**The health and medical needs of Victoria’s older female prisoners, 1860-1920**

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We don’t often consider prisons as a place where people *want* to be placed by authorities. However, Mary Godsil was one such convicted offender who in 1916 asked a judge to place her back into prison after the benevolent society she was forced to stay with did not offer her acceptable conditions. Godsil argued that staff at the Bendigo Benevolent Asylum did not treat her with respect, hence why she had left and instead given herself up to the police and asked for entry to Pentridge (*Evening Echo,* 1916, p.2). Staff at Pentridge had treated her well, Godsil said, while at the asylum when she had last been ill she had been denied proper nutrition. Mary had been convicted of vagrancy and insufficient means of support on 9 occasions between 1912 and 1918. At her last appearance in court aged 79 years she asked to be sent to prison for life as she did not wish to be sent to the Bendigo Benevolent Asylum again – the judge sentenced her to 12 months instead, to which Godsil responded “I hope to not live that long”. Her wish did not come true, although she was not to last long after release from prison, with her death certificate revealing that she died in East Melbourne in 1920 aged 81 years.

Older women are very often invisible in criminological research. To the extent they are visible at all, they are typically imagined as victims of crime. The same is true of historical research (Brogden and Nijhar, 2000). There is thus little we know about older women’s experiences of prison or criminal offending (Turner and Trotter, 2010) including how these experiences may have shifted over time. It is understandable why this is the case: prisons are primarily set up to house young, male offenders. Within such an institute women are out of place, and older women especially so. Older women are therefore doubly invisible in prisons – they are a minority within a minority (Handtke, Bretschneider, Elger, Wangmo, 2015; Reviere and Young, 2004). But this lack of visibility of older women to policy makers, prison authorities, and even members of the public is now causing headaches – imprisonment rates in Victoria and indeed all through Australia have been steadily increasing since the 1980s with significant jumps in the early 2000s. While male rates of imprisonment have plateaued, women’s imprisonment rates are rising, and the rates that have leaped the most is that of women first encountering the criminal justice system as offenders over the age of 50.

The current lack of scholarship on historical offending by older women makes it difficult to situate the contemporary trend within a long-term perspective, something that this paper hopes to go some way to redress. The data for this paper is sourced from the Victorian Central Register of Female Prisoners. Between 1860 and 1920, 6,042 women were imprisoned in Victorian prisons. While most offenders were young, there was a considerable cohort who could be considered older offenders. 652 women (10.9 per cent) can be identified as aged 50 years or over when first imprisoned. Offenders over the age of 40 accounted for 1,665 of the women in the dataset (27.6 per cent). What either the research or the legal system considers as “older” is problematic as there is no clear definition of who would be considered an “older” offender, with authorities and policy makers often using various age ranges. In some contemporary jurisdictions and research, older offenders and prisoners are counted from the age of 40-45 years, while elsewhere the definition of older offenders begins at the age of 65 (Baidawi et al, 2011; Aday and Krabill, 2006; Yorston and Taylor, 2006). For the purposes of this study, women who were first convicted aged 50 years and over will be counted, as this has been the operational definition of older prisoners by contemporary researchers in Victoria and by the state government for a considerable time now (Stojkovic 2007; Turner and Trotter, 2010; Baidawi et al., 2011).

Before turning to the specific experiences of our sample of older female offenders, it is necessary to understand the general prison conditions these women faced, as well as the prevailing attitudes towards their health concerns. Between 1860 and 1920, women in Victoria were largely imprisoned in institutions built with men in mind, and during the 1860s and 1870s were sometimes incarcerated not in purpose-built prisons at all, but in hulks docked in Port Philip Bay. The use of these hulks points towards the persistent issue of overcrowding that dogged Victoria’s prison system throughout the nineteenth century, until the overall number of persons being incarcerated began to decline from the turn of the century. Both newspaper and parliamentary reports from the period suggests that prisoner health – and well-being more generally – was a low priority to authorities, or staunchly defended as a non-issue, because these gaols were only housing criminals (The Argus, 21st December 1906, p.4).

The extent to which the older female prisoners could truly be considered criminals though is debateable. 79.1 per cent of older women were imprisoned on minor public order charges, with 39.4 per cent imprisoned on charges of vagrancy, begging, or lacking a lawful means of support. While these offences could be directed at removing people from the streets who were considered public nuisances, in the case of older women in particular such charges were more likely to be related to poverty than criminal disorderliness. Women, already excluded from a range of economic activity by nineteenth-century gender ideologies, found their labour further marginalised as they aged. The social welfare available to them during this period was also limited: the old-age pension was only introduced in Victoria in 1900, and while growing demand led to the development of an array of charitable institutions from the 1880s the stringent conditions that attached to such charity meant far from all those in need were able to access it.

In comparison, theft offences including larceny or receiving stolen goods amounted for only 17.3 per cent of offences for older women, 9.5 per cent were imprisoned for violent offences, and miscellaneous offences and arson accounted for 9.7 per cent of offence types. Charges of vagrancy were sometimes used as a means of punishing suspected prostitutes, and it is likely that in old age some women turned to sex work in order to survive. However, only 7 women in the older cohort were imprisoned on charges of soliciting prostitution, and while more may have been involved in sex work and convicted on other charges, it seems likely that for many older women, poverty was their only offence. Certainly, in the first two decades of the twentieth-century older women’s imprisonment dropped drastically- whereas over 60 per cent of the women were first imprisoned in the 1870s and 1880s, first imprisonment in 1900 was only 7.7 per cent, dropping to 4.4 per cent of the sample by the 1910s.

Indeed, some of these women charged with vagrancy were sent by magistrates to prisons as a means of ad hoc welfarism, including as a way to ensure that they received health care in the lead up to the end of their lives. In 1866, the Chief Medical Officer of Victoria thus observed that “The large amount of sickness which comes under treatment in the gaol, is not to be attribute to any unhealthiness in the building or site, but simply to the fact that the gaol is an hospital, to which all the destitute sick that come before the different benches of magistrates are sent, in the absence of any other way of disposing of them” (p,7). Again in 1870 it is noted that “The mortality, however, was considerably greater than in the previous year. This arose from the fact that a number of persons taken up by the police in the· country districts and committed to the gaol as vagrants were in a destitute state, laboring under mortal disease, and proper objects for hospital treatment. There were seven of these cases in all, who, when admitted, had no chance of living, and only swelled the mortality of the gaol” (p.5). And yet again in 1874 “All the serious sickness and all the mortality was owing to causes independent of the gaol, many cases of chronic and some of incurable disease having been sent to the gaol in the absence of room in the public hospitals, benevolent asylums, &c. These persons were mostly of the criminal class, but several of them had committed no crime, and were sent to gaol to preserve them from destitution” (p.6). There is an inherent tension in the reporting of prisoners’ health concerns. On the one hand, authorities acknowledge that many of those suffering health concerns were imprisoned not for crime, but for welfare concerns. The lack of prior criminal histories on the part of women who first entered the prison system after the age of 50 offers support for this contention, suggesting that they had for the most part previously lived blameless lives. On the other hand, however, officials – in an effort to downplay the State’s responsibility to these older prisoners – consistently portrayed their health issues as the result of lifestyle choices contingent upon membership of the ‘criminal class’.

For instance, while the Chief Medical Officer’s return of diseases in the Melbourne and Western Gaols for 1860 indicated that disease was greater than in the past, leading to a higher level of mortality than for the last 2 years principally from influenza and diarrhoea, the CMO was adamant that “this did not in any way arise from the unhealthiness of the prison” (p.6). Instead it was emphasised that the Western Gaol was largely a holding facility for drunkards, vagrants or “lunatics. For female prisoners, ulcers – another leading cause of mortality that year – were deemed indicative of, as the CMO wrote, “a life of bad choices and habits”. Similar euphemisms were used frequently by officials to infer that responsibility for health issues almost always rested with sufferers themselves, and were directly traceable to the vices of the criminal classes: sexual immorality, drunkenness and general rough living.

Drunkenness undoubtedly was the bane for physicians and prison officials. Some 105 women (16.1 per cent) of the cohort had at least one drunkenness charge that led to imprisonment. Annual reports on the state of the prisons in the colony are replete with Inspectors and other prison authorities highlighting the extent to which drunkenness was affecting prisoners prior to their imprisonment, how prisons were being used as makeshift hospitals and poor houses, and suggestions for the formation of inebriate asylums that might provide more appropriate treatment for such individuals. The 1865 CMO’s report declared that a quarter of the cases of illness in the gaol were attributable to drunkenness directly, while the rest were indirectly due to alcohol. By 1874 it was only one-fifth of illness within the prison that were attributed to alcohol. The 1875 CMO report reads primarily as a medical practitioner’s exasperation with the number of prisoners ending up in prison due to drunkenness:

The gaol is a premium on drinking among the lower and criminal classes. They are 'taken up' by the police either drunk or delirious, sent to the gaol, placed in a comfortable hospital, treated with the greatest care and watchfulness, and with all the appliances of medical science and skill, and when they get well are usually discharged by the benches of magistrates without any punishment” (p. 6).

A suggestion from the Inspector-General in 1914 was the drunkenness should be dealt with not as a low-level offence but rather as a serious crime due to not only the number of crimes committed while under the influence, but that prison no longer served as a deterrent for drunkenness. While older women are not frequently noted by the authorities in these returns and reports, comments about drunkenness do often also include examples of so-called “old women” who were habitual inebriates and occupants of the prisons. There was little sympathy for the elderly who found themselves imprisoned, especially as they were considered to not only be responsible for their ill-health and condition, but unredeemable within the system.

Bronchitis cases, which were very numerous in the 1860 report, were also considered the fault of the predominantly older male and female offenders who were suffering from it- their drinking habits were considered the cause for their susceptibility. While alcoholism can be a risk factor to bronchitis and other respiratory illnesses, especially pneumonia, this is often due to a bacterial infection resulting in the respiratory illness (Kelly, Advocat, Harrison and Hickey, 2011). The CMO in 1874 noted that “There is not, probably, in the world, a more healthy place than the Melbourne Gaol; well situated, well built, ventilated and drained; the inmates properly dieted and clothed, and kept clear of the excesses to which their class is liable outside the walls, are subject to very few ailments, and these of a trifling nature” (p.6). It is likely though that the Draughty conditions within the old Victorian-era prisons also contributed to the pneumonia of many an older prisoner. And while Melbourne Gaol may have been well planned, space was at a premium in many of these institutions – accommodation for women at the asylums was poor with up to seven women at one point in a small hospital ward at one time, and “in the daytime turned into a small yard with little or no shelter from the sun; the consequence of this was, that nearly the whole seven had to be kept in strait jackets, and closely watched, being unavoidably exposed to causes of excitement, owing to want of proper accommodation for lunatics. Their noise and language have been at times exceedingly annoying and troublesome to other (sane) prisoners (CMO Report, 1864, p.17)”. Lack of space at other benevolent institutes led to prisons being overcrowded and places where diseases spread- measles broke out at Melbourne Gaol in 1874 but was contained. Although asylums and other benevolent institutions around Australia tended to have young women rather than older ones in their care (Vreugdenhil, 2012) , a number of older women, 34 of the 652, were transferred out of prisons.

Why these 34 women were transferred is difficult to deduce. For 2 women at least in 1914, their advanced aged being “quite unfit for prison discipline” led to their being released from prison and admitted to homes for their care (Victorian Parliamentary Paper, no. 30, 1914, p. 5). For 18 of the 34 women transferred to a lunatic asylum, a lifetime of cycling in and out of the prison system more than likely exacerbated their poor mental health or illness and was a reason for their continued imprisonment. In these cases, the women appear to have had their first conviction listed in their late fifties or early sixties, but their last conviction is noted as being over the age of 70 at the time of their transfer out of prison, with criminal careers spanning up to twenty years. The onset of dementia or Alzheimer’s in this cohort would also act as an incentive by prison officials to transfer them into other institutions that could potentially better cater to their needs. On the other hand, women who were transferred to a lunatic asylum with shorter criminal careers (12 months or less between their first and last offence) tended to be women aged in their fifties; it is possible that they were exhibiting behaviours that authorities considered more problematic and requiring immediate medical intervention.

Several of the elderly women do have details about physical marks and disabilities that can help paint a picture about their health. 17 per cent (n= 116 women) have notations about their physical health. For many there is a litany of physical attributes that could have been linked either to criminal activity (either as offenders or victims) or contribute to an ongoing criminal career due to difficulty finding or undertaking paid employment. For example, although Melbourne had from 1862 an institution for the deaf and blind, nine women in the cohort had notations about deafness or blindness. Mary Wilson, who was imprisoned for larceny and embezzlement, was sentenced to a term in prison in 1865. Servants, Frances Johnston, Mary Weaver, and Mary Stevenson, who were all blind in one eye, had not only the blindness but additional scarring, arthritic hands and a lack of teeth to contend with. These additional ailments could very well have acted as a barrier to employment. Yet, although this institute existed, these women were not transferred out to the one institute that may have been able to assist.

How other women suffering from physical infirmities were dealt with by the prison officials is not part of the prison reports. Women like Margaret Jones, who was paralysed in her arms and legs, and Catherine Shaw who had a deformed spine and damaged fingers, would also have been unlikely to find work as servants easily. Others with scarred features, missing teeth, deformed hands and spines, ears slit (potentially due to assaults or DV), and notes claiming that certain women were “not perfectly sane” would have had possible care needs that were not being met externally to the prison, thereby facilitating their pathway to criminality due to necessity, and would have had specific medical needs within the prisons. Although prison officials certainly saw a lot of the work that they did for prisoners as being hospitalisation and care rather than as imprisonment, when the prisoner entered with a physical impediment there does not seem to have been much focus on their needs in official records beyond recording these physical marks.

Deaths of elderly female prisoners were certainly recorded in the prison registers but are either missing or glossed over in reports about prisoner health and well-being. 51 women (7.8 per cent) died while incarcerated. For some the records state merely that they died in prison, but for others authorities included a cause of death. For some women the description is merely that they passed away from “old age and debility”, others were victims to the diarrhoea illnesses that are mentioned in the CMO or prison investigator reports. Death from exhaustion, paralysis, peritonitis, cancer, apoplexy, and heart and brain disease are the various other causes of death established by prison officials. Sarah Norey’s record states that the verdict of death “was general diseases of all the important organs of the body” (prisoner id 2119).

Conclusion

The older female prison population is growing in Australia (Baidawi et al. 2011). In the space of a decade between 2000 and 2010 there was a 222% increase in the imprisonment of older women which far outstripped the rise of younger women and men in prison. In Victoria during this period there was a 194% increase in older female prisoners aged 50 years and over, and an aging population is not the cause. The causes for the drastic rises in imprisonment include mandatory sentencing removing judicial discretion, courts handing down harsher penalties for those who challenge age related stereotypes, and less intervention options available for older populations due to the focus on supporting young people and preventing them from entering the prison system (Turner and Trotter, 2010). Older women’s criminal activity today still differs to that of men’s- often crime is committed for necessities and such criminal activity involves petty crimes and shoplifting (Aday 2003). Other research has suggested that older women’s offending is linked to psychological and physical factors as well as domestic situations (such as unfavourable living situations and domestic violence) (Codd 1996).

It has also been discovered by researchers that prisoners often have a biological age that is 10 years older than their chronological age, resulting in an earlier onset of old age health concerns than amongst the non-incarcerated population (Turner and Trotter 2010). Many will be suffering from depression, and cognitive impairments alongside social isolation, and reduced levels of mobility, disability and suicidal ideation (Turner and Trotter 2010). It is very likely that similarly to today’s older female prisoners, those from our 1860-1920 cohort also suffered from a wide-variety of physical and psychological health concerns that authorities did not consider noteworthy, nor were changes made to the prisons themselves to improve the situation of those incarcerated. It would however appear that the introduction of a variety of welfare safety-nets from the 1900 right through to the late-twentieth century curbed older women’s imprisonment. Austerity and cost saving measures, rolling back of medical and mental health services, as well as continued lack of attention to domestic violence perpetration prevention, and the wide gap between older women’s and men’s financial situations (namely through superannuation and savings) are those areas that need addressing in order to turnaround the high rate of imprisonment of older women in Victoria and Australia today.