae; ~~47~~ ~~47~~ ~~47~~  
~~cast~~

Heart: R(HV) dilated by green  
 usually blood red, foramen oval  
 open; dilated size of shilling coin.

Liver: Cyanotic, more firm than  
 usual.

Spleen: Slightly swollen, capsule tense,  
 pulp blood brown, soft.

Kidneys: Suprarenals ~~kidneys~~ ~~slightly~~  
 small

Stomach: about 1 table spoonful of  
 sour, smelly soft mass of mucus  
 with - mucus wall

Intestine: gaseous distension; content  
 present yellow, slimy, some sandy  
 mucous velocity, flattened in low  
 portion of ileum; in case was swollen.

Mucous glands: ~~no~~

Blood: empty.

No internal injuries

Source: Wellcome Library GC/140/4/286



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**1885.** *First Report of Her Majesty's Commissioners for Inquiring into the Housing of the Working Classes.* C4402.

**1886.** *Forty-Eighth Annual Report of the Registrar-General of Births, Deaths, and Marriages in England.* C4896.

**1887.** *Forty-Ninth Annual Report of the Registrar-General of Births, Deaths, and Marriages in England* C5138.

**1888.** *Local Government Act.* C41.

**1890.** *Fifty-Second Annual Report of the Registrar-General of Births, Deaths, and Marriages in England.* C6478

**1900.** *Sixty-Second Annual Report of the Registrar-General of Births, Deaths, and Marriages in England.* Cd761

**1904.** *Report of the Inter-Departmental Committee on Physical Deterioration.* Cd2175.

### **Archives**

**Charles Booth Online Archive** (Referenced Booth 2005)

- The Booth survey documents at the British Library of Political and Economic Science. <http://booth.lse.ac.uk/static/a/5.html> [accessed 31/10/2004].

**London County Council** (Housed at the London Metropolitan Archive - references prefixed LCC)

- **LCC/PC/COR/1/65/ 9/10/1920** Letter from James Ollis, James Chief Officer, Public Control Committee to Walter Schroeder.
- **LCC/PC/COR/1/65/ 9/10/1920** Letter from Walter Schroeder to James Ollis, London Metropolitan Archive.

**London Metropolitan Archive** (References Prefixed LMA)

- Coroners' Registers (LMA: COR/A/009).

**Registrar General Census 1901**(Housed at the The National Archive-references prefixed TNA)

- 1901 *Census of England and Wales*. References are for the digitised version <http://www.1901census.nationalarchives.gov.uk/index.html> [accessed 31/1/2005].

**St Pancras Vestry Records** (Housed at Camden Local Studies Centre, Holborn Library)

- **Sykes, John.** 1890-1914 (inclusive). *Annual Report(s) of the Medical Officer of Health*. St Pancras. St Pancras Vestry.
- **Vestry of St Pancras Health Department.** 1893. *Housing of the Working Classes Act 1890. Enquiry on behalf of the Secretary of State by D Cubittnichols Esq (Arbitrator), Minutes of Evidence with Reference to the South Saint Pancras Scheme*. London . Vestry Hall.

**Wellcome Library** (Medical Archive, Euston Road, London)

- Case files of Dr Ludwig Freyberger GC/140/1-6





## **Periodicals and Newspapers**

**British Medical Journal.** London. Online archive.

**Child's Guardian, The.** National Society for Prevention of Cruelty to Children. British Library, Colindale.

**Lancet.** London. Online archive.

**Liverpool Mercury.** Local History Centre, Liverpool.

**St Pancras Guardian.** London. British Library, Colindale.

**Times, The.** London. Online archive.

## **Note on referencing for digitised periodicals and newspapers**

During the writing of this thesis the catalogues of a number of publications have been digitised and made available online.

References from these digitised sources have been used for The Times, Lancet, and British Medical Journal and the Registrar General's Census 1901

References to The Times have been made as follows: (The Times: Day Month Year: Page: Column). Both the Lancet and British Medical Journal published two volumes per year and page numbers are repeated during the year. References to these publications in the thesis therefore use the unique issue number of each edition and are made as follows: (Name: Year: Issue: Page Number). Supplements are numbered with the addition of a (S)upplement number as (Year: Month: Issue: Supplement: Page). References to the Census 1901 are given as (TNA: Series: Piece: Folio: Page).

## **Reference Abbreviations**

**BMJ** - British Medical Journal

**BPP** – British Parliamentary Papers

**LCC** – London County Council

**LMA** – London Metropolitan Archive

**ONS** – Office for National Statistics

**RG** – Registrar General Census 1901

**SPV** – St Pancras Vestry

**STPG** - St Pancras Guardian

**TNA** – The National Archive