The State of the Prisons

Deaths in prison

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Prison must be a peculiarly unpleasant place to die, and yet every year about 50 to 70 people die while they are prisoners in England and Wales.^{1,2} About 20 prisoners die in NHS hospitals; between 10 and 20 die by their own hand; up to 10 die of other unnatural causes; and most of the rest die in the prison hospital. The high number of deaths, and of suicides in particular, has caused concern, and the Chief Inspector of Prisons is currently conducting a study into suicide in prison.

Suicide

In England and Wales in 1982, 2781 of the 49.3 million inhabitants killed themselves (5.6/100 000),³ whereas 17 prisoners among a daily average population of 44 000 did so (38.6/100 000).¹ Obviously, great caution is necessary in interpreting these crude figures; in particular, the daily average prison population is a changing one, and prisoners are most likely to kill themselves in the first month in prison.⁴ But this difference in the incidence of suicide between prison and the community has been seen for a long time and in many different countries. A prison doctor from Parkhurst observed in 1913 that the suicide rate among prisoners was three times that of the general population,⁵ and Dr D O Topp, another prison doctor, found a similar order of difference reviewing prison suicides from 1880 to 1971.⁴ He reported, too, that the suicide rate over that time declined from about 60/100 000 to about 40/100 000.

When we consider the sorts of people in prison (those dependent on alcohol and opiates, the mentally disordered, etc), the circumstances in which they are held, and the reasons for their being there it is perhaps not surprising that the suicide rate in prison is so much higher than that in the community.

That said, among the 3000 or so prisoners in Northern Ireland there has not been a suicide since 1975; if the same rate prevailed as in England and Wales some eight would have been expected. Suicide is also rare in Broadmoor. Furthermore, in the state prison of Southern Michigan a concerted campaign has reduced the suicide rate to 0.6/100 000 (Orlowski, RJ, paper presented at the second world conference on prison health care, Ottawa, 1983).

In the Michigan scheme all potentially suicidal prisoners are referred to State prison psychiatric services. The unit contains one full time and two part time psychiatrists, a clinical psychologist, a clinical social worker, and a psychiatric nurse. It serves a prison population of 5000 (80% of whom are black) and the referral rate is 60/1000 per year. All referrals are seen by a psychiatrist, and there is a wide range of responses—from, for example, simply moving the prisoner to another cell to admitting him to a strip cell and removing all his clothing.

Similar measures are taken in Britain, only in a less coordinated way. In Brixton, for instance, the prison with the melancholy distinction of having the highest suicide rate, those who are considered suicidal will be admitted either to the hospital or to the "psychiatric wing." This wing is a classic two storey *Porridge* type building that contains about 100 prisoners, many of them doubled up. It is probably the nadir of the prison system, and anybody who wants an instant introduction to the failings of the prisons should journey to Brixton.

At the bottom of the wing there are four strip cells (or pads in prison argot) for prisoners who are in danger of harming themselves or others. (The picture shows a strip cell in Pentonville; the ones in Brixton are much the same.) The prisoners are literally stripped, and all objects which they might use to harm themselves are removed. Sometimes the walls are padded so that even if they throw themselves against the walls they can do little harm, but prisoners do succeed in harming, and even killing, themselves in these cells. The strip cells in the psychiatric wing at Brixton are often full, whereas the one in Long Lartin, a maximum security prison that contains about 400 prisoners in the middle of their sentences, is rarely used. In the 30 minutes or so that I spent in the psychiatric wing at Brixton there were two flare ups, and the strip cells simply could not accommodate all the prisoners whom the officers wanted to put in them. Admittedly this was at a meal time, an explosive time in all prisons. I went into the cell with the doctor at Brixton to see one of the men who had been admitted; the near naked man covered in tattoos cowered in a corner and had much more of the pathetic than the nasty about him.

Strip cells are used much more in remand and local prisons than in maximum security prisons,^{6,7} and the suicide rate is similarly much higher in the remand and local prisons.² The prison department produces figures on the use of restraint, and 1002 prisoners (898 men, 104 women) had to be restrained in 1982.⁷ This was an increase overall from 1981, when 833 prisoners (703 men, 130 women) had to be restrained.⁶ The department puts the increase in the use of restraint in men down to an increase in "refractory prisoners."⁷ Most prisoners (93%) are restrained for non-medical reasons, and in neither year were any women restrained for medical reasons. Over 90% of the

men restrained on medical grounds are restrained in a "protected room" (strip cell) and only rarely are "loose canvas jackets" used. I am suspicious that these figures are underestimates—for in Brixton, as I have said, and in other prisons that I visited I saw several people being restrained, and if you were to multiply these figures to a total for all prisons for the whole year I would expect them to be much larger. Perhaps there are various definitions of what constitutes restraint, for all prisoners are in one sense restrained.

Many of the prisoners who kill themselves have never been restrained because nobody has ever suspected that they are suicidal. Dr Topp's study showed that the suicide rate was eight times higher among those sentenced to 18 months or more, and that they were most likely to kill themselves at the beginning of their sentences. Nearly two fifths of the 186 prisoners who killed themselves between 1958 and 1971 had had psychiatric treatment, and 39% were under treatment from the prison medical service; but in only 15% had the suicidal tendency been recognised. Dr Topp estimated that about 60% could have been saved.⁴ The prison department report for 1982 says that 243 prisoners injured themselves with apparent suicidal intent, as opposed to 214 in 1981.¹ In addition, 784 prisoners in 1982 injured themselves less seriously so that suicide was not considered to be a motive, as opposed to 952 in 1981.⁸ In Michigan, too, many prisoners injure themselves without any intention of committing suicide. Dr Orlowski made it clear that many of his patients are manipulative and aggressive. A typical response to the standard psychiatric question "What can I do for you?" is for the prisoner to yell: "Get me the hell out of here, you honkey, that's what you can do for me."

Barry Prosser—"unlawfully killed" in Winson Green Prison

Barry Prosser ran a small business in the West Midlands. He suffered from a depressive illness and had a drink problem. In 1975 he broke a window after an evening's drinking, was charged by the police, and spent two weeks on remand in Winson Green prison for medical reports to be written. The doctors agreed that he should be given hospital treatment rather than a prison sentence, and he was given inpatient psychiatric treatment for two months.

In July 1980 his wife left him and went to live with her father. On the evening of 1 August Prosser created a disturbance outside his father in law's house, and was charged with criminal damage and remanded to prison. The prison doctor investigated Prosser on 8 August, and, although he found him to be calm and rational, an order recommending psychiatric treatment was signed in view of his past history.

Over the next few days his condition deteriorated, and after keeping his cell mates awake all night on 11 August he was transferred to the prison hospital. He brightened up, however, and had his third remand hearing on 13 August. His wife had visited him in prison, and at this hearing a full bail application was made with the support of Mrs Prosser. It was refused. Mrs Prosser saw her husband again on Monday 18 August in the prison hospital, and she thought that he seemed unwell. A psychiatrist saw him that same day and found him stable and amicable (he was at this time being prescribed 4 mg of haloperidol daily). He was last seen in good health by a "red band" (a trusted prisoner who has extra freedom) at 6 pm that evening—he had been given his haloperidol at 4 pm.

At 7.10 pm one of the prison doctors was called because Prosser had gone "completely berserk." The doctor saw Prosser

through the window of a strip cell (he was a big man—6 ft 3 inches tall), decided that he was "very disturbed," and prescribed 50 mg of chlorpromazine to be given by injection. (Prosser was known to be "phobic" about injections.) By 8 pm some 11 officers had assembled to give the injection, but when they came to do so Prosser was lying on the floor and offered no resistance. Something had happened to Prosser between 7.10 and 8 pm. He was heard groaning during the night and then was found dead at 5.25 am. The police were called; they arrived at 9.15 am and arranged for the body to be taken away.

At the Birmingham Coroner's Court on 15 April 1981 the jury were presented with evidence that Prosser had extensive injuries and delivered a verdict of "unlawfully killed." The prison officers argued that Prosser had killed himself by throwing himself against the strip cell walls, but the argument was not accepted. Three prison officers were eventually tried in Leicester on a voluntary bill of indictment, and after a 15 day trial were acquitted. A defence pathologist produced evidence at the trial that Prosser's extensive injuries could have been self inflicted. The only person who was able to give evidence about what happened in the prison hospital that evening was another "red band." He made allegations in the Coroner's Court that prison officers had attacked Prosser, but he did not make these allegations in his original statements. He repeated his evidence at the trial, but the judge warned the jury not to place too much importance on uncorroborated evidence.

The only conclusions I can draw from this story are that it is especially difficult to investigate deaths in prison and that our current system seems inadequate.

The Chief Inspector's inquiry

The inquiry of the Chief Inspector of Prisons into suicide in prison is the first general study that he has undertaken; up until now his work has been concentrated on inspections of individual prisons. He will no doubt be considering Dr Topp's study, and I hope that he will also look at the work that has been done in Michigan. He will be examining as well the evidence produced by PROP, the National Prisoners' Movement.⁹ This makes the point, which has been made in a book by Geoff Coggan and Martin Walker,¹⁰ both of PROP, that they do not accept that all suicides are true suicides. They think that some of these prisoners have not died by their own hands; the evidence they have for this assertion comes from individual cases where coroners' juries have delivered open verdicts (see box).

They also suggest that prisoners should not be stopped through repressive measures from killing themselves. Suicide is not illegal outside the prison, and, indeed, it is not illegal inside when it comes to hunger strikes. PROP believes that the Chief Inspector should not call for a tightening up of procedures for observing those prisoners who are thought to be suicidal but rather recommend that the prisons should be made much more humane and that the response to the suicidal prisoner should be more caring than punitive. One recommendation that PROP makes for reducing the suicide rate, which may sound slightly ludicrous to those who know nothing of prisons, is for the "provision of telephone call boxes for uncensored and private use by prisoners in all prisons." Prison mythology certainly has it that a common cause of distress, and potentially suicide, among prisoners is the receipt of a "Dear John letter" [a letter from a wife or girlfriend breaking off a relationship] and access to a phone might well help defuse such acute anxiety. Telephones exist in many prisons abroad, and even if they did not prevent suicide they would help make the prison more normal and would save the welfare officers much work. There will probably always, however, be a certain category of high security prisoner—particularly in Northern Ireland—who could not be allowed open access to a phone.

Another snag with responding to the problem of suicides by simply tightening up the observations made on those who are thought to be suicidal is that, as I have said, many of those who succeed in killing themselves have never been thought to be suicidal. Both Dr Topp's study and Dr Orlowski's experience confirm this. Furthermore, an American psychiatrist has recently concluded after a prospective study of 4800 patients, "Identification of particular persons who will commit suicide is not currently feasible, because of the low sensitivity and specificity of available procedures and the low base rate of this behaviour."¹¹

Death from hunger strike

One form of suicide that presents special problems for prison authorities the world over is a hunger strike. The problem has been particularly severe in Northern Ireland, where hunger striking has long been a traditional form of protest. Thirty prisoners joined the hunger strike in the Maze prison in 1980 and 1981, and 10 of them eventually died.

Hunger strikes present ethical and emotional difficulties to prison doctors. The ethical problems are at least temporarily resolved in Britain: it is for the individual doctor to decide how to treat a hunger striking prisoner, but, that said, any doctor who decided to force feed a prisoner who was in his right mind would find himself in deep water. Before 1974 prison doctors did force feed hunger strikers, but after a prison doctor in Brixton refused to do so a statement was made by Roy Jenkins, then Home Secretary, making it clear that an individual doctor was free to make such a decision.¹² Indeed, it is now accepted practice not to force feed,¹³ and force feeding was never seriously considered in Northern Ireland.

Ethical codes have fashions, however, just like everything

else, and maybe a time will come again in Britain when it is seen as right to force feed hunger strikers. When I was in Canada in the summer of 1983 the prison doctors were force feeding a hunger striker. One particular problem with the ethics of leaving a hunger striker to die is that even though he might start his strike in his right mind sometime before he dies (and usually only very shortly before) he loses his faculties. How then for the next few days can the doctor continue to be sure that the prisoner knows what he is doing and wants to continue? He cannot.

One spin off of the debate in 1974 over force feeding was that it gave some insight into the working of the prison medical service—that is, that what the director said went. Only when an individual prison doctor at Brixton stood up to the director was the custom of years overturned. But, that said, the service was only following what society thought to be the correct course. The key legal decision was over the case in 1909 of a suffragette who was force fed.¹⁴ The judge ruled that force feeding was the duty of the prison officials to preserve the health and lives of those in custody. This meant that the suffragette was held down by a wardress while a doctor forced milk and brandy into her mouth with a spoon. Later she was fed through a tube. This scene of force feeding with a spoon now seems not only rather disgusting but also slightly absurd and laughable, but as recently as 1974 in the case of a hunger striker who died in Parkhurst the prison doctor told how a metal clamp had been used to force open the prisoner's mouth.¹⁵

The ethical problems are at least temporarily largely out of the way, but the emotional difficulties remain. I spoke to some of the doctors who looked after the Maze hunger strikers; they had found it a dreadfully draining experience to sit watching those men die. There was always a doctor on the premises, but, although most of the prisoners were willing to be examined and have blood tests, the doctor was usually doing nothing except talking to them and waiting for them to die—a strange experience for any man but particularly for doctors, who are attuned to action. What is more, this whole grisly scene was enacted in the brightest of limelight with journalists and film crews from all over the world and even the Pope's envoy arriving.

From 1978 to 1981 those same doctors went through "dirty protests" at the Maze, going everyday into cells stinking to high heaven and awash with faeces and urine. Prison doctors have to undertake some extremely unpleasant tasks, and this should be remembered by all their critics.

Other deaths

In addition to the 17 deaths due to suicide in English and Welsh prisons in 1982, another 44 prisoners died, 13 of them from non-natural causes. Three died from fires in their cells, four from hanging, two from drug overdoses, one from an accident with a tractor, and three from other causes.¹ All deaths in prison must be reported to the coroner, and he must summon a jury and hold an inquest. (One worry about this requirement is that it is not clear whether "prison" in the Coroners' Acts includes borstals, detention centres, and community homes.²) With the 13 non-natural deaths the verdict was misadventure in four, accidental death in three, and lack of care in one who was found hanged. An open verdict was returned on the other five. The verdict of lack of care has naturally caused some unhappiness in the prison medical service.

Much concern has been shown about the number of deaths in prison and the way that they occur. Geoff Coggan and Martin Walker of PROP, the National Prisoners' Movement, say in their book on deaths in prison that many of the deaths can be put down to the dreadfulness of prison life, and that some are the result of brutality and negligence on the part of prison staff.¹⁰ Most of their book consists of accounts of seven deaths in prison, in all of which there were suspicious circumstances.

The most notorious of these cases is that of Barry Prosser, who died in Winston Green prison, Birmingham, in August 1980 (see box). The verdict of the coroner's jury was "unlawfully killed," and three prison officers were tried for murder. They were found not guilty in March 1982. Another notorious case was that of Richard "Cartoon" Campbell, who died in Ashford Remand Centre in March 1980 (see second box). The verdict on him was death from self-neglect.

Roger Geary of the National Council for Civil Liberties has investigated deaths in prison,² and after observing that allegations of mistreatment by both staff and doctors are common he writes: "Unfortunately, such allegations cannot be either supported or refuted as detailed information is either not collated or is kept secret." He, as well as Coggan and Walker, was unhappy about the coroners' system, arguing that it was inadequate for fully investigating prison deaths. In my opinion, it is still true that the system is not adequate for investigating fully the circumstances surrounding prison deaths. The authorities should remember that the public is bound to be much more suspicious about deaths that happen in prison rather than in hospital or at home and that accordingly they should bend over backwards to dispel all suspicions.

Roger Geary was also critical in his report that the prerogative of mercy was not used more for those prisoners dying of natural causes. In 1979, for instance, 43 prisoners died from natural causes, and yet the prerogative of mercy was used only 13 times—and in four of those cases for pregnant women. Geary quotes the case of a 91 year old man who died of cancer in Parkhurst in 1978. But he does not mention that in many cases the prisoner has nowhere to go to die, nor does he emphasise that many prisoners die in NHS hospitals, just as do many of the population. Sad as it may be, for some of the prisoners prison is home and as such may be the best place for them to die.

English and Welsh prisons are not alone in having high death rates. For instance, death rates among white prisoners aged 25 to 34 serving more than a year in two Tennessee prisons

are six to seven times higher than in the comparable population outside the prison.¹⁶ Homicide is one of the causes of death, and the homicide rate for all prisoners serving more than a year in the Tennessee prisons is a staggering 620/100 000 compared with 12/100 000 for the rest of Tennessee. Homicides do occasionally occur in British prisons as well: a prisoner in Parkhurst was killed by a fellow inmate in 1981.

Death by fire

A cause of death that is causing great concern currently among both prison staff and prisoners is death by fire.¹⁷ As I have said, three prisoners died through fires in 1982,¹ and three also died through fire in 1981.⁸ But for every death there are a great many fires, and a number of prison staff, including doctors, have come very close to being severely burnt. In 1974 there were 64 cell fires in England and Wales, and the number has risen steadily—there were 158 in 1981.¹⁷ The deputy director of the prison department mentioned the problem in his annual report for 1982 and speculated that the increase in fires may be due to "the deprivations that occur as a result of overcrowding, and the long periods which some prisoners spend on remand."¹¹

Most of the fires are probably started deliberately by prisoners, but the problem is greatly exacerbated by the toxic smoke given off by the polyurethane mattresses that are used in prisons. At its 1982 conference the Prison Officers Association passed a motion calling for the mattresses to be replaced,¹⁷ and the prison department now says that new mattresses are being introduced.¹ Another problem, says the National Prisoners' Movement, is that many of our overcrowded prisons are a dreadful fire risk and that systems for evacuating prisoners in the case of fire are inadequate. The Chief Inspector of Prisons has agreed in some cases and was, for instance, critical of fire precautions at Manchester prison.¹⁸ The Home Secretary did, however, act on both of his formal recommendations.

Richard Campbell—"deaths from self neglect" in Ashford Remand Centre

Richard Campbell, an 18 year old born in Britain of Jamaican parents, appeared in Camberwell Magistrates' Court on 3 March 1980 charged with attempted burglary and he was remanded in custody to Lewes Prison. A week later he reappeared in court and was remanded to Ashford Remand Centre for medical reports; doubts about his mental state seemed to have arisen because of his Rastafarian language and beliefs.

Campbell started refusing food but not fluids the day that he arrived at Ashford, and he seems quickly to have become thoroughly miserable in the dismal surroundings. On 19 March he was seen by his probation officer, who scarcely recognised him. The prison doctors decided that he was a highly disturbed schizophrenic, and this diagnosis was confirmed by one of the consultant psychiatrists who regularly visited the centre. On 21 March Campbell collapsed and was taken to Ashford General Hospital, from where he was transferred to a mental hospital and seen by the duty registrar. The junior psychiatrist found him mentally normal but noticed how weak and dehydrated he was and offered to admit him for observation. He would not, however, allow a prison officer to stay with Campbell, and so the remand centre authorities took the prisoner back to the centre.

By the 26 March Campbell had lost more weight, and an

attempt was made to have him admitted to another hospital under the Mental Health Act. The psychiatric registrar thought him too physically ill for the psychiatric unit but offered admittance to a medical ward, which the prison authorities refused. Back at the remand centre the prison doctors began to force feed Campbell with milk and Complan. He gained 24 lb during the next four days, but on the morning of 31 March he was found dead in his cell.

At the inquest held on 8 May the pathologist gave evidence that Campbell had died from "dehydration due to schizophrenia." The jury returned a verdict of "death by self-neglect" and added a rider criticising the lack of adequate medical staff and facilities at the remand centre.

Campbell's family were unhappy with this verdict and arranged for the Battersea and Wandsworth Trade Council to hold a public inquiry. Many individuals and groups, but not the Home Office, gave evidence to this two day inquiry, which concluded: (a) that there had been no good evidence that Campbell was schizophrenic; (b) that he had been failed by the legal profession, by the probation service, and by the authorities at Ashford Remand Centre; and (c) that he died "because of the negligence of the authorities."

Reducing prison deaths

The number of prison deaths can probably be reduced. Better conditions might lead to reductions not only in suicides but also in other causes of death—both natural and non-natural. Efficient, comprehensive, humane suicide prevention schemes, like the one in Michigan, might be able to reduce further the number of suicides. Replacement of mattresses and better fire schemes might reduce deaths from fire. Finally, it might be possible with a little imagination and community cooperation to find better places to die for those who at the moment have little option but to die in prison.

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MATERIA NON MEDICA

"There's no business like show business"

The festive season brings about a curious transformation amongst a few, otherwise normal, members of hospital staff up and down the country. I am talking about the Christmas show. Doctors, nurses, paramedics, ancillary staff, those with minor or major talents, low or high rank, all gather together to make a contribution. The result is often an entertainment of surprisingly high standard and is a tribute to the team approach.

The *dramatis personae* includes many stock characters: the bearded physics technician who, with cigarettes in one hand and soldering iron in the other, assembles—out of coat hangers, cardboard boxes and a disused ECG machine—an eight track mixing desk and spotlight panel; the physiotherapist of dubious gender who transforms a bunch of pallid, uncoordinated minor players into a gyrating, high kicking chorus line that would make Busby Berkley proud. But everyone plays a part: the speech therapy department relinquishes its tape recorder; the medical illustration team designs the eye catching posters, which you can guarantee will not be ready until the night before, just like those slides you wanted. One is reminded of the scope of the hospital community. There is not an expert or prop that cannot be located on the premises.

The backbone of the show must be the junior doctors. It is from their spirit, coupled with frustration and need for self expression, that a good show springs. What better way to vent anguish about the rota, the bureaucracy, the consultants than through barbed humour? Let's face it, some of our more flamboyant seniors would be most put out if they were not portrayed on stage. They know that the force underlying their justified ridicule is a deep affection. Administrators are common targets but it is difficult to be funny about those faceless grey men, who command no generous feelings. Other slices of hospital life, like the best tragedies, contain the seeds of humour. "The cardiac arrest sketch" is a staple of medical revues. An endless succession of "crash calls" occurs on the stage until finally the exhausted physician discards his cannulae, ignores the bleep, and lights up a cigar: cue "Hamlet" advert theme music. Black comedy certainly, and a necessary cathartic for the memories of those shambolic arrest calls.

It is no accident that some of the most successful comedy teams of the last two decades have included doctors—Jonathan Miller ("Beyond the Fringe"), Graham Chapman ("Monty Python"), and Graeme Garden ("The Goodies"), to name a few. Many skits lend themselves so well to the hospital context that one speculates whether that is where they originated. For instance, the piece from "Monty Python" about the Yorkshire miners with each character reflecting on his early poverty, though he now basks in affluence: replace these by consultants who remind us that when they were young they had to *pay* for the privilege of cleaning the boss's shoes and being on call twenty five hours a day, and you have a perfect satire. Then there's the sketch which had Cleese, Barker, and Corbett portraying the upper, middle, and lower classes respectively. This transforms effortlessly into con-

sultant, registrar, and houseman with superb effect. Plagiarism rules, with minor modifications.

The Christmas show tradition is threatened by the newer modernist, concrete and glass hospitals, which though equipped with the most advanced technology, lack an essential facility: the concert hall with piano. This alarming development must be halted. As morale within the health service declines and as hospitals become the target for politicians, pressure groups, and the media, the Christmas show is more vital than ever. "So let's go on with the show . . ."—TONY DAVID, registrar in neurology, Glasgow.

Bonfires in Portugal

Walking one evening through the quiet streets of the small Portuguese fishing port of Ericeira (from where Manoel II, the last king of Portugal, embarked for exile to England in 1910), we suddenly heard noisy laughter, lively music, and the splutter of fireworks. Round a corner we saw the church of St Peter (São Pedro) brightly illuminated and the square lit up and filled with onlookers. Excited children were running about, some in fancy dress accompanied by musicians. Wine and grilled sardines were being consumed. The centres of attraction were the two bonfires. Over the larger one jumped the older boys and girls, over the smaller the younger brothers and sisters, anxiously watched by their relatives. But what was it all about? It was 28 June, the eve of St Peter's day, the festival of S Pedro. Unwittingly, we were participating in a ceremony going back to remote antiquity, well before the days of Christianity.

It seems strange that these harmless amusements once earned the stern disapproval of grave and learned men. According to W C Hazlett's *Dictionary of Faiths and Folklore*, an edict of AD 680 by the third Council of Constantinople threatened excommunication to those who by ancient custom made bonfires "over which also they use ridiculously and foolishly to leape. . . ." In *The Golden Bough* Sir James Frazer gives many examples throughout Europe of midsummer bonfires, most commonly on the eve of the summer solstice turned into the festival of St John. Young people jumped over the fires to have luck with the harvest, to prevent disease of cattle, or to bring about some other kind of good fortune. In Belgium at one time celebrations on the eve of St Peter's day resembled those of St John's eve and jumping over the bonfires was believed to prevent colic.

Near S Pedro some children were selling the blue thistles that grow locally. We were not clear about their significance and when we left we threw them on the fire. They were hastily retrieved by the youngsters, and we were told that they should be put on the roof and then those sleeping in the house would see the faces of their future wives or husbands. We decided the hotel was too impersonal and so we flung them on a conveniently low roof on our way back and wished the occupants pleasant dreams.—A L WYMAN, Barnes, London.