

St Ebba's Hospital, Epsom

A Surrey History Centre Research Guide

The references starting SHC refer to records held at the Surrey History Centre, 130 Goldsworth Road, Woking, Surrey GU21 6ND, England. Telephone: 01483 518737. Fax: 01483 518738. Email: shs@surreycc.gov.uk

The Ewell Epileptic Colony, later known as St Ebba's Hospital, was opened on 1 July 1903 by the London County Council. It consisted of nine villas and originally accommodated 326 patients. In 1909 two more villas were built and the number of patients was increased to 429. From 1918 to January 1927 the institution served as a war hospital and treatment centre for neurasthenic ex-servicemen and was administered by the Ministry of Pensions. In February 1927 it returned to the LCC as a mental hospital and was enlarged by a further two villas and additional outbuildings.

In 1930 the Mental Treatment Act permitted for the first time the reception of voluntary patients in public mental hospitals. St Ebba's was readily suited to this purpose and plans for the enlargement of the hospital were prepared. The extensions were completed in two stages, the first in 1936 and the second in November 1938. Many of the voluntary patients at St Ebba's were admitted after attendance at out-patient clinics at various teaching hospitals. Students from these hospitals attended St Ebba's to see cases and receive instruction on them and staff from St Ebba's held out-patient clinics in London.

In 1948 the Hospital became part of the National Health Service and was governed by St Ebba's and Belmont Hospital Management Committee. A special unit for the treatment of adolescents was established at St Ebba's in 1949. In 1962 the South West Metropolitan Regional Hospital Board changed the use of St Ebba's Hospital from a psychiatric hospital to a hospital for mentally subnormal patients. The change came into effect on 27 February 1962 and psychiatric patients ceased to be admitted on 17 March.

On 1 Apr 1982 Merton and Sutton Health Authority was formed from the former Merton, Sutton and Wandsworth Area Health Authority and St Ebba's was included within the new administrative area to serve Merton and Sutton, Richmond Twickenham and Roehampton and Wandsworth Health Authorities. In April 1990 responsibility for St Ebba's was transferred to Mid Surrey Health Authority. In 1991 Mid-Surrey Health Authority's Mental Handicap Services Unit applied to become an NHS Trust and this was granted in April 1995 with the creation of Surrey Heartlands NHS Trust. It is now part of Surrey and Borders Partnership NHS Trust.

Important: please note that any patient records less than 100 years old and staff records less than 75 years old are likely to have access restrictions. Individual records are not available to view through this website. For details on viewing records please see the [Access To Mental Hospital Records](#) page.

The main accession numbers to find records for St Ebba's Hospital at Surrey History Centre are [6292](#), [6380](#), [6390](#), [7329](#) and [7856](#) (click on the individual links to see the archive records).

The principal series of records held at Surrey History Centre relating to individual patients are as follows, although there are gaps in some series.

Alphabetical Registers, 1903-c.1957

These provide details of the date of admission, reference number, patient's name, the union to which they were chargeable (until 1929), whether they were removed from the asylum or died there and the date of removal or death.

Admission Registers, 1914-1949, 1991-1994

These are particularly useful for service personnel during the Great War and Aliens during the years 1927-1938.

Medical Registers, 1903-1948

Details include date of admission, civil register number, date of discharge, transfer or death, patient's name and whether private or pauper, marital status, occupation, age on admission, type of attacks, duration of attacks, aetiological factors, bodily state on admission, form of mental disorder and observations.

Civil Registers, 1914-1953

These were compiled in accordance with Rule 4 of the Rules of the Commissioners in Lunacy dated 31 Oct 1906 which required the Clerk of every asylum to make an entry in a Civil Register of Patients immediately upon the reception of a person as a lunatic. Details include the date of any previous admission, general reference number, admission date, date of reception order, date of continuation of the reception order, whether the patient was directly admitted to the asylum or transferred, patient's name, private or pauper status, address, previous institution, sex, marital status, religion, county or borough to which chargeable, date of discharge, transfer or death and name of institution they may have been transferred to.

Case Books and Files, 1903-1960

The case books include a statement of the name, age, sex and previous occupation of the patient, their marital status; an accurate description of the external appearance of the patient upon admission, habit of body and temperament, appearance of the eyes, facial expression, any peculiarity of shape of head, state of the pulse, tongue, skin and the presence of any bruises or injuries; a description of type of mental disorder, the manner and period of attack, an account of the symptoms, changes produced in the patient's manner, whether the patient suffered from delusions, irrational conduct or morbid or dangerous habits, whether the memory had failed, the presence of epilepsy or of ordinary or general paralysis and historical information, the supposed causes of the attack, previous habits, whether active or sedentary, temperate or otherwise, whether there had been previous attacks, whether any relatives had suffered in a similar way, whether the patient had undergone any previous treatment or had been subject to any restraint. Subsequent entries describe the course and progress of the case and recording the medical and other treatment with the results. In addition, all special circumstances affecting the patient, including

seclusion and mechanical restraint, had to be recorded. In addition to these particulars, the case books usually record the case number of the patient and include photographs taken of the patient's front and side views.

Medical Treatment Registers, 1903-1960

These include register of leucotomy operations, electroencephalograph reports, register of mechanical restraint, 1903-1956 and disease registers, 1904-1957.

Medical Journals, 1906-1918

These are daily summaries of the number of patients in the hospital. They list those in seclusion, describing the period of and reason for the treatment. They also list those undergoing medical treatment and describe the nature of their bodily disorder. Deaths, injuries and violence among the patients are also recorded.

Discharge and Transfer Registers, 1903-1994

The details included in each register comprise the date of discharge or transfer, date of last admission and the name of patient, stating whether private or pauper. If the patient was discharged the new address was given. If the patient was transferred to another asylum the name of that institution was noted. Medical details were only provided of those patients who were discharged 'recovered'.

Registers of Deaths, 1907-1994

These provide details of the date of death, the date of last admission, the number of the patient in the civil register, the name of the patient and whether they were private or pauper, their sex, age, the duration of their last attack of mental illness, the forms of their disorder on admission and at death, the principal and contributory causes of death and whether these were confirmed by a post-mortem. For registers of the Horton Cemetery that served all of the Epsom Cluster hospitals between c.1902 and 1955, see 6376. An index to these registers has been prepared by our volunteers, Mike and Gill Couper.

Post Mortem Registers, 1904-1953

Registers of Enquiries About Patients, c.1904-1956

These are particularly useful for tracing the home address of patients and the names of their family and other visitors.

Psychiatric Social Worker's Case Files, 1935-c.1962

These typescript reports provide much important information about the psychological and family background of particular patients. Details include name, home address, ward name, reason for admission, name of informant, details of previous mental illness and nature of present condition, family history of mental illness in either parents or siblings, home conditions, father's occupation and financial means. Personal details relating to the patient in particular include type of birth, whether breastfed, course of development, early behaviour, later behaviour, schooling and qualifications, employment, interest in sex, health, habits and personality. Many of the reports also include much personal information on other members of the patient's family, together with correspondence with the patient and the family.

Ward Report Books, 1952-1983

These comprise daily reports relating to patients and events in a ward. The forms record the ward temperature, visits by officers, and the number of adults or children in the ward, on leave, at Osborne House in Hastings or in the clinical area. The names of all staff on duty throughout the day are recorded and details are given of patients having special treatment. Admissions, discharges, transfers, accidents, seizures, suicide attempts, seclusions and deaths are also recorded.

Staff records, 1893-1989