Policing Public Health in Queensland, 1859-1919

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Abstract

Histories of public health in colonial and immediately post colonial Queensland do not, in general, mention any role for the police. Equally, histories of the Queensland police are as reticent on the subject as their medical colleagues. Annual Reports from Commissioners of Police and Commissioners of Public Health to the Parliament are also silent on the subject. Yet it is evident that, especially in the nineteenth century, the police played an important role in the management of some diseases, both acute and chronic.

In this thesis, I investigate the public health role of the Queensland police: starting with the New South Wales Towns Police Act of 1838, which empowered the police of proclaimed towns to order the removal of obstructions and nuisances, the police then moved into more ‘medical’ areas. As an important part of their function, the discipline and control of the populace in public places, they became involved in the early management of persons suspected of being of unsound mind. Later, with the Contagious Diseases Act of 1868, the police became involved in the complicated nexus between prostitution and venereal diseases, a nexus that would lead directly to the Fitzgerald Inquiry of 1989. Aborigines were also widely perceived to be affected by venereal diseases; since they did not in general live in towns proclaimed under the Contagious Diseases legislation, they were ignored by the primary health advisory body, the Central Board of Health. The police, trying to establish better relations with the Indigenous population after the carnage of the Frontier Wars, attempted to help out those who seemed to be suffering the most.
The discovery of gold had profound demographic effects, including the ‘invasion’ of the gold fields by a large number of Chinese labourers, people who soon came to be labeled as the importers of the dread disease of leprosy. The police were instructed in 1892 to arrest suspected ‘lepers’, and were expected to look after them during the long periods that often occurred between arrest and confirmation of diagnosis, at which point they would escort the unfortunate patient to a lazarette. In addition, they performed important social roles, dealing with matters of compensation for goods destroyed (from fear of contagion), to investigating the social conditions of families left without bread winners, and other activities.

Scarcely had the police got to grips with the problems of leprosy than, in 1900, an outbreak of bubonic plague struck Queensland. Once again the police were called upon to monitor the maritime quarantine (through the work of the water police), and to prevent patients with, or suspected to have, bubonic plague, from leaving their houses and potentially spreading the disease. Similar activities were involved in the great influenza pandemic of 1918 to 1919.

In addition to these roles, the police also chased up smallpox contacts; they were involved in food distribution programs for malnourished Aborigines, and they attempted to control the opium trade that was leading to great demoralization of the Aboriginal population.
This thesis aims to examine exactly what the police did in the field of public health, asks why they had to shoulder such a burden, and asks why this work has been largely ignored by historians of both public health and the police.
This work has not previously been submitted for a degree or diploma in any university. To the best of my knowledge and belief, the thesis contains no material previously published or written by another person, except where due reference is made in the thesis itself.

Gerald Hugo Réé  B.A., M.B., B. Chir. (Cantab)
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## Contents

**Acknowledgements**

**Statement of Originality**

<table>
<thead>
<tr>
<th>Introduction</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>0.1 The historiography of public health</td>
<td>4</td>
</tr>
<tr>
<td>0.2 What is public health?</td>
<td>6</td>
</tr>
<tr>
<td>0.3 Medical police</td>
<td>10</td>
</tr>
<tr>
<td>0.4 The English Moral Revolution</td>
<td>13</td>
</tr>
<tr>
<td>0.5 Causes of death</td>
<td>15</td>
</tr>
<tr>
<td>0.6 The thesis</td>
<td>16</td>
</tr>
</tbody>
</table>

**1.0 A brief history of the Queensland police**

| 1.1 Introduction                                 | 18   |
| 1.2 Maintaining the peace in Britain             | 19   |
| 1.2.1 Police in Ireland                          | 24   |
| 1.3 Police in Australia                          | 26   |
| 1.3.1 New South Wales                            | 26   |
| 1.3.2 Queensland                                 | 33   |
| 1.4 Police duties                                | 42   |
| 1.5 Training the police                          | 47   |
| 1.6 Extraneous duties                            | 48   |
| 1.7 Conclusions                                  | 60   |

**2.0 People, doctors and disease**

| 2.1 Introduction                                 | 61   |
| 2.2 The people                                   | 61   |
| 2.2.1 The Aboriginal population                  | 61   |
| 2.2.2 The European population                    | 64   |
| 2.2.3 The Pacific Islanders                      | 67   |
| 2.2.4 The Chinese                                | 69   |
| 2.3 Notification of births, marriages and deaths | 75   |
| 2.4 Health and Disease                           | 76   |
| 2.4.1 The medical profession                     | 77   |
| 2.4.2 Disease                                    | 85   |
| 2.5 Public health administration in Queensland   | 88   |
| 2.5.1 Sanitation and the Central Board of Health | 89   |
3.0 Policing lunatics

3.1 Introduction
3.2 Lunacy legislation in Britain
3.2.1 Moral management
3.3 Lunacy legislation in Australia
3.3.1 Queensland
3.4 The Queensland police and ‘persons of unsound mind’
3.5 Police and doctors
3.6 Insanity in Aborigines
3.7 Suicide
3.7.1 English law and custom
3.7.2 Suicide in Australia
3.7.3 Suicide in Queensland
3.8 Alcohol and mental disease
3.9 Conclusions

4.0 Policing the venereal

4.1 Introduction
4.2 The ‘social evil’
4.3 Venereal diseases
4.3.1 Gonorrhoea
4.3.2 Syphilis
4.4 Attitudes to syphilis
4.5 Prostitution in Australia
4.6 The epidemiology of venereal diseases in Queensland
4.7 The Contagious Diseases Acts in Britain
4.7.1 The Queensland Contagious Diseases Act
4.8 Lock Hospitals
4.9 The Hobbs Report
4.10 Opposition to the Contagious Diseases Acts
4.11 Venereal diseases and Aboriginal populations
4.12 Further police involvement
4.13 Conclusions

5.0 Policing ‘lepers’

5.1 Introduction
5.2 Leprosy, the disease 219
5.3 The revival of leprosy in the nineteenth century 222
5.3.1 Contagious or hereditary? 225
5.4 Leprosy in Queensland 230
5.5 Police involvement 239
5.6 Conclusions 265

6.0 Policing Quarantine 267

6.1 Introduction 267
6.1.1 What is quarantine? 268
6.2 Quarantine in Australia 271
6.2.1 Quarantine in Queensland 274
6.3 Smallpox 277
6.4 Bubonic plague 282
6.4.1 Plague epidemics 284
6.5 Bacteriology of plague 287
6.6 The international sanitary conference of 1897 289
6.7 Preparations for plague in Queensland 291
6.7.1 Plague in Queensland 305
6.8 The role of the police 308
6.8.1 The water police 309
6.8.2 Land police 310
6.9 Spanish influenza 319
6.9.1 Influenza, a viral infection 323
6.9.2 The looming threat 325
6.10 Interstate quarantine 331
6.10.1 Land quarantine 333
6.10.2 Sea quarantine 339
6.11 Influenza in Queensland 341
6.11.1 The metropolitan epidemic 342
6.11.2 Influenza in country Queensland 348
6.12 Influenza in Aboriginal communities 352
6.13 Conclusions 353

7.0 Conclusions 357

Appendices
1. Miasma theory 378
2. Lunacy 382
3. The origins of syphilis 387
4. The early history of leprosy 389
5. Plague epidemics 396
Illustrations

1.1 David Seymour, first Queensland police commissioner 35
1.2 William E. Parry Okeden, second police commissioner 49
1.3 William G. Cahill, third police commissioner 57
2.1 ‘Awake, Australia, awake,’ anti-Chinese cartoon 70
2.2 Death the Night watchman (cartoon) 91
2.3 Dr. Kevin I. O’Doherty 94
4.1 Dr. William Hobbs 187
5.1 Cottages for white patient on Peel Island 236
5.2 C. J. Pound, Director of the Stock Institute, 1893-1932 239
6.1 The barque *Royal Dane* 267
6.2 Police guarding a plague house 311
6.3 Sir John Huxham, Home Secretary in 1919 328
6.4 Temperature parade at Wallangarra camp 335

Tables.

4.1 Women discharged from prison for offences against the *Contagious Diseases Act* 182
4.2 Admissions to the Brisbane lock hospital, 1869-1878 189
5.1 Articles about leprosy in British Medical Journal, 1885-1893 224
6.1 Plague in Queensland 308
6.2 Influenza in Queensland, 1918-1920 348

Bibliography 399
Acknowledgements

The subject of this thesis started as a study of leprosy, a disease in which I had a particular and long time interest. However, it soon became apparent that, within historical circles, leprosy in Queensland had proved to be a popular subject; with the encouragement of my supervisor, I therefore extended my research to other diseases that had a significant impact in colonial Queensland. I soon realized that one factor that seemed common to many of the diseases I was investigating was the shadowy presence of the Queensland police. Ross Patrick, in his monumental *History of Health and Medicine in Queensland 1824-1964* makes no reference to the role of the police; while Ross Johnson, in his equally monumental history of the Queensland police, *The Long Blue Line*, devotes a considerable number of pages to the problem of the extraneous duties that the Queensland police carried out, but says remarkably little about their role in the management of ‘public health’. Yet it soon became apparent to me that the police played, and continue to play, an important role, and thus this study was born. The idea was entirely my own, but was encouraged by my principal supervisor, Professor Paul Turnbull.

I first approached Professor Turnbull when he was Professor of History at James Cook University in Townsville, and he agreed to be my supervisor. His move from Townsville to Griffith University reduced to a great extent the tyranny of distance, and enabled the development of a fruitful and useful cooperation. I am grateful for his most invaluable input, comments and opinions, without which none of this work would have seen the light of day. Jonathan Richards is a Griffith University academic with an encyclopedic knowledge of Queensland history, and how to make use of the State Archives. He gave generously of his time to teach me how to follow paper trails in the often irrational system of filing in the Archives. His input has been particularly invaluable, and my heartfelt thanks also go to him. Following the departure of Professor Turnbull to the University of Queensland in 2009, Associate Professor Regina Ganter very kindly agreed to take on the role of Principal Supervisor, not an easy task when the thesis was almost completed; she has made many valuable comments, for which I am very grateful.

Much of this work involved research at the Queensland State Archives. Without the assistance of the staff, who have been unfailingly helpful, it would have been impossible to continue. Both Queensland Health and the Police authorities readily granted me access to restricted files in the archives, and I am particularly grateful to Peter Croft and Christina Bruinjasma at Health, and Heather Mitchell at the Police Headquarters for facilitating this task. Likewise the staff at the Queensland State Library, the Fryer Library of the University of Queensland, the Griffith University Library, the Herston Library at the Royal Brisbane Hospital have all provided cheerful and uncomplaining assistance. All the illustrations are from the John Oxley Library, and published with their permission. I spent some time at the Wellcome Library for the History of Medicine in London, whose staff have always been most helpful. When the focus was particularly on leprosy, the Queensland branch of the Australian Medical Association (of which I was not a member) allowed me access to their small but significant historical collection. I am
extremely grateful for this. My friend, and classical scholar Robin Adams provided the comments on Diogenes Laertes, for which I thank him.

This work has been in progress for a number of years. My wife Berenice has been uncomplaining at the amount of time I have spent in searching dusty archives, leafing through books in libraries and in my room writing up this material; I owe her a great deal and thank her most happily for her understanding.

**Warning**

I have used the language of the times in the text; thus Aboriginal men were spoken of as ‘boys’, and women as ‘gins’. Pacific Islanders were commonly spoken of as ‘kanakas’ and also labeled as ‘boys’. Patients suffering from Hansen’s Disease were labeled as ‘lepers’, a pejorative term that also meant a person shunned on moral grounds, while the disease itself was called leprosy. Persons of unsound mind were called ‘lunatics’. All of these terms are considered, correctly, offensive today. Their use is justified on historical grounds; and must not be taken as a personal endorsement.
Abbreviations used in the text and footnotes.

B.M.J British Medical Journal
M. L. A. Member of the Legislative Assembly
Q. G. G. Queensland Government Gazette
Q. P. D. Queensland Parliamentary Debates
Q. P. G. Queensland Police Gazette
Q. P. P. Queensland Parliamentary Papers
Q. S. A. Queensland State Archives
Q. V. & P. Queensland Votes and Proceedings
Introduction

In September 2006, after a series of crises in South East Asia and later in Eastern Europe that resulted in a number of human deaths from avian influenza, the Queensland Government published an action plan for Pandemic Influenza, should the disease (or other non-avian variants of potentially pandemic influenza) ever reach Queensland. Among the key agencies identified to deal with a major health threat are the Premier’s Department, the Health Department, the Department of Emergency Services, and the Police Service. That the police are involved is no surprise, since any major epidemic or pandemic has the potential to cause considerable social disruption which may, in turn, lead to an increase in criminal activity. Furthermore, archival records show that the Queensland Police Service has had, since the founding of the Colony of Queensland in 1859, a significant public health role which has been rarely mentioned in studies dealing with nineteenth century public health. This thesis is the result of extensive research, conducted in the Queensland State Archives and in the colonial newspapers over a number of years, of the part the police played in disease control. Ross Patrick, a previous Director-General of Health for Queensland, made no comment on the role of the police in his ‘History of Health and Medicine in Queensland’. This work was not solely about public health, but was, rather, a positivist panegyric to the medical profession. While some failures of public health are acknowledged, their causes are not discussed in detail.

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Enid Barclay focuses largely on the functions of the Central Board of Health in her study of Public Health in Queensland, with only a passing reference to the police as escorts or guards. In her thesis on mining injuries in northern Queensland towns during the late colonial and early post-colonial period, Lori Harloe comments sympathetically on the important role the police played in these towns in preventing death from illness and starvation, but the study lacks significant detail of this aspect. There are no other general histories of public health in Queensland, though a number of articles dealing with specific diseases are available, none of which focus on the role of the police in the control of these.

Historian Alison Bashford has taken a different approach to (some) public health issues in colonial Australia, emphasizing the ‘lines of hygiene’ that divided the pure from the polluted, the fit from the unfit, one race or gender from another. Sometimes these ‘lines of hygiene’ led to the incarceration of those on the ‘wrong’ side of the line for shorter or longer periods of time. She focused especially on smallpox and vaccination, on leprosy, and on quarantine. She wrote about tuberculosis, but only in the context of the early twentieth century when rates of disease had already dramatically declined, and

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sanatorium treatment became available (for a few). Though tuberculosis was the single biggest cause of death in Queensland during the nineteenth century, Bashford ignored this period. She also excluded sanitation from her work, yet this, or rather the lack of sanitation, in the growing white towns of Queensland, was to lead to more deaths, of both adults and children, than any other cause. That ‘miasmas’ allegedly caused these deaths in no way diminishes the importance of sanitation. The Central Board of Health was instituted to deal with sanitary matters, citizens wrote more letters to the papers on matters sanitary than any other medical subject, editors wrote columns and politicians talked endlessly about the subject, yet very little was done throughout the nineteenth and early twentieth centuries. Bashford did, however, recognize the importance of race in her chapter on leprosy, and of gender in a chapter on the ‘venereal’.

At the same time the only history of the Queensland police barely mentions health issues, except briefly in relation to the Contagious Diseases Act, and the escort of lunatics to the Goodna Asylum or those with leprosy to the lazaret. Yet the Queensland Police became involved in more than merely these situations.

The response of the Queensland authorities to health problems was reactive rather than proactive. There were few public health bureaucrats. The Central Board of Health employed an inspector from 1885, but his work was limited to sanitary matters in Brisbane. A considerable amount of the public health responses therefore fell on the police, who were not trained for this type of work, but were the only government agents

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available whose services cost the treasury nothing extra. Public health responses were also complicated by dissent within the medical profession about the causes of, and therefore about the best way to deal with, specific disease. The police found themselves in an unenviable position, having to manage sick people in an environment where neither the authorities, nor the medical profession, could provide legitimate answers to the problems they faced. I have therefore included some discussion of areas of dissent in the chapters dealing with specific disease, to highlight some of the legitimate concerns of the police.

0.1 The historiography of public health

The development of public health in either Australia or Queensland occurred within the context of nineteenth century British developments, an area which has been intensely scrutinized. Perhaps the most important history of public health was physician George Rosen’s History,\(^8\) published originally in 1958. Rosen surveyed the history of public health from Greco-Roman times to the 1950s. His work was uncommon at the time for focusing on social and economic issues, rather than being a eulogy to the medical pioneers of public health. His approach was that of social progressivism, and he acknowledged the lead that the British had taken in public health thinking by the middle of the nineteenth century, as sanitary theory became equated with public health. His approach was unashamedly western, focusing on European and North American issues only. Historian Anthony Wohl has described in great detail the political development of

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sanitary theory in Britain. Medical historian Dorothy Porter focused on social, political and economic relations between classes and organizations, with particular emphasis on the twentieth century in her history of public health from ancient to modern times. She emphasized the centralization of public health services that occurred in Britain, and contrasted this with the situation in the United States, where local initiatives, often of a voluntary nature, were established. These texts all refer to developed countries. The problems of developing countries are barely mentioned while the peculiar situation of white settler colonies in Australia—or elsewhere—received no specific mention. None of these texts saw any role for the police.

Race clearly was an issue for colonial settlements. In general, the colonizers perceived the populations of colonized countries as inferior. With the spread of sanitary theory through the colonial world, the indigenous populations also came to be increasingly perceived as contaminated. In the Australian colonies, the Aboriginal population was thought to be facing extinction, and was, therefore ignored by proponents of public health. By the last decade of the nineteenth century, it became clear that the race was not destined for the ‘eternal darkness in which all savage and inferior races are surely destined to disappear.’ Displaced from their tribal lands, Aboriginal people

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increasingly came to live in settlements (reserves) or on the fringes of towns, where significant interactions with the white population occurred. Generally it was the police who informed the authorities of the existence of health problems within these indigenous communities. By the late nineteenth century, Aborigines, with their alleged inferior sense of hygiene, were seen to pose a risk to white children. The Chief Clerk of the Queensland Education Department wrote in 1895 that the admission of ‘half-caste’ Aboriginal and Pacific Islander children to schools would lead to ‘almost certain risk of physical and mental contamination to the white pupils for whom the school was instituted.’ Among the infections of concern were syphilis, leprosy and hookworms.

0.2 What is public health?

Today, most people accept that an important function of the modern State is the

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14 Walter E. Roth. *Annual Report of the Northern Protector of Aboriginals for 1900 Q.V. &P. 1901:4; 1329-1337*. See also Dr R. Rendle’s letter to the Colonial Secretary, 28 July, 1900, Q.S.A. A/69442, in-letter 12521.

15 In 1895, the principal of the Emu Park School wrote to the Department of Public Education, asking that three Kanaka boys attending the school be removed, as one of them was the son of a recently deceased ‘leper’. (Queensland State Archives (Q.S.A). COL 264, 22 March, 1895).

16 See Warwick Anderson. *The Cultivation of Whiteness. Science, Health and racial Destiny in Australia*. Melbourne University Press, Melbourne, 2002 p 145 A similar perception occurred in New Zealand about the threat of Maori germs. Katrina Ford. ‘A menace to the wellbeing of the European; Maori, germs, and public health in New Zealand, 1900-1914. Paper presented at the 11th Biennial Conference of the Australian and New Zealand Society of the History of Medicine, Perth, 2009. In the 1920s, the Queensland police were extensively involved in assisting the organizers of the hookworm campaigns. As infected persons were not segregated, these campaigns are not considered in this work.
protection of the health of the people. This function is required, not from motives of altruism or social justice—though this may be the stated purpose—but rather for utilitarian commercial, economic or military purposes. A healthy population is one able to work, or defend itself against outsiders, while an unhealthy one is an economic embarrassment. It follows therefore that what the State sees as important may not be the same as what individual members of the State consider important. The public health, however it may be defined, is therefore as firmly grounded in the culture, political economy and mores of a community as it is in the diseases of the community. Furthermore, perceptions of risk vary in different cultures and at different times, and those perceptions may be unrealistic, unstable and influenced by illusions of control.17 A disease may be rare but excite great community concern, or common and be accepted as part of life. It may be important for the state, but not for the majority of individuals who make up the state, or important for the community, but ignored by the state. Furthermore, concepts of disease are cultural and ideological constructs that may change with time. A disease, common and ignored a hundred years ago, may have become sufficiently rare in the twenty-first century to excite considerable excitement and concern.18

Public health comes at a cost, in terms of money, human resources and infringements of human liberties. Legislators, about to make laws for the public health, may have all the

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18 Tuberculosis is an excellent example, ignored in colonial times, today a source of anxiety, but controlled by a large medical/bureaucratic administration.
expert advice necessary, but if they do not have the cash or human resources to fulfil the plan, then compromise becomes necessary. Equally, a perceived threat to individual liberties—the issue of compulsory vaccination against smallpox in the nineteenth century was an obvious example—may cause a good public health response to be abandoned, and this was an important issue in the days of *laissez-faire*. The ways of ‘Public Health’ are sometimes obscure.

In modern times, the World Health Organization has defined health as ‘a state of complete physical, mental and social well-being, and not merely the absence of disease.’ By this impossibly utopian definition, the majority of the world’s population must be considered unhealthy, and the situation is probably getting worse, not better. AIDS, obesity, poverty and terrorism spring immediately to mind as examples of conditions causing increasing dis-ease. In the middle of the nineteenth century, health was defined more simply as the absence of disease and again, by this more pragmatic definition, few at this time qualified as genuinely healthy. Sickness was everywhere. Infancy and childhood were particularly dangerous times, but even if childhood was survived, further threats to the health of the adolescent and young adult appeared. If the individual was lucky enough to survive into middle age, then a multitude of chronic and often painful conditions were ready to bring life to an end. Despite these calamities, populations increased, due to high birth rates and slowly decreasing mortality rates. While life expectancy, and quality of life may have improved during the nineteenth century, it was nonetheless not a life of health. Infectious diseases caused a significant proportion of this burden of ill health. During the twentieth century these gave way to the more difficult
problems of heart disease and cancer, often associated with smoking, over-eating and what are now called life-style issues. Increasing material wealth and well-being were also associated with a decreasing birth rate, leading to the modern day problem of an aging population. By the middle of the twentieth century infectious diseases declined significantly. Some physicians believed all infectious diseases could be conquered, either by inoculation or antibiotic therapy. However, despite optimistic forecasts (and the extraordinary success of smallpox eradication culminating in the declaration of the world as smallpox free in 1979) infectious diseases did not disappear, and new ones emerged. The most dramatic of these new infections was HIV/AIDS, a disease that could be transmitted in a variety of ways, including homosexual acts between consenting adults. In some jurisdictions, such acts were criminal offences, (such as Queensland in the early days of the new epidemic). HIV/AIDS can also be transmitted by the use of shared needles for injecting illicit drugs, another generally criminal activity at the time. In consequence of the association of HIV/AIDS with criminal activities, the police showed considerable interest in the disease, and particularly those who had contracted it. Further police interest came with the awareness that some infectious diseases could be significantly associated with bio-terrorism. The American anthrax threats, in the wake of the destruction of the World Trade Center, in September and October 2001 led to widespread police activity,19 not only in the United States, but in other Western countries also. The police today are as aware of infectious diseases as they were after the founding of Queensland as an independent British colony in 1859 and the term ‘medical police’ might be aptly applied to this part of their functions.

0.3 Medical police

The term ‘medical police’ has very specific meanings within the context of public health. Michel Foucault has suggested that state medicine first developed in eighteenth century Germany. *Staatswissenschaft*, the Science of the State, introduced the State as a legitimate object of scientific (and especially statistical) study and rose to a greater prominence in the fragmented Germany of the late eighteenth and early nineteenth centuries than in either Britain or France. Where, in these latter countries, the registration of births and deaths was introduced to measure the increase in population (and therefore the labour force), in Germany there arose a concept of state medicine aimed at improving not just the labour force, but the entire population that combined to form the State.\(^{20}\) Wolfgang Thomas Rau first employed the term ‘medical police’ in 1764\(^ {21}\) but the full flowering of the concept came later with the publication, between 1779 and 1817, of Johann Peter Frank’s six-volume *System einer vollständigen medizinischen Polizei (A Complete System of Medical Police)*. Frank considered that if the internal security of the State became the subject of general police science, then medical police would be a model of protection of the people against the harmful consequences of dwelling together in large numbers.\(^ {22}\) The term police is derived from the Greek *politeia*, meaning state, government, or administration, and in Frank’s terminology the word is apparently used in the Johnsonian sense of ‘the regulation or government of a city or country, so far as


regards the inhabitants’.\textsuperscript{23} Brenda White defines police as a set of regulations for remedial action.\textsuperscript{24} Ludmilla Jordanova identifies four broad meanings of medical police, ‘first, the administration of the health and well-being of the populace as a whole; second, the control of medical practice and practitioners; third, legal medicine and fourth, the science of hygiene,’\textsuperscript{25} though in the preface to Volume I Frank distinguishes forensic medicine from Medical Police. Foucault gave four attributes to medical police. Firstly, a system of observation of sickness, based on information from hospitals and doctors around the state. Secondly, the standardization of both medicine and medical practice (Foucault makes the point that doctors were the first ‘standardized individuals’ in Germany). Thirdly, an administrative organization for overseeing the activity of the doctors, and lastly, the creation of regional medical officers.\textsuperscript{26} Despite different interpretations of the term, it is clear that medical police encompassed a broad bureaucratic public health concept, and had nothing to do with police as generally understood today, which perhaps explains why the role of the modern police is not found in this literature.

\begin{thebibliography}{9}


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Frank’s system, though filled with the spirit of enlightenment and humanitarianism, is largely a guide for the bureaucrats of enlightened despotism such as prevailed in Germany and some other European States, but clearly those who toiled in these areas were not policemen in the sense we use the term today. Frank’s system was incompatible with the English liberal democracy associated with the development of industrial capitalism in the nineteenth century that initially favoured the parochial model of public health control, but later came to accept the necessity for some central intervention. In Foucault’s opinion, the German system of state medicine was replaced in France by urban medicine, concerned with the physical health of towns, the supply of water, building regulation and the circulation of the air, rather than with the health of the population. In Britain, the focus came to be on the labouring classes. Though the discourse of public health management might have been vastly different in Germany and Britain in terms of political ideology, Carroll has convincingly argued that in practice they came to be remarkably similar.

The term medical police was not generally favoured in England. In an anonymous English review, in 1862, of a pamphlet entitled ‘The Domain of Medical Police’, written by a German doctor who lived in America, the reviewer complained that the author


advocated a more aggressive and intrusive system of sanitary police than would be deemed consistent with constitutional government in Britain.\(^{30}\)

Between the middle of the eighteenth century and the middle of the nineteenth, the word police itself underwent, in the English-speaking world, a profound shift of connotation. By the time Peel’s New Police were established in 1829, the word meant a system for the maintenance of public order, for the prevention of crime and the detection and apprehension of offenders, not the regulation of a city or state. It had lost its governance connotation, so that police was now merely considered an administrative arm of government, albeit dealing with crime, the protection of property and maintaining the peace and the \textit{status quo}. Later the word was applied to the specialized personnel who constituted the police force. In Queensland, as will be seen, police as an administrative arm of government was taken to extreme lengths.

\textbf{0.4 The English moral revolution}

Between 1780 and 1850, the English ceased to be ‘one of the most aggressive, brutal, rowdy, outspoken, riotous, cruel and bloodthirsty nations in the world, and became one of the most inhibited, polite, orderly, tender minded, prudish and hypocritical.’\(^{31}\) Harold Perkin, a social historian of the English people, called this extraordinary about turn in behaviour and manners the Moral Revolution. Its genesis lay in the works of the


Evangelists, the Benthamites, and Dissenters. The Moral Revolution led to the imposition of a middle class morality on much of society. With time, this led to a decrease in cruelty to animals, to criminals, to lunatics and to children.\textsuperscript{32} Slavery was abolished, transportation came to an end, the number of capital offences was radically reduced\textsuperscript{33} and the prisons cleaned up.\textsuperscript{34} The Moral Revolution also brought about a shift in attitude towards public health. The development of sanitary science, which dichotomized the environment into pure and polluted, took on the form of a moral crusade.\textsuperscript{35}

A second consequence of the Moral Revolution was the introduction of new statutes and bye-laws dealing with minor offenders, drunks, vagrants, homosexuals, prostitutes, carpet beaters and kite flyers, Sunday traders etc. whose behaviour was ‘objectionable’ to middle class morality, but not so much to the working classes, who became the main offenders against these petty regulations. In pursuing these offenders, the police not only increased their rates of arrest, (and therefore their perceived efficiency) but also contributed to the social control of the population, and especially the working class population. The colonies noted these changes and adapted them to colonial situations.

\textsuperscript{32} The world’s first society for preventing cruelty to animals began in England in 1824 as the Society for the Prevention of Cruelty to Animals (later, the RSPCA). A society for preventing the abuse of children was only founded in 1884, initially as the London SPCC, later the NSPCC.

\textsuperscript{33} Victor A.C. Gatrell. \textit{The Hanging Tree: Execution and the English People 1770-1868} Oxford University Press, Oxford, 1994. In this book, historian Gatrell described the circuitous and sometimes devious route taken to reduce the number of capital offences in Britain.

\textsuperscript{34} Perkin. \textit{The Origins of Modern English Society} 1969 pp 281-282.

0.5 Causes of death

It is evident that medical terminology, as used in nineteenth century Queensland, may not be directly comparable to modern terminology. The Queensland Registrar-General published annually the vital statistics of the colony, including causes of death. The terminology used to describe the cause of death is subject to a variety of distortions. For example, the terminal event for a person dying from tuberculosis may be an attack of dysentery, with cause of death recorded as dysentery, rather than tuberculosis. Physicians may make diagnostic errors, or death may not be certified by a medically qualified person. Perhaps most importantly, the diagnostic term used by the Registrar-General may not be appropriate. Though typhoid and typhus had been clinically distinguished by the middle of the nineteenth century, the Registrar-General continued to use the word ‘typhus’ long after it was agreed typhus was probably rare in Queensland and most deaths in this group resulted from typhoid fever. ‘Consumption’ caused many deaths in colonial Queensland. This imprecise term encompassed deaths associated with cough (sometimes with the expectoration of blood), fever and wasting. While pulmonary tuberculosis probably caused most of these deaths, there are many other diseases with similar symptoms which can end fatally. The true cause may not be evident unless a post-mortem examination is performed, but these were not routine. Fortunately, most of the diseases discussed in this thesis caused no particular diagnostic problems, with the exception of the venereal diseases. During the period under discussion, the term ‘venereal diseases’ referred mainly to syphilis and gonorrhea.\footnote{Chancroid, a disease that causes localized genital ulceration without systemic manifestations was for long confused with syphilis.} No diagnostic tests for
either of these diseases existed until late in the nineteenth or early in the twentieth century. Syphilis may have been confused with yaws, especially in northern Aboriginal populations. The tendency of many observers, both lay and medical, to label people as infected with ‘the venereal’ makes it impossible to decide which of these two diseases was being considered, though syphilis seems the more likely. Leprosy and plague were well defined diseases, while influenza, especially within an epidemic situation, provided no great diagnostic difficulties. Lunacy was judged on behavioural criteria, with little evidence of diagnostic precision. Most patients were categorised as suffering from mania, dementia or melancholy, with or without the added effect of ‘intemperance’.  

0.6 The thesis

In this thesis I move beyond the frame of inquiry offered by Alison Bashford, who examined specific diseases that led to the enclosure of people. I also look at how this was undertaken, specifically, how did the Queensland police enforce such enclosures of peoples, or, in the words of Johann Peter Frank, how did they act as medical police? Why did the police have to undertake these tasks? And why has this medical role of the police been consistently ignored in historical accounts? Both historians of the police and of ‘public health’ have seen the role of the police in this area as relatively minor. I argue that it may have been minor, though exactly how minor is impossible to decipher from official reports or archival material, but it was nonetheless important.

Though the cast of characters includes Indigenous people, Pacific Islanders and Chinese, as well as those of British or European descent, this history will necessarily have an ethnocentric bias. It will look at my perception of the role and experience of the police, not how an Aboriginal, or non-white people perceived the role; that history has yet to be written.

Since a great deal of colonial practice was the result of British experience and law I am juxtaposing the British context with that of colonial or early post colonial Queensland in most chapters. The first two chapters examine the development of the police service and the establishment of health services in a rapidly developing colony. The next three chapters deal in a roughly chronological order with medical situations that involved the police: the management of persons of unsound mind between 1859 and about 1900, prostitution and venereal disease between 1859 and 1913, and leprosy between 1877 and 1913. The penultimate chapter deals with those quarantinable diseases that involved the police: smallpox, plague and Spanish Influenza. The final chapter will sum up and answer the questions set out earlier in this introduction—what did the police do in the field of public health and why did they do it?
1.0 A brief history of the Queensland police

1.1 Introduction

Though a system of constabulary had been part of the British landscape for centuries, the development of the first professional police force in London in 1829 was an important milestone in the history of policing. The colonies watched these changes with interest, adapting the British experience to their own needs. The Australian police, though born of British experience, developed along different lines.

The period from the last quarter of the eighteenth century to the middle of the nineteenth saw extraordinary changes in the social and demographic structures of Britain, changes which would have significant impact on the Australian colonies. Among these changes was the perception of rising crime rates (though historian Victor Gatrell has argued that the crime statistics were spurious and the apparent increase was due to an increased rate of prosecution). The alleged increase in crime was related to a perceived need to maintain discipline within an expanding industrial and economic climate, and the spectre, in the context of the American and French Revolutions, and the Napoleonic wars, of civil disturbance, particularly from a rapidly growing working-class population. Transportation, immigration, and finally a new police would be part of the solution to the

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demographic and social problems of the time. However, in colonies such as Queensland that started with relatively small European populations within a geographically large area, police were often the sole arm of government in many parts of the colony. As such they undertook numerous extraneous duties, including medical duties, for which they were not trained. This chapter therefore looks at how the police developed in Britain and in Queensland, and how it came about that in the colony, the police took on a significant public health role.

1.2 Maintaining the peace in Britain

Contrary to popular misconception, policing did not start, in Britain or elsewhere, with Sir Robert Peel and his New Police in 1829. What Peel did was develop the notion of a ‘specialist’ police force. Prior to Peel’s reforms, policing in Britain was a parochial and inefficient craft, dependent on catching felons rather than preventing crime. The system worked reasonably well so long as the peace officers knew the people in their communities. The most glaring weakness of the system was rioting, for which the authorities generally called in troops. The situation changed with the demographic changes of the Industrial Revolution. In 1801, only London had a population greater than 100,000, while by 1851 ten such towns existed, and 23 per cent of the population lived in

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towns with populations greater than 100,000. The demographic transition was also associated with significant economic changes as the landed gentry, who had controlled the wealth of the state, saw economic and political powers transfer to middle-class capitalists, industrialists and entrepreneurs.

The English Moral Revolution came with, though not necessarily caused by, the end of the American Revolutionary War, the start of the French Revolution, and an increasing fear of proletarian mass action, triggered by such episodes as the Gordon Riots of 1780. Crime came to be perceived, not as a function of individual depravity, but as a social issue bred in the squalor of back-streets. The absence of a significant police force led to considerable anxiety among the ruling classes, and also aggravated the symptoms of political and social disturbance which culminated in the Peterloo massacre of 1819.

Though there initially existed much opposition to the idea of a centralised and government-sponsored police force — the propertied classes seeing this as an affront to their traditional liberties, based on local authority — Peel’s New Police came into

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8 The Gordon Riots were anti Catholic- riots organized by Lord George Gordon and his Protestant Association and directed against the Papists Act of 1778, which relieved Catholics from certain penalties, particularly from taking the religious oath when joining the British Army.


existence in 1829, originally in metropolitan London, later in the boroughs (1833) and rural areas (1839). In introducing his metropolitan police bill, Peel endorsed the idea that crime was increasing rapidly in the country. This was due, he said, not to poverty, but to the depredations of habitual offenders. The traditional parish boundaries confined the peace officers, but not the criminals, while the lack of coordination between the parishes severely obstructed the task of dealing with crime. In Peel’s opinion, habitual criminals moved from places with efficient watch systems to places with inefficient or no watch systems. The New Police, he said, would not cost more than the old system and their efficiency would enable significant reforms of the penal code to be undertaken.¹¹

London’s metropolitan police were the first of a new style of police, poorly paid but professional and ultimately responsible to the Home Secretary. In 1829, the barrister Sir Richard Mayne, one of two Justices of the Peace appointed to be in charge of the London Metropolitan Police, wrote

‘the primary object of an efficient police is the prevention of crime: the next that of detection and punishment of offenders if crime is committed. To these ends all the efforts of police must be directed. The protection of life and property, the preservation of public tranquility, and the absence of crime, will

¹¹ Rawlings. *Policing, A Short History* 2002, pp 114-115. Peel’s mention of reforms of the penal code reflected the beliefs of many who opposed a police system, but believed crime could be controlled by reform of the criminal code, particularly by the appointment of stipendiary magistrates.
alone prove whether those efforts have been successful and whether the objects for which the police were appointed have been attained.'

Though Peel stressed his New Police was not a military force—being armed only with a baton for self-defence—he borrowed the organizational structure of the police from the military, including ranks, uniforms and a hierarchical system of command and discipline.

The issue of rural policing in particular was complex and prolonged as the traditional rural ruling classes tried to determine their places in the new order of things. After the Whig Government of 1830 had to contend with the Swing riots and public disturbances associated with the defeat in the House of Lords of the Reform Bill of 1831, Home Secretary William Lamb, Viscount Melbourne, drafted a bill for a national police force, but this was never presented to parliament. In 1836, Chadwick, advocating for a Royal Commission into rural policing (with himself as a commissioner), noted that a way to make a new police force less obnoxious was “to divest it as much as possible of the aspect of a merely penal agency, and make it an agency for many useful sanitary and immediately beneficent purposes, the prevention of calamities as well as crime.”

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12 Quoted in: [http://www.met.police.uk/history/definition.htm](http://www.met.police.uk/history/definition.htm).

13 The Swing Riots (so called because threatening letters to local rural landlords were signed by ‘Captain Swing’) were riots by agricultural labourers, initially in South-East England, later spreading north, whose livelihood was threatened by decreasing wages, and the threat from mechanized threshing machines.


The Constabulary Report of 1839, largely drafted by Chadwick and based on the findings of the Royal Commission which sat from 1836, showed that in the countryside, considerable amounts of minor crime were either not reported or were not prosecuted while at the same time, much reported crime was not solved. The authors of the report recommended the establishment of a professional, rural police force which would receive general direction and responsibility from ‘the supreme executive’, while day to day supervision would be under the magistracy. The presence of the force would act as a deterrent to crime and a professional force would apprehend more criminals thereby enhancing the deterrent value. The authors strayed into sociological hypothesis by declaring that blameless poverty and destitution did not lead to crimes against property, but rather thieves found that they could make more money from depredation than from honest work. Vagrants were categorized as thieves, and all rural crime was attributed to the labouring classes.16

Chadwick wanted a single national police force, but the County Police Act of 1839 did not go as far as he recommended, merely allowing magistrates in the counties to appoint a permanent police force, to be paid by the county, if the local constabulary was perceived to be inadequate to deal with local crime.17 It would not be until 1856 that all counties were compelled to introduce county police forces.


17 Philips and Storch, Policing Provincial England 1829-1856, 1999, pp140-141
If crime was due largely to habitual offenders, preventive policing, by arresting people for minor misdemeanours, would prevent the inevitable progress from petty to major criminal. The police determined to establish their authority on the streets. With the support of parliament and local governments, they initiated operations to control traditional working class problems, such as drinking and gambling, but also new ones, including kite flying, carpet-beating (in public places), and other petty nuisances, not because the police approved of moral improvement, but in order to prove and consolidate their authority. Persons charged with such minor offences were brought before a police court, presided over by a police magistrate. As the middle classes, who benefited most from the order the police generated, came to appreciate the role of the police, so the police came to focus increasingly on the un-represented, un-propertied, working class. The Benthamite ideal of a preventive police, whose prime function would be the prevention of crime, followed by the apprehension of criminals if prevention failed, gave way through the nineteenth century to a perception of controlling social order, through the control of working-class recreations, customs and usages which were not, in themselves, criminal.

1.2.1 Police in Ireland

The situation in Ireland was different from that of England and Wales. Absentee English Protestant landlords ruled a rural, unruly and Catholic peasantry which lacked tenure of

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18 Rawlings *Policing: A Short History* 2002, pp. 154-156
its tenant farms.\textsuperscript{19} The English style of justice of the peace and parish constable, which maintained some form of law and order in England, had no chance to perform as well in Ireland. The abortive rebellion of 1798 was followed in 1800 by the Act of Union, which took away the limited autonomy of the Protestant Ascendancy which had ruled Ireland since the seventeenth century. However, unrest continued. In 1814, Peel, at the time Secretary for Ireland, introduced a Peace Preservation Act which empowered the Lord Lieutenant to send a chief magistrate and a specially appointed body of armed men to any part of the country proclaimed to be in a state of disturbance.\textsuperscript{20} While initially effective, the peace preservation force eventually proved inadequate to deal with more widespread disturbances that required military assistance. In 1822, the \textit{Constabulary Act} was passed, setting up a national police for Ireland. The Royal Irish Constabulary was quite different from Peel’s Metropolitan police of seven years later. It was a centralized, quasi-military force designed specifically to deal with rural unrest. It was armed and consisted of both foot and mounted police. In contrast to the London police, members of the Irish constabulary lived in barracks.

Australian (and other) colonies, when establishing their professional forces, examined both options; most chose a pragmatic mixture of both the Irish and the English systems, and added their own contributions.


1.3 Police in Australia

1.3.1 New South Wales

Early governors of New South Wales were aware of the issue of an apparently steeply rising crime wave in Britain, since, *inter alia*, they had to cope with the influx of convicts this generated. Royal Marines of the New South Wales Corps performed the earliest policing function, but their drunken excesses led to a need to free the colony from military control and lay the foundations for permanent civilian control. In 1789, Governor Arthur Phillip appointed a Night Watch consisting of well-behaved convicts. In 1810, Governor Lachlan Macquarie re-organized the police, forming, in 1811, independent police units under the control of magistrates. In Sydney ultimate control of the police was vested in a superintendent, hospital contractor, dealer in spirits and police magistrate D’Arcy Wentworth. Wentworth said in 1819 that his men were selected from ‘emancipated and free persons’ while several were recruited from retired soldiers of the 102nd and 73rd regiments. In 1820, Macquarie came under scrutiny from Royal Commissioner John Thomas Bigge, appointed by Secretary of State for the Colonies Lord Bathurst to enquire into conditions in the colony, and the effectiveness of

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transportation as a form of punishment. Bigge’s report was critical of Wentworth\(^{24}\) and his men, many of whom were dismissed for drunkenness.\(^{25}\) He recommended, among other reforms, the appointment of a superintendent of all police in the colony.\(^{26}\) In 1825 Bathurst appointed F. N. Rossi, a Corsican with experience of police work in Mauritius and Bengal to the position of superintendent of police. Despite Bigge’s recommendations, Governors Sir Thomas Brisbane and then Sir Ralph Darling postponed the change to a centralized administration.\(^{27}\) Mounted Police, recruited from the military, were raised in 1825 to suppress crime in the pastoral regions and to recapture runaway convicts and remained independent of the superintendent. This force was abolished in 1850. The Water Police followed (1830) to deal with crime around Sydney Harbour, Sydney Police (1833), patterned on the London New Police, Border Police—responsible to the Commissioner for Crown Lands for policing the various land regulations in the unsettled squatting districts and for settling disputes between Europeans and Aborigines,—in 1839\(^{28}\) and, after the Border Police had become a moribund force,\(^{29}\)

\(^{24}\) Ritchie. *The Bigge Report*, Volume 2. The Written Evidence, pp 165-166. Bigge damned Wentworth’s conduct, saying he came into conflict in his roles of hospital contractor and superintendent of police; he was disinclined to prosecute unlicensed spirit sellers (Bigge believed firmly in the relationship between alcohol and crime); Wentworth, he claimed, sacrificed his public duty to his private interests, and as a surgeon had shown little professional experience!


Native Police in 1848. Native police, a coercive body, enforced and removed any dissidence by non-cooperative Aborigines. Its only objective was to disperse Aboriginal tribes and make the land safe for pastoral enterprise.\textsuperscript{30} A lack of communication, cooperation and central supervision between these various forces led to considerable inefficiency. The need, in the early years of the penal settlement, was to contain public order within a convict society. The police made great efforts to closely regulate the lives of convicts and ex-convicts. At the same time, a close relationship developed between the police and rural magistrates, many of whom represented significant landholding interests. The association took on a class-conspiratorial appearance.\textsuperscript{31} The involvement of the magistrates, appointed by government, effectively meant the police also came under government direction,\textsuperscript{32} a significant contrast with community policing in Britain at the time, but more in line with the Irish model.

The Sydney police were modelled on the London Metropolitan police, but with significant differences—in particular, they were armed with cutlasses and staves.\textsuperscript{33} The Sydney Police Act\textsuperscript{34} and the later Country Towns Police Act of 1838 authorised the

\begin{itemize}
\item \textsuperscript{29} Raymond Evans. \textit{A History of Queensland} 2007, p 71.
\item \textsuperscript{30} Jo Kamira. Indigenous Participation in Policing-from Native Police to now- has anything changed? Paper presented at the History of Crime, Policing and Punishment Conference convened by the Australian Institute of Criminology in conjunction with Charles Sturt University; Canberra, 9-10 December 1999.
\item \textsuperscript{31} Mark Findlay. \textit{Introducing Policing Challenges for Police &Australian Communities}. Oxford University Press, South Melbourne, 2004, p 21.
\item \textsuperscript{33} Milte and Weber. \textit{Police in Australia} p 23.
\item \textsuperscript{34} \textit{An Act for the Regulation of the Police of the town and port of Sydney and for removing and preventing Nuisances and Obstructions}, 4\textsuperscript{th} William IV, no 7 1833.
\end{itemize}
appointment of certain magistrates—to be called police magistrates—who would be responsible for quelling riots and breaches of the peace, controlling vagrancy and upholding laws and regulations. The magistrates could nominate a number of ‘fit and able men’ as a police force for the towns to which the magistrate was appointed. Police magistrates sat alone, while justices of the peace, generally local notables, sat in pairs, and had no powers to raise a constabulary. The police force was to preserve the peace, prevent robberies and other felonies, and apprehend offenders. The constables had powers to arrest loose, idle, drunk or disorderly persons found in the streets between sunset and 8.0 am and were to ensure no carpet beating, flying of kites, breaking of horses or other minor misdemeanours took place on public streets. The New South Wales Vagrancy Acts (1835 and 1851)—modelled on English legislation—further enhanced police powers by entitling police to control idle and disorderly persons, rogues and vagabonds. Historian Michael Sturma pointed out that a police force needed to be seen to be effective and therefore an effective and increasingly professional police force in Sydney led, in mid nineteenth century, to a decline in theft and violence, but an increase in the number of arrests for relatively minor crimes, (drunkenness, disorderly conduct, breaches of the peace, etc). In Sturma’s opinion, arrests for minor offences

35 Police magistrates generally had some legal training.

37 The problems relating to establishing ‘time’ in the Australian colonies is the subject of Graeme Davison’s book, *The Unforgiving Minute: How Australia Learned to Tell the Time*. Melbourne, Oxford University Press, 1993.


resulted directly from police initiatives and from readily observable actions, such as drunkenness. Before 1850 police received a portion of the fines levied for these minor offences, thus encouraging arrests. He also believed that the police exercised wide discretionary powers, and made many arrests, not to deal with law breakers, but to coerce respect from those who appeared to be lacking in proper attitudes and behaviour.\(^{40}\)

Despite attempts from 1850 onwards to place the entire colony under a single administrator, it was only in 1862, after Victoria (1851) and Queensland (1859) separated from New South Wales, that a new *Police Regulation Act* amalgamated all New South Wales police units into a single service

Though modelled on British policing models, the New South Wales police had three unusual manifestations to deal with that were not part of the general British experience—the problems of convictism, Indigenous resistance, and civilian disturbances, particularly during the gold rushes of the 1850s and 1860s, some of which, such as the Lambing Flat riots in central New South Wales in 1861, were racially motivated.\(^{41}\) Convictism was largely resolved by the ending of transportation to the eastern mainland colonies in 1839—though the stain of convictism remained for decades. Though numerous convicts remained in New South Wales after 1839, the local police and benches\(^{42}\) had by then become sufficiently professional to control these remnants.


\(^{41}\) Finnane. *Police and Government*, 1994 pp 23-30. Other civilian disturbances included the problems of bushranging and race riots, particularly anti-Chinese riots. Riots occurred in London also, but were generally related to political issues.

\(^{42}\) ‘Benches’ refers to the magistracy
The northern corps of Native Police under Commandant F. Walker formed in 1848 combined European firepower and leadership—often men with a British military background—with Aboriginal bushcraft and tracking skills. Similar native forces had earlier been raised in Victoria, South Africa, Ceylon and India. The original intention of the force was to protect the Aborigines from the depredations of the whites, but this intention was soon lost as the Native Police established a reputation for dealing out vigorous punishment for supposed ‘outrages’ committed by Aborigines. Their function was to allow and promote the settlement of New South Wales by white settlers at the expense of the Aborigines; they rarely performed any other duties. Historian Chris Cunneen has pointed out that conflict between Indigenous and settler populations at the frontiers increased the likelihood of a centralised approach to policing, since governments were required to protect settlers, and, increasingly from 1836 came under some obligation and scrutiny from the Imperial Government to protect Indigenous people.

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45 Historian Jonathan Richards, in his PhD Thesis, noted that the Native Police were not a police force in the generally accepted sense, (p 25) rather a military formation of “irregular light cavalry” distinguished by its use of extreme violence (p 64).

46 Christopher Cunneen. Conflict, Politics and Crime. Aboriginal Communities and the Police. Allen & Unwin, Crows Nest, NSW, 2001. P 48. In 1836, the British government established a select committee to investigate the condition of Aborigines in British colonies and develop appropriate policy. The committee was chaired by Thomas Fowell Buxton, a noted social reformer who led the anti-slavery movement in the House of Commons after the retirement of William Wilberforce in 1825.
control of the Native Police passed from the Inspector-General of Police in Sydney to the
government resident in Brisbane.\textsuperscript{47}

The discovery of gold in the Blue Mountains of New South Wales by Edward Hammond Hargraves in February 1851 led to an unprecedented gold-rush. In that year alone, the New South Wales government issued over 12,000 gold-miners licences. On 11 June, 1851, ten days after Victoria separated from New South Wales, gold was discovered in the new colony by James Esmond. Further and larger discoveries at Ballarat and then Bendigo followed. The gold rushes led to some social unrest, as men deserted their jobs and families, and thousands of gold seekers arrived from overseas. Between 1851 and 1861, the population of Victoria grew from 77,345 to 540,322.\textsuperscript{48} Tension between the Australian miners and the authorities over the injustice of the goldfield licenses and police corruption led, in 1854, to the battle of the Eureka Stockade.\textsuperscript{49}

By 1852, Chinese miners were coming to the Australian gold fields, initially in small numbers, but in the first three months of 1854, the influx increased.\textsuperscript{50} Controlling relations between Chinese and Australian miners would prove a difficult task for the local police, given their own racism.\textsuperscript{51}

\textsuperscript{47} Jonathan Richards. \textit{The Secret War, A true History of Queensland’s Native Police} University of Queensland Press, St. Lucia, 2008, p 85.

\textsuperscript{48} Weston Bate. \textit{Victorian Gold Rushes}. McPhee Gribble/Penguin Books, Fitzroy, Victoria, 1988, p.27


\textsuperscript{50} \textit{The Argus}, (Melbourne) 24 March, 1854.

1.3.2 Queensland

Moreton Bay was a penal settlement from 1823 until 1842, when the district was opened for free settlement. Policing in the penal settlement had been a military responsibility. Once free settlement was permitted, authority was first invested in the Crown Land Commissioner, Dr Stephen Simpson. On 22 January, 1843, Captain John C. Wickham RN arrived in Moreton Bay as the Government Resident and the first Police Magistrate in the northern district.\(^52\) He organized a small constabulary under his control, in line with the *Towns Police Act* of 1838. Though New South Wales legislation, the act continued in force in Queensland throughout the nineteenth and early twentieth centuries. The *Towns Police Act* was extended to Ipswich in 1851, Drayton in 1855, Brisbane in 1856, Rockhampton in 1859, Gladstone and Toowoomba in 1860, Dalby (1861), Warwick (1862), Gayndah (1865), Roma (1866), Townsville (1871) and subsequently numerous Queensland towns.

The *Towns Police Act* referred to streets and public places. The *Police Jurisdiction Extension Act* of 1881 gave powers for the proclamation of places belonging to or controlled by an ‘Association’, such as racecourses, or Schools of Art, places where

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\(^52\) *Sydney Morning Herald*, 26 January, 1843.
people occasionally gathered in numbers which might lead to disturbances needing police control.  

By the time of Separation on 6 June 1859, there was increasing disagreement in Queensland about who should be responsible for the police, whether the benches or an Inspector-General. The first Colonial Secretary, R. G. W. Herbert wished to institute the post of Inspector-General to have complete control of the Queensland Police, but the benches objected.  

A Select Committee established in 1860 recommended against the post of Inspector-General. A bill to appoint a single officer to be in charge of all police introduced in 1862 was defeated by supporters of the bench. The following year Herbert returned with similar legislation and this time, the Police Act of 1863 was passed. The first Police Commissioner was appointed in 1864. Like many others in charge of colonial police forces David T. Seymour came from an Irish and military background (figure 1.1). The Police Magistrates continued to be involved in police matters. The Rules of the Force of 1864 only said that Officers of Police who were in the Commission of the Peace should

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53 See, for example, Q.S.A. A/44515, in-letter 07445 to Commissioner of Police, 13 May, 1899, in which Sergeant Kelly asks that the Mount Morgan School of Arts be proclaimed under the Act, since public entertainments were frequently held there, but if disturbances occur, the police had no power to act.

54 By order of the Executive Council, E. V. Morisset, Commandant of the Native Police, was appointed Inspector-General, but never took up the post. Q.S.A. EXE/E1, Meeting 60/3, 1 January, 1860.

55 Brisbane Courier, 21 May, 1862.


57 Q.G.G. 1864:1;1 appointment as acting commissioner, Q.G.G. 1864:1;424 confirmed as commissioner.
not take bench duty but on-going problems led Colonial Secretary Arthur Hodgson, a fervent supporter of the benches, to introduce new rules in 1869 that specifically placed the white police under the control of the benches. At the same time, he appointed twenty-one Police Magistrates as Inspectors of Police. Seymour, in evidence to the second Select Committee investigating the Police Force in 1869, stated that if he, the

Figure 1.1 D.T. Seymour, Queensland’s first Commissioner of Police, 1863-1895 (John Oxley Library)


Commissioner, and a Police Magistrate were at a riot, he would, under the new rules place himself under the Police Magistrate, even though the latter was a junior officer. He pointed out to the committee the absurdity of the situation. The inevitable result was administrative confusion among the ranks, resolved the following year with a change of government, when the new Colonial Secretary, Arthur Palmer, cancelled the appointment of the magistrates as police inspectors and the Commissioner ruled alone.

Appointment of officers was the responsibility of the Governor, on the advice of the Executive Council. The Commissioner was responsible for the appointment of sergeants and constables. He had no power of dismissal without ministerial approval, but his recommendations were nearly always accepted.

Water police were raised in 1859. The sub-inspector of water police was also appointed a health officer, and was permitted to board ships in this capacity. The term ‘health officer’ was widely used to describe a variety of different functions. ‘Health officers’ did not have to be medically qualified. A health officer boarding a ship merely had to ask the captain and the ship’s doctor about sickness on board during the voyage, as well as at which ports the ship had called.

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The key to the financial security of the colonies during the nineteenth century lay in the sale of land, primarily for the pastoral industry. In 1840, brothers George and Patrick Leslie became the first free settlers on the Darling Downs.63 A number of squatters followed and occupied large parcels of the new colony. The Aboriginal inhabitants of these lands did not, however, cede their lands lightly. The greatest violence in Queensland was on the frontier, and especially the northern, and north-western frontiers, involving some atrocities by and many against the Aborigines.64 Here the Native Police, founded in 1848 as a New South Wales corps, but transferred to Queensland in 1859, perpetuated the violence, meeting ‘outrage’ with reprisal until the European settlers had achieved their aims, the possession of land, while the decimated Aboriginal population was reduced to a state of half-starved, dispossessed, hopelessness. A Select Committee of the Queensland Parliament on the Native Police Force in 1861 concluded that disbanding the force would be disastrous, that some of the problems of the Native Police Force came from inefficiency, indiscretion or the intemperate habits of some of the officers. The committee added that it could not countenance the indiscriminate slaughter of the Indigenes, but noted attempts to Christianize or educate this population, (labelled as ‘cannibals’,65 and ‘sunk in the lowest depths of barbarity’) had proven useless.66 In


64 For a detailed account of the functions and roles of the Native Police, see Richards. The Secret War. 2008. Resistance by Aborigines was commonly referred to as ‘depredations’.

65 References to cannibalism in colonial Queensland are, according to historian Regina Ganter, unreliable; inferring cannibalism from inadequate evidence, second or third hand evidence, or a misreading of native mortuary practices. Regina Ganter. Mixed Relations Asian-Aboriginal Contacts in North Australia. University of Western Australia Press, Crawley W.A. 2006, pp 163-164. As late as 1900, Dr Richard Rendle, writing from Normanton, worried about half caste children in black camps, saying ‘those who are not fattened up, killed and eaten by the blacks (as very many are) grow up a curse to themselves and a danger to the white population.’ Q.S.A. A/69442, in-letter 12521 to Colonial Secretary, 28 July, 1900.
1867, the Colonial Secretary reminded the police commissioner it was his duty to issue explicit orders to the officers of his force to put an immediate stop to all unnecessary harshness or cruelty towards the Aborigines, otherwise the government would be forced to make severe examples of any who disobeyed, but the carnage continued and the Commissioner continued to defend the Native Police. Historian Jonathan Richards notes that Queensland authorities were familiar with the nature and workings of the Native Police, since its officers were appointed by Executive Council, individuals moved easily between the Native Police and other branches of the Public Service, including the police. It was not ‘a shadowy distant elite, but almost a normal part of colonial administration.’ In his ‘Notes on the Condition of the Aborigines of Queensland’ the Reverend Duncan MacNab, a Catholic priest, wrote, ‘when a squatter has his men or his cattle speared by the blacks (no matter that they may have been impelled to the commission of the outrage by hunger, or by the seduction of their women, or by the murder of a comrade...) he sends for the Native Police to disperse the Blacks — which means to shoot them.’

It was only later in the century, after many Aboriginal people had been killed, that the attitude of the police changed, from trying to ‘disperse’ the native population, to one of trying to come to terms with them, through the distribution of food and medical care, and promises of shelter in camps, pastoral stations or on the

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66 Q. V. & P., Report of the Select Committee of the Queensland Legislative Assembly into the Native Police Force. 1861: 393-574.

67 Q.S.A. COL/Q4, in-letter 67/160 to Commissioner of Police, 26 February, 1867.


70 Q.S.A. COL/A316, out-letter 2895 from Lord Kimberley to Officer Administering the Government of Queensland, 22 April, 1881.
fringes of towns. The Native Police declined after the turn of the century, but continued to exist in the Cape York Districts for a number of years.

It has been commonly stated that where colonial police were armed and subjected to ‘central control’, they were following an ‘Irish’ model. Historian Richard Hawkins disputed this, suggesting there was a need for a re-assessment. He cited as an example, the case of the Canadian North West Mounted Police, who were both armed and government controlled, and therefore followed the ‘Irish’ model; however, he noted significant disparities in equipment, structure, operating conditions and, particularly, in their relationship to society. Historian Mark Finnane has noted that the apparatus of British and Irish policing found its home most comfortably in the cities. The various ‘frontiers’ of the empire marked the temporary limits of imperial conquest, administration or settlement. Here the colonial police, concerned with protecting property and maintaining social order in disputed areas, chose various means, not based on British or Irish experience, to achieve their aims, including the raising of quasi military forces, with

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72 Q.S.A. COL 140, copy of an unnumbered letter from Horace Tozer to the Governor of Queensland, Lord Lamington, 10 October, 1897; the Native Police Camp at Coen was still functioning in 1908, see POL/J22, in-letter 18599 to Commissioner of Police, 14 October, 1908.


or without indigenous participation and with, or without the consent of the local people. The Queensland Native Police was a typical example of a frontier force raised with Indigenous participation and the full support of the white population living in the frontier areas.

In their attempts to control the white populations, the police enforced the public morality of the governing classes through the enforcement of regulations against drunkenness, obscene language, after hours drinking, gambling, Sunday trading, etc (the Imperial Sunday Observance Act of 1677 was only repealed in Queensland in 1984). These regulatory functions exactly mimicked the functions of the English police. The senior officer in any police station attended meetings of the Licensing Boards to advise on the suitability (or otherwise) of applicants.76

The behaviour of the police was expected to be impeccable. Constables who drank on or off duty were liable to instant dismissal, while sergeants or senior constables could be reduced to the rank of constable.77 (In Victorian and other forces, drunkenness was common among the rank and file members of the police, but dismissals were rare, owing to the need to maintain manpower levels.78) At the same time, the Commissioner sent a private memorandum to all officers warning that the name of any officer found guilty of

76 Q.S.A. A/5067, memorandum from Commissioner of Police, 19 March, 1884.
77 Q.S.A. A/45260, General Order 610. 2 April, 1879. Associating with prostitutes was also cause for dismissal, see Q.S.A. A/40110, Edmond O’Brien, who was dismissed from the police in 1885 after being found in a house of ill repute; A/40191, Alfred Wavell, who was dismissed in 1874 for marrying ‘a well known prostitute’ without permission; A/38844, Michael Holohan was dismissed in 1900 after being charged with ‘misconduct with a prisoner,’ a well known prostitute; and others.
being drunk on any occasion would be forwarded to the Colonial Secretary with a recommendation of dismissal.\textsuperscript{79} Between 1864 and 1867, numerous police were dismissed for drunkenness on duty.\textsuperscript{80} By 1873, Commissioner Seymour claimed that the police had achieved a good standard of professionalism, and their efficiency was more than satisfactory. Life was not easy for a Queensland policeman. They worked long hours, often under difficult circumstances, for low wages. In north Queensland, where the cost of living was high and the climate particularly trying, Seymour had found it necessary in 1873 to raise the pay for his constables to keep them in the Force,\textsuperscript{81} despite which, the following year, allowances paid to the police in Cooktown and on the Palmer were reduced, leading to a number of resignations.\textsuperscript{82} Commissioner Seymour noted in his Annual Report for the year 1868 that in many rural areas, policemen had to live in public houses and hunt for their horses in the bush. He also noted that, in escorting prisoners to major centres for trial or imprisonment, police travelled in total over 150,000 miles in the space of a year.\textsuperscript{83}

\textsuperscript{79} Q.S.A. A/45260, private memorandum from Commissioner of Police to all officers, 2 April, 1879.

\textsuperscript{80} Q.S.A. POL/4, for a number of such cases.

\textsuperscript{81} Q.S.A. COL A/188, in-letter 2320 to Colonial Secretary, 15 January, 1873. COL A/238 in-letter 2758, to Colonial Secretary, 9 May, 1877, Seymour says that in view of the advancing state of settlement in the north, and the decreasing cost of living, he was proposing to further reduce the allowance to a new scale which varied between one and three shillings per day.

\textsuperscript{82} Cooktown Courier, 18 July, 1874.

\textsuperscript{83} Report of the Commissioner of Police for the Year 1868, Q.V.& P. 1868/9:1; 243-244.
1.4 Police duties

The primary duty of the police was to patrol populated areas, in the towns on foot, on horseback in the rural areas. Small towns were patrolled between the hours of 9 am and 11 pm while stations in larger towns were open 24 hours a day. The constant patrolling brought visible and minor offences, such as drunkenness, obscene language or disorderly behaviour, to the attention of the police who reacted accordingly. I have examined the police diaries of a number of rural and urban police stations, which describe in some detail what the police did in these areas. Between 1895 and 1897 in Herberton, a small rural police station staffed by a sergeant and three constables, the sergeant generally stayed in the station while one constable patrolled the town, on foot, between the hours of 9 am and 1 pm, and 7 pm and 11 pm. The second constable patrolled the town between 2 pm and 6 pm and also between 7 pm and 11 pm. The third might be on mounted duty, patrolling through the surrounding bush and to neighbouring towns that did not have a regular police presence, or away on leave, or sick. In addition to regular patrols, the constables took turns acting as watch house keepers, and attended police courts. They were on duty seven days a week.\textsuperscript{84} The diaries record for 1902 and 1903 ‘special occurrences’, which included escorting an occasional lunatic or prisoner, investigating crime, attending shows, sports and races to ensure no disorderly conduct, arranging agricultural returns, compiling jury lists, serving summonses, taking an Aboriginal woman to the Government Medical Officer as a suspected leper, visits to slaughter yards, checking brands, attending license court, and investigating unexpected deaths. Crimes

\textsuperscript{84} Q.S.A. A/38007, diary of duty and occurrences, police station, Herberton, 1895.
attended to included theft, illegal branding, willful damage to property, sly grog selling, absconding from hired service, desertion from Royal Navy vessels, selling opium to Aborigines and cattle and horse stealing. Misdemeanours, such as being drunk in a public place, were not recorded in this station.

By 1875, eight years after James Nash discovered gold in a creek bed, Gympie possessed a large police station, supervised by an inspector or, when he was leading a gold escort, a sergeant. The staff was made up of 2 senior constables, 3 mounted constables, and 7 foot constables. The station was open 24 hours a day, with one officer on duty from 9 pm to 5 am. Mounted police were on patrol, or, when not patrolling, undertook stable duties. One of the senior constables was responsible for the town duties. Some foot constables also undertook stable duties or other fatigue duties. The diaries for 1900 make no mention of the threat of plague, while the diaries for November 1918 say nothing about the end of the Great War. There is no mention of Spanish influenza for the first 3 months of 1919. The special occurrences refer largely to more serious crime, murder, cattle rustling, drunken policemen, and the investigation of unexpected or sudden deaths. Time was spent on escort duty, of prisoners, lunatics and gold, as well as attendance at races, sports and shows, collecting electoral roles, serving summonses, attending court and collecting agricultural statistics.

The diaries do not provide any sort of statistical evidence of how much time was spent on any medical or other duty. An alternative source of information are the watch house records, which detail the offences for which people were held in the watch houses. The

85 Q.S.A. A/38006, diary of duty and occurrences, Herberton, 1895 to 1897.
watch-house records of the small towns of Kilkivan,86 Adavale, north east of Quilpie,87 and Kuranda,88 demonstrate the typical small town problems of the Queensland police. The great majority of first charges89 were for drunkenness, for disorderly conduct (drunk or sober), for using obscene, abusive or profane language in a public place, and for robbery, stealing or larceny. Relatively minor crime and breaches of public morals accounted for over sixty percent of first charges laid. The only consistent medical item in these records is the arrests on suspicion of being of unsound mind, which accounted for 5.1% of first charges. There were two attempted suicides in Adavale between 1887 and 1891, two in Kuranda between 1887 and 1901, and two in Kuranda between 1902 and 1913.

The third source of information on police duties is the annual reports of the Commissioner of Police. In 1870, Commissioner Seymour stated that crime, with the exception of horse and cattle stealing, was not prevalent,90 but by 1877 the situation had changed, with an increasing range and severity of crime. Detailed crime statistics were now reported annually,91 giving the numbers of people charged with particular offences. Unfortunately, the statistics do not also include the number of individuals against whom

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86 Q.S.A. A/50499, Kilkivan Watch-house Charge Book.
87 Q.S.A. POL6A/Q1, Adavale Watch-house Charge Book.
88 Q.S.A. B/3063, Kuranda Watch-house Charge Book.
89 If an inmate was charged with several offences, I have only counted the first. Those charged with drunk and disorderly behaviour, for example, frequently received a second or third charge, such as resisting the police, or abusive language.
charges were laid. A man might be charged at the same time with being drunk in a public place, with using abusive language and with resisting arrest and all three offences would be counted separately. For the purpose of this thesis, the reports enumerate those charged on suspicion of being of unsound mind, with attempted suicide, and with breaches of the Contagious Diseases Act. Between 1878 and 1900 women charged with disorderly conduct were categorized as ‘disorderly characters’ or ‘disorderly prostitutes.’ The statistics for these categories of charges are contained in the relevant chapters. Leprosy patients, plague suspects, smallpox contacts and others, though sometimes treated by the police as criminals, were not enumerated in the annual reports, since they were not charged with an offence.

The organisation of the police in Queensland was highly hierarchical. The Commissioner, responsible to the Colonial or Home Secretary, worked through the new officer ranks of inspector and sub-inspector. In 1866, Thomas H. Barron, the Chief Clerk and accountant in the Police Department (and a magistrate) was appointed as Inspector, to perform the Commissioner’s duties during his absence. In line with the change of policies of 1869, Barron’s promotion to Inspector was repealed, but he continued to act as deputy. In 1872, Henry Browne was appointed a ‘travelling superintendent’, to visit and inspect outlying stations, but this post lapsed in 1873. In 1896, John Stuart, a long

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92 Q.V.& P. 1869:1:689. During the Royal Commission into the Queensland Police of 1869, Commissioner Seymour, asked whether he was ‘subject to the regulation and control of the Colonial Secretary’, replied ‘entirely.’ In 1896, the title of Colonial Secretary was changed to Home Secretary

93 Barron’s career came to an end when he was dismissed in1881 for ‘financial irregularities.’ (Richards. “A Question of Necessity” 2005, p 109).
serving police officer, was appointed Chief Inspector, to be the second-in-command to the Commissioner and a replacement for the travelling inspector. The colony was divided into a number of districts, each under the command of an inspector. A sub-inspector or a sergeant had responsibility for sub-districts, controlling a small number of constables. Discipline was maintained through constant monitoring of duties by senior officers and periodic surprise visits to stations. Relations between police and the local community were kept as distant as possible through constant staff transfers. Lower ranks could only communicate with senior ranks through intermediary ranks. If a constable wished to report something of note, he notified his sergeant, in writing, who would pass the communication on to the (sub) inspector, and so on until the report reached the commissioner. The commissioner might then, depending on the nature of the report, forward it to the Under Secretary in the Colonial Secretary’s or Justice Department office, or to the chief inspector, for a comment. Once all the necessary opinions had been collated, the commissioner reversed the process, back to the inspector, then through him to the lower ranks. By this means all concerned with the matter became aware of the appropriate response.

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96 Despite the quasi military ranks, the uniforms and the armaments, constables were allowed a great deal of discretion in their management of individuals, something the military of the time would not accept for the private soldier.
1.5 Training of the police

The Queensland Police Act of 1863 stated that no person was to be appointed a constable unless he was of sound constitution, able-bodied, of good character and able to read and write. No educational test was employed except literacy and an assessment the candidate was of normal intelligence. In England and Wales, the training of the police, as well as other aspects of recruitment, promotion and pay, were, after the passage of the County and Borough Police Act of 1856, under the supervision of Her Majesty’s Inspectorate of Constabularies. Here, the development of a national police force was hampered by the intransigence of county governments. In Australia, a centralised approach to policing was established by the middle of the nineteenth century in each independent colony, which enforced uniform standards for that colony.

In Queensland, recruits spent some two or more months in the Police Depot in Petrie Terrace. Much of the time was spent in drilling, including rifle drill, and on gymnastics. The Drill Instructor read the Rules of the Force to the recruits, and examined them on the rules. They did not study the acts of the parliament, but were given instruction in how to make arrests, how to write reports and how to apply for a summons. By the end of the century, training had advanced a little. Drill was still emphasized, but now each

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98 Tasmania was an exception to this general rule, where a centralized police force was not established until 1898.
100 Q.S.A. EDU/Z2909, Physical Training Chart, by F. Loose, Director of Exercises, Queensland Police Force, 1892.
Monday, a squad of recruits would attend the Central Police Court in Brisbane to familiarise themselves with court proceedings. Also one evening a week, a squad attended the Legislative Assembly, when in session, to hear the debates, and ‘to get to know the public men of the colony’. 101 In 1898, W. E. Parry Okeden, Queensland’s second police commissioner, (fig. 1.2) arranged for Dr F. G. Connolly, a member of the Central Board of Health, to give a course of ten lectures on first aid, but funds were not available to make such teaching a regular practice. 102 Constables who went out into rural areas were poorly prepared for any medical or other extraneous tasks they might have to undertake.

1.6 Extraneous duties

Extraneous duties are duties undertaken for other government departments which do not directly link to police work. Such work had been seen by Edwin Chadwick as a useful means of ensuring the acceptability of a new police force. The duties which were undertaken can, in general, be defined as clerical, or social and regulatory. Some extraneous duties performed by the Metropolitan police included lighting lamps, calling the time, inspecting weights and measures and other unwelcome public services, many of


The Irish Constabulary also performed a series of generally unwelcome extraneous duties. An (unnamed) Constabulary Officer complained in 1859 of the duties imposed on the police:

\begin{quote}
\textbf{Figure 1.2. W.E. Parry Okeden, Commissioner of Police 1895-1905} (John Oxley Library)
\end{quote}
Revenue Police duties; Enforcement of Fishery Laws; Suppression of smuggling; Comparing Standard Weights and Measures; Billeting of Troops on the March; Revision of Brideswell Books;\textsuperscript{105} Supervision of Petty Session Clerk's Accounts; Surveillance of Ticket-of-leave Convicts; Distribution of Collection of Poor Law Voting Papers... Agricultural Stock... with many other minor duties too numerous to mention.'\textsuperscript{106}

In the British South African colonies, especially in the rural areas, the police acted as general servants of the colonial power, and performed both clerical and social duties, including enforcing health regulations.\textsuperscript{107} American police from the 1860s undertook an extensive social welfare role, particularly by the provision of overnight lodging for the homeless, and by the return home of lost children.\textsuperscript{108}

Australian colonial clerical duties included acting as clerks of Petty Sessions, goldfield bailiffs, inspectors of distilleries, crown land rangers, inspectors of slaughter houses, registrars of births, marriages and deaths, collectors of agricultural statistics and even court house cleaners.\textsuperscript{109} In New South Wales, social welfare duties were part of police

\textsuperscript{105} Bridewell: a House of Correction.


function from an early date. Standing Order 21 of 1847 said that ‘every man...was to take notice of any nuisance or dead animals on or near his beat...he should report this to his inspector,’ who would convey the information to either the inspector of nuisances or the city surveyor. In 1870, revised rules stated that ‘if a constable observes anything in a street or highway likely to produce danger or public inconvenience, or anything which seems to him irregular or offensive, he will either remove it or report it to his superior officer (rule 67). The police also managed lunatics, dangerous or otherwise and, in Victoria, managed Chinese leprosy patients in and around Ballarat.

Though the primary and initial functions of the Queensland police were said to be the maintenance of the peace, the prevention of crime and the arrest of malefactors, these soon expanded to include acting as gold escorts, serving warrants and summonses, checking for missing persons and investigating causes of death. A number of early medical practitioners were appointed as coroners before Separation. A coroner’s jury

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114 Gold escorts were popular duties, as police received double pay while in charge of the gold. At the Royal Commission into the police in 1889, the use of gold escorts came under scrutiny and criticism. By 1899, the Commissioner of Police made it clear that the police took no responsibility for the gold, merely acting as escorts for those who had charge of the bullion. Q.S.A. POL/J3, in-letter 06589 to Commissioner of Police, 4 April, 1899, with comments by W.E. Parry-Okeden.
assisted the coroner. However, the sparse population and lack of local government such as existed in England and Wales meant that Queensland could not effectively copy English legal practice. Under the terms of the *Inquests of Deaths Act* of 1866, juries were no longer to be summoned and magisterial enquiries replaced coronial enquiries.\(^\text{115}\) The police generally conducted the inquest before the magistrate or Justices of the Peace. Occasionally, and especially in the case of Aborigines, the police by-passed inquests. The general letter book for the Port Douglas police station describes how, in 1899, following the report of a death of a female Aboriginal, the sergeant ‘carefully examined the body...and finding no marks of violence and from full enquiries among the [A]boriginals, no suspicious circumstances,’ ordered the body to be buried.\(^\text{116}\) Deaths of individuals while in police custody always led to an inquest.

In addition to these quasi police duties, the police became increasingly involved in work for other departments. In 1864, Seymour issued a General Order that members of the police force were not to accept any additional appointments without his consent,\(^\text{117}\) but on the same day appointed four sub-inspectors to be rangers of Crown lands (protecting

\(^{\text{115}}\) As early as 1860, the Executive Council were already of the opinion that a magisterial enquiry were as effective as coronial enquiries in the majority of cases of ‘sudden or mysterious death’, but did nothing about it until 1866. Introducing the bill into the Legislative Council, the Postmaster General said that already most inquests were held before a magistrate; the testimony of a medical man might be invaluable for his technical knowledge, but medical men ‘were not, as a rule, acquainted with the technicalities of legal proceedings.’ Debates of the Queensland Legislative Council, 25 April, 1866. In June 1865, the handling of a coronial inquiry by Dr Sachse of Toowoomba was criticized in the Legislative Assembly for his lack of knowledge of legal technicalities. Debates of the Queensland Legislative Assembly, 29 June, 1865. In 1882, the Central Board of Health proposed that, in view of the numbers of children dying from neglect and want of proper medical attention, coronial enquiries be restarted, but this did not come about. Q.S.A. COL/A335, in-letter 2493, 8 May, 1882 to Colonial Secretary.


\(^{\text{117}}\) Q.P.G. 1864:1;5.
livestock and property) and inspectors of slaughter houses. The most important extraneous duty was acting as clerk of petty sessions, for which a policeman could receive an additional yearly salary of £5, £10 or even £25. Duties of the clerk of petty sessions included issuing summonses, taking injunctions and generally running the magistrate’s office. Gradually, other duties were added, so that, by 1901, the list of extraneous duties performed by the police included:

1. Acting clerks of Petty Sessions
2. Registrars of the small debts court
3. Agents for the curator in intestacy
4. Agents for the Official Trustee in Insolvency.
5. Inspectors of slaughter houses.
6. Assistant district registrars of births and deaths.
7. Electoral registrars
8. Acting land agents.
10. Customs officers
11. Acting mining registrars.
13. Inspectors of brands

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118 Q.P.G. 1864:1; 8 the role of inspectors of slaughter houses was not a public health one, rather to ensure that animals taken for slaughter were not stolen.


15. Inspectors under the *Tobacco Act* of 1894.

16. Inspectors of breweries.

17. Protectors of Aborigines, after 1898.

18. Inspectors of stock.


20. Caretakers of Government bores and flood warning stations.\(^{121}\)

By 1908, the number of extraneous duties performed by the police had increased to forty-five, now including some ordered by the Commonwealth Government, such as the supervision of sugar growers (to ensure growers claiming rebates under the Excise Tariff and Sugar Regulations of 1902 did not employ coloured labour.\(^ {122}\) The Attorney-General wanted police reports in cases of petitions for divorce, with respect to whether the petitioner had been guilty of adultery, or had been an accessory to, or connived at the adultery of the other party to the suit, or whether there had been collusion between the parties.\(^ {123}\) Commissioner Seymour objected to extraneous duties\(^ {124}\) and angrily rebutted suggestions the police may have refused to perform some of these extraneous duties.\(^ {125}\)

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\(^{122}\) Q.S.A. POL/J34, circular 265 from Commissioner of Police, 26 November, 1902.

\(^{123}\) Q.S.A. POL11/A2, unnumbered circular memorandum, 20 December, 1901.

\(^{124}\) Report of the Commissioner of Police for the Year 1886. Q.V. & P. 1887:1; 103. See also Q.V.&P. 1894:1;711.

\(^{125}\) Q.S.A. COL/A88, in-letter 398 to Colonial Secretary 1 February, 1867 in which Seymour denies his officers refused to collect stock and agricultural returns for the Registrar-General’s department.
Despite objections from Seymour to the Royal Commission into the ‘General Working of the Civil Service’ of 1889 that such extraneous duties cost his department both in money and man hours, the Commission ignored his complaints.\textsuperscript{126} He sent a circular memorandum to his inspectors saying he had a strong objection to the legitimate functions of the police being interfered with by any extra duties being imposed on them, but in view of public convenience, could not raise any strong objections to the extra duties, so long as the officers had the permission of their superiors to undertake the extra duties.\textsuperscript{127} The principle of extraneous duties was explained in a minute written by Colonial Secretary Sir Horace Tozer in 1891, though presumably accepted long before:

In many localities it may be necessary for the Govt. [sic] to have an agent for a variety of purposes, and it often happens that there is not sufficient population or the place is not of sufficient importance to justify a larger expenditure than in the maintenance of police. Applications are made by all Departments for the use of the police to save them needless expense of separate officers. The Commr. [sic] objects, and has always objected to this amalgamation of offices, alleging it interferes with the discipline of the force and oftentimes renders the officer practically useless for police purposes. To some extent this may be correct, but as a rule in this sparsely scattered Colony, constables in outside districts can if they are efficient and zealous officers perform the several duties. I therefore


\textsuperscript{127} Q.S.A. POL11/A1, circular memorandum no. 129 of 1889, 27 June, 1889.
decide as a general principle that when there is no other Govt. Official in the town
or district capable of performing the extra work, the Police must do it.\textsuperscript{128}

In 1897, the second Commissioner, W. E. Parry-Okeden, who had been a Colonial Under
Secretary, said he recognised that, ‘as a first principle Government business should be
treated as a whole’. It was therefore right government should assign to any of its officers
those portions of its business as it considered appropriate, but also pointing out that while
this led to a great saving for government departments, it added considerably to police
expenditure, and diminished efficiency.\textsuperscript{129} The Report of the Police Inquiry Commission
of 1899 recommended that extraneous duties be performed by appropriate officials,
leaving the police to do their proper work.\textsuperscript{130} The recommendations were ignored. In
1907, Commissioner W. G. Cahill (figure 1.3) complained to the Home Secretary about
the amount of extraneous duties carried out by the understaffed police officers at Winton
and Richmond. The Home Secretary of the time, Peter Airey, minuted that many of these
duties were ‘merely nominal’ and the burden was more apparent than real.\textsuperscript{131} Five years
later Cahill sent a circular memorandum to his officers, reminding them that police duties
must always take precedence over extraneous duties, and asking how many of these
duties were being carried out. Most replies indicated that extraneous duties took up a
considerable amount of police time, but public health was rarely mentioned, except in
relation to slaughter houses, prostitutes or habitual drunkards. Only Inspector Hugh

\textsuperscript{128} Q.S.A. A/45179, in-letter 08,872 to Commissioner of Police, 10 August, 1891.

\textsuperscript{129} Annual Report of the Commissioner of Police for the Year 1901.

\textsuperscript{130} Q.S.A. POL/R1, Report of the Police Inquiry Commission, 1899, recommendation 11.

\textsuperscript{131} Q.S.A. A/45181, in-letter 07077 to Home Secretary, 18 June, 1907.
Malone, of the Cairns police complained that a disagreeable duty performed by the police was watching lepers, sometimes for months before the patient was taken to a lazarette.\footnote{Q.S.A. A/45181, replies to Commissioner of Police W.G.Cahill’s circular memorandum no. 718 of 30 April, 1912.}

**Figure 1.3 Police Commissioner Geoffrey Cahill, 1905-1915** (John Oxley Library)

Extraneous duties continued. As late as 1996, officers complained to the Queensland Police Service Review that pressure on them to perform non-policing duties, especially for other departments, distracted from their operational roles. Regrettably, what these
duties consisted of is not stated. Police officers performing clerical extraneous duties were formally notified through the Police Gazette.

The Queensland police were involved in a number social welfare issues, for which they were neither trained nor formally appointed: the management of lunatics in public places, the management of prostitutes at risk of venereal disease, the detention of individuals suspected to suffer from leprosy, and supporting quarantine regulations. In addition to these, which form the basis of this thesis, The *Towns Police Act* gave police limited powers to control nuisances. In 1873/4 police charged numerous people with allowing cows or horses to dirty the streets of Brisbane or for leaving dead animals on the streets. In 1883, the police commissioner reminded his men that if they came across dead animals on their beat they should report the matter to the local mayor or Divisional Board Chairman. The police could make enquiries about ownership of such animals and could prosecute if the owner refused to abate the nuisance. In 1903, a police sergeant visited the Dee Rush Gold field, near Mount Morgan, to look into the sanitary condition of the field. He reported that 250 to 300 miners camped at the site, but these appeared to be clean, there was an abundance of water, and there had been no sickness. In 1912, Constable Watson was appointed an inspector of nuisances in Birdsville, at a salary of £15 per annum.

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134 See Q.S.A.CPS1/AW17, for numerous examples between 1873 and 1874.

135 Q.S.A. A/45276, in-letter 22688 to Commissioner of Police, 11 November, 1903.

By the end of the nineteenth century, there was still no significant medical bureaucracy in Queensland. Government Medical Officers were not public health doctors, while Health Officers to either local boards of health or local authorities (after the passage of the *Health Act* of 1884), were more concerned with sanitation and childhood infectious diseases such as scarlet fever, measles and diphtheria than with problems such as lunacy, venereal disease or leprosy.

From the 1880s the police, particularly in frontier areas, were ordered to take greater control of Aborigines, and problems of Aboriginal health. The *Queensland Licensing Act* of 1885 forbade the sale of alcohol to Aborigines, and the police spent much time attempting to prevent this. The *Sale and Use of Poisons Act* of 1891 made it an offence to allow Aborigines access to smokeable opium. The act was circumvented by selling Aborigines opium charcoal.137 The *Aboriginal Protection and Prevention of the Sale of Opium Act* of 1897 led to considerable activity on the part of the police attempting to control the sale of any form of opium to Aborigines, who had become addicted to the substance, in part because some employers paid their wages in the narcotic.

Exotic diseases might be controlled by quarantine, and great faith was placed in maritime quarantine. If, however, a disease breached the maritime quarantine, then the next step had to be the detection and segregation of those suspected or diagnosed as suffering from

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137 Opium charcoal is the ash that remains after smoking opium, which still contains quantities of narcotic, and is taken by mouth.
that disease. For compulsory segregation, supported by law, an energetic police force would be an invaluable resource.

1.7 Conclusions

The stated functions of the Queensland police were the prevention of crime, the arrest of malefactors and the preservation of order. The police patrolled towns and the surrounding bush, and dealt vigorously with visible disorder, such as drunkenness and its associated problems. Because of their dispersal throughout the colony, and in the absence of a significant bureaucracy outside Brisbane or other major towns, the police soon accrued a large number of extraneous duties, some of which were medical. They received no training for these extraneous roles. The medical role was understated by Police Commissioners throughout the nineteenth and early twentieth centuries, yet it was an important role.
2.0 People, doctors and diseases

2.1 Introduction

At Separation from New South Wales the European population of Queensland was estimated to be just over 25,000, mostly concentrated in the South East corner of the new colony. The Aboriginal population, living in the region for possibly as long as 50,000 to 60,000 years,¹ and estimated to be above 200,000 at the time of the British invasion, declined rapidly after the arrival of the new colonists and the inevitable contact occurring between the two populations. In this chapter, I will look at how the populations of Queensland changed, what were the developmental factors associated with these changes, and the part that disease (and therefore doctors) and health legislation played in these changes.

2.2 The people

2.2.1. The Aboriginal population

The first Queensland population census, held in 1861, specifically excluded Australian Aborigines. Instructions to census collectors stated, ‘Chinamen, Malays, Polynesians, and all other foreigners, of whatever nation or color, are to be counted; but the native

blacks (aboriginal of Australia) are not to be included. Though the 1881 census enumerated some Aborigines, the first formal count of this population was made at the census of 1901. Conventional wisdom, based on census data, says that the low point for Aboriginal populations, some 22,500, was reached at the census of 1921. Gordon Briscoe disputes these figures, arguing that the low point for aboriginal populations, ignoring the effects of inaccurate estimates, was somewhere between 1881 and 1901. On-going debate between Briscoe and demographers continues. Causes of the decline included acute, imported exotic diseases to which the Aborigines had no immunity, such as smallpox, measles and influenza. More slowly, tuberculosis and venereal syphilis proved lethal for many, while other causes included the destruction or usurpation by the settler population of native food sources. How many died as a result of the wilful killing of large numbers as part of the process of ‘dispersal’ by the Native Mounted Police and pastoral interests on the frontiers is unknown. Alcoholic liquors, previously unknown to the Aborigines, and no doubt opium, interacted significantly with other causes to the decline in population and the demoralisation of the traditional social order. The indigenous population was perceived to be facing extinction. Historian Henry Reynolds

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has outlined the social Darwinian assumptions underlying this perception. This population was consequently never considered relevant in any health legislation, and the specific needs of aboriginal people were largely ignored until late in the nineteenth century. In addition, it seems unlikely that nineteenth century sanitary theory, which dominated public health thinking, had any conception of how to deal with Aboriginal disease.

Concerned by criticism of the lack of policies for the Aboriginal population, the Queensland Government appointed a Commission of Aborigines in 1874 to enquire into ways to ameliorate the condition of this population. Over the course of the second half of the nineteenth century, the only government agency that dealt with Aborigines was the police, initially via the Native Police Force. In his annual report for the year 1879, Seymour foresaw the gradual disbanding of this force, with native troopers being reallocated to police stations as trackers. As Aboriginal resistance was overcome, the police also came to appreciate that much distress was occurring in Aboriginal communities. In 1884, Seymour noted that Aborigines were stealing food because they were starving, largely since white settlers had usurped their traditional food sources.

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8 Churches and some private individuals showed considerable, if paternalistic, concerns for Aboriginal welfare throughout the century, establishing reserves and missions in various parts of the colony.

9 Q.V.& P. Report of the Commissioner of Police for the year 1879. 1880:1:707 It was only in 1911 that the last remnants of the Native Police disappeared.

Increasingly, the police reported outbreaks of disease among the Aborigines. The culmination of this activity came with the *Aboriginals Protection and Restriction of the Sale of Opium Act* of 1897, which made the Police Commissioner the Chief Protector of Aborigines. Among his first actions was to appoint police officers as Protectors, who came increasingly to play a role in Aboriginal health matters.

### 2.2.2 The European population

During the period of Aboriginal decline, from 1824 to the end of the nineteenth century, the white population increased dramatically. In 1846, after the close of the penal settlement four years earlier, the population of what would become Queensland was estimated at 2,257, increasing to 8,575 in 1851, to 25,020 at Separation,\(^\text{11}\) and to about half a million at the census of 1901. In contrast to the Aboriginal population, the white population was youthful, with 43% under the age of 20 in 1861 and 46% in 1901. In 1861, 32% were Australian born, rising to 65% by 1901. Of those born outside Australia, the majority came from the British Isles, 55.5% in 1861, falling to 25.1% in 1901. There was an obvious male preponderance, with 151.8 males per hundred females in 1861, and a ratio of 125.5 in 1901. The male preponderance was augmented by immigration policies that favoured men judged according to their youth, vigour and physical usefulness, who were enjoined to work hard and reproduce rapidly.\(^\text{12}\)

\(^{11}\) The figures for 1846 to 1859 come from William Coote. *A History of the Colony of Queensland from 1770 to the close of the Year 1881*. Brisbane: William Thorne, 1882 Volume1 p 64.

Wedgwood’s ‘eleventh commandment,’ thou shalt not be idle’, suited the moral tone of the post-convict colonies. In 1861, the sex ratio of the British migrants, the largest single group, was 271.4, falling to 130.5 in 1901. The male preponderance was also greater in the rural and northern tropical areas, matching perceived needs—aggressive expansion of settlement, the ruthless destruction of aboriginal populations (and aboriginal rights), the Kanaka trade, acrimonious class conflict (in later years), and environmental exploitation requiring not only capital, but the masculine traits of brawn and determination. At the same time, these needs also led to the development of a colonial morality, copied from Britain, which stigmatized the poor, the idle and the chronically unwell, a trine often intimately linked (ill health leads to unemployment which leads to poverty). The poor furthermore might bring destitution upon themselves through improvidence, lack of thrift and intemperance. Temperance, morality and respectability formed the basis of ‘genteel’ life.

The increase in the non-Aboriginal population of Queensland was largely due to immigration. Competition for migrants was fierce, not only from New South Wales and Victoria, but also from other British colonies (and America), many of them places much

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14 Between 1861 and 1907, 246,923 migrants of all races came to Queensland, of whom 166,523 were males, giving a male sex ratio, per 100 females, of 207.1.*Commonwealth Year Book*, vol 2, 1910, p 169.


17 Historian W. Ross Johnston has shown that throughout the Nineteenth Century, America provided the greatest allure for intending British migrants, with the empire always taking the minority. Johnston. *Great*
closer to ‘home’. The journey itself was fraught with problems, from diseases on board ship, to the effects, after the opening of the Suez Canal in 1869, of heat during the transit of the Red Sea, apart from the purely maritime problems of storms and shipwreck.

The migrants were needed to develop the new colony. At separation from New South Wales on 6 June 1859, the political leaders of the nascent colony of Queensland faced four quite formidable challenges. Firstly, the human resource, (this referred only to the white population) was tiny—some twenty five thousand people for a country of almost 670,000 square miles (1,435,000 square kilometres) in area. Secondly, the new colony had negligible financial resources. At separation, the Queensland treasury contained only 7½ pence, a paltry sum that was stolen one night soon after. More seriously, a bill from the New South Wales government for £20,000 for public works carried out before separation further stretched the financial resources of the treasury. Cash revenue receipts

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19 Q.S.A. COL/A486, in-letter 0490 to Chief Secretary from the Central Board of Health, 15 January, 1887.

20 The greatest dangers to emigrant ships were at Sydney and Melbourne, though how many passengers who died in such tragedies were destined for Queensland is unknown. See Peter Stone. *Encyclopedia of Australian Shipwrecks and other Maritime Incidents*. Oceans Enterprises, Yarram, Victoria, 2006.


in 1860 totalled only £175,000, rising to £223,000 the following year.\textsuperscript{23} Thirdly, if infrastructure was to be developed, the financial resource would need to be obtained through loans. By 1865, the colonial public debt stood at a million pounds, a figure that would increase to forty two million pounds by the end of the century. By 1892, Queensland had a higher per capita debt than the United Kingdom, and the largest debt in the British Empire.\textsuperscript{24} The fourth problem was geographic. Much of Queensland lay within the tropical zones. It was doubted whether Europeans could work in such areas without damage to their health and risks to their lives. Furthermore it was widely believed that by the third generation of continued residence in the tropics, the people would lose all Caucasian physical characteristics.\textsuperscript{25} If these beliefs were correct, then populations more suited to work in the tropics would be required, while science would have to resolve the genetic issue.

\subsection*{2.2.3 The Pacific Islanders}

Agricultural hopes for the new colony of Queensland lay first in cotton. The shortages induced by the American Civil War, and the perception that the east coast of Australia would prove suitable for cotton stimulated the development of a number of plantations.\textsuperscript{26}


\textsuperscript{24} Evans. \textit{A History of Queensland}, 2007 p 113.


The failure of cotton encouraged an interest in sugar cane. The need for coolie labour was soon raised. Initially, Indian labour was proposed. Though Regulations for the importation of coolies from British India were published in 1863, the system was cumbersome and likely to be expensive. A simpler and cheaper solution presented itself to employers. In 1863, Robert Towns, a New South Wales entrepreneur, introduced Pacific Islanders to Queensland to work initially in his cotton plantations, and later in sugar cane plantations. The methods used to persuade the Pacific Islanders to come to Queensland caused great controversy, despite legislation designed to prevent abuses. This population increased to a maximum of just over 12,000 in 1883, before declining slowly. The islanders were expelled in 1906 as a result of the Commonwealth Pacific Islands Labourers Act which specified that all labour agreements with Islanders would cease at the end of the year 1906, and authorised the Minister for External Affairs to order the deportation of any such Islanders. Only 1654 Islanders were granted exemption from expulsion. Males constituted the majority of Pacific Islanders who came to Queensland. Here they suffered a very high mortality, particularly from

\[27\] Q. V. & P., Asiatic Labour (Despatches relating to) 1861, pp 627 – 650.

\[28\] Queensland Government Gazette 11 February, 1863.


\[30\] This act, and the Commonwealth Immigration Restriction Act of 1901, which prohibited the immigration of any person who could not pass a written test in an European language, are commonly seen to be the start of the ‘White Australia’ policy.

pneumonia, dysentery and tuberculosis. A government report of 1878 noted that, up to March 1878, 13,937 Pacific Islanders had been introduced into Queensland, of whom 5,570 had been repatriated, but 1,694 (12.15%, or one in eight) had died. The Islanders were suspected of carrying leprosy, but were also stereotyped at the time as a primitive, murderous people, who were frequently mentioned in police records for crimes of violence.

### 2.2.4 The Chinese

The discovery of gold, in both New South Wales and Victoria in 1851, stimulated a gold rush which soon included an increasing number of Chinese. As the southern gold fields dried up, the new colony of Queensland, competing for migrants, encouraged the search for new gold fields. After short-lived rushes at Canoona, Gympie and Mt Morgan, news spread of further gold discoveries, particularly in the 1870s. James Venture Mulligan discovered significant quantities of gold at the Palmer River in 1873. By 1877—a year in which no census was taken—the estimated Chinese population of Queensland was about seventeen thousand, though official figures suggest the numbers increased from 538 in 1861, to a peak of 11,206 in 1881, before declining to 3,806 by 1921. During the

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32 Q. V. & P., Statistics of South Sea Islanders to March 1878, 1878:2;39.

33 The Bulletin, 9 February, 1901. See also Q.S.A. PRI/8 for a return showing the numbers of Islanders convicted of crimes (and especially crimes of violence) between 1885 and 1895.


35 Commonwealth Year Book, vol 17, 1925. p 952.
period 1875 to 1877, almost 22,000 Chinese arrived in Cooktown alone.\textsuperscript{36} During the colonial period, males made up more than 95\% of the Chinese population. Much anti-Chinese feeling (figure 2.1) related to the perceptions that they were an immoral race.

Figure 2.1. *The Boomerang* February 11, 1886 The caption reads, ‘Awake, Australia, Awake’ (John Oxley Library)

\textsuperscript{36}Kathryn Cronin. The Chinese Community in Queensland. *Queensland Heritage*, vol 2, 1971, pp 3-13. Cooktown was the major port of entry for the Palmer Gold Fields.
(seducing European girls of tender age, having promiscuous intercourse with European women, gamblers and smokers of opium). Furthermore, despite significant cultural achievements to their credit, sociologists attempted to prove the racial inferiority of the Chinese by focusing on the perceived Chinese adherence to tradition and custom, a conservatism foreign to the dynamic progress of the Anglo-Saxons. More dangerously, ‘Chinese germs’ gave rise to either nameless diseases, or diseases referred to by such emotionally charged words as ‘plague’, or, more ominously, leprosy. A progress report from the Queensland Central Board of Health in 1877 said it had ‘long been foreseen that the Chinese invasion of the Palmer Gold Fields …would bring to our shores some of the formidable contagious diseases prevalent in the East.’ While the focus was on the threat of smallpox, the board threw in, as a sideline, the danger from the probable importation of the loathsome disease of leprosy, which it said was very prevalent among the Chinese. The Townsville Herald in 1888 said that leprosy was far more common among the Chinese than was generally known, often making its first appearance in their

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38 See, for example, Raymond Evans, Kay Saunders and Kathryn Cronin. Race Relations in Colonial Queensland, University of Queensland Press, St. Lucia, 1993, p 259.


40 Throughout the latter part of the nineteenth century, leprosy was often described as ‘loathsome’.

hands. That the disease was transmitted by contagion was undoubted.\textsuperscript{42} The Chinese had already been widely blamed for the introduction of leprosy into Hawaii,\textsuperscript{43} other Pacific islands\textsuperscript{44} and Victoria.\textsuperscript{45} The expression ‘leprous Mongolian’ was not uncommon in the nineteenth century.\textsuperscript{46} A deputation of the Employers Association to the Chief Secretary in 1887 said of the Chinese,

‘They form centres of support for all that is most degraded in the European population. To these slums European women are drawn, who develop into the most debased kind of courtesan, and become in turn sources of unspeakable moral contamination. Experience shows that a Chinese slum in our towns, though not openly very disorderly, becomes a human cesspool in which moral disease assumes its most malignant and infectious form.’\textsuperscript{47}

The situation in Australia mimicked that in America, where, by the mid nineteenth century, the Chinese were feared, hated, persecuted, and handed the ultimate debasement

\textsuperscript{42} \textit{Townsville Herald}, 29 December, 1888. See also \textit{The Bulletin}, 21 August, 1886 which said ‘disease, defilement, depravity, misery and crime- these are the indispensable adjuncts which make the Chinese camps and quarters loathsome to the senses and faculties of civilised nations.’


\textsuperscript{44} Aristide Le Dantec. \textit{Precis de Pathologie Exotique}. Paris: Octave Doin, Editeur, 1900 p 612.


\textsuperscript{46} May. \textit{Topsawyers: the Chinese in Cairns 1870-1920}. James Cook University, Studies in North Queensland History, No 6 1984, p 98. ‘Leprous’ here has two meanings: a sufferer from leprosy; and a person suffering from moral corruption.

\textsuperscript{47} Q.S.A. COL A 512, Objections to Chinese Immigration Submitted to the Chief Secretary by a Deputation representing the Employers Association, on 18 July, 1877.
by being barred from the country by the *Chinese Exclusion Act* of 1882.\textsuperscript{48} A number of acts were passed in the Australian colonies between 1855 and 1888, endeavouring to limit the numbers of Chinese permitted to land in Australia, despite objections from the British government, which had entered into treaties of peace and amity with the Emperor of China; these treaties gave the Chinese the liberty to enter into engagements with British subjects for service in British colonies.\textsuperscript{49} However nothing as severe as the American exclusion act was allowed in any Australian colony. Anti-Chinese sentiment was at least in part responsible for the call for a ‘White Australia’ policy,\textsuperscript{50} which only started to crumble in 1966.

Though the Chinese worked in the gold fields in large numbers, they also worked in other areas, as storekeepers, pastoral workers, market gardeners (supplying fresh fruit and vegetables to Europeans),\textsuperscript{51} herbalists, interpreters and letter writers. They developed furniture and other factories.\textsuperscript{52} Resentment against the Chinese was strongest in the gold fields, where they were perceived to steal and hoard gold to take back to China, rather than contributing to the wealth of the colony. However, once the Chinese were seen as a


\textsuperscript{49} Q. V. & P., Despatch from her Majesty’s Secretary of State for the colonies to the Officer administering the Government of Queensland. 1877:1; 815-816.

\textsuperscript{50} *The Boomerang*, 4 April, 1888.

\textsuperscript{51} Joseph Bancroft, the most eminent physician in colonial Queensland, considered it possible that leprosy might be transmitted by food, especially green vegetables handled by Chinese gardeners. Quoted in: Helen G. Clements. *Science and Colonial Culture: Scientific Interests and Institutions in Brisbane, 1859-1900.* Ph.D. Thesis, Griffith University, 1999, p 222.

declining force, and colonial social and economic dominance no longer felt threatened by
the Chinese, they became better tolerated by European colonizers,\(^{53}\) though the
perception the Chinese might ‘re-invade’ Queensland in the late 1880s led to an anti-
Chinese riot in Brisbane on May 5, 1888.\(^{54}\) Despite the negative perceptions, social
historian McNaughtan believed that the Chinese were generally an energetic and law-
abiding people, ‘no more vicious than equivalent sections of the Australian population’\(^{55}\)
One writer, from New South Wales, said of the Chinese,

‘When we speak of inferior and superior races, if we are to test that superiority by
order, by respect to the laws, by industry or by any other test which it is usual to
apply to subjects, we fear the balance would be very far from being struck in our
favour...they (the Chinese) are not seen rolling about the streets in a state of
drunkenness; they are not seen covered with rags. They do not cast their poor upon
the public charity. They have a very extensive organization to relieve and protect
each other.’\(^{56}\)


\(^{56}\)Sydney Morning Herald, 2 August, 1861.
2.3 Notification of births, marriages and deaths

The collection of vital statistics, originally called ‘political arithmetic’ and generally left to individuals or private groups to collect, came to be seen in the nineteenth century as one of the most important functions of the state, as governments began to recognise the importance of understanding changes in population.\(^{57}\) In 1836, British legislation created the General Register Office to collect and record details of births, marriages and deaths. The first census of the population was held in 1841. Death registration was compulsory, but registration of births remained optional until 1874 in deference to sensibilities about illegitimacy.\(^{58}\) Anyone could make a death registration. The situation was somewhat better in Queensland, where, among the most important functionaries of the new colony of Queensland was the Registrar-General of Births, Marriages and Deaths. A census was held in 1861 and thereafter at decennial intervals. Based on the census return, the returns of births and deaths and notifications of the numbers of migrants to and from Queensland, the Registrar-General was able to compute, in inter-census years, a total population enumeration by age, sex and race. He also published, annually, the vital statistics of the colony. From these he was able to calculate mortality rates for different populations and different diseases. Life expectancy at birth was not calculated until the twentieth century, but would have been low as a result of high infant mortality rates, and unreliable, as a result of the high rates of adult immigration. Between 1901 and 1910, the

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life expectancy at birth for all Australians was calculated at 55.2 years for males, and 58.8 years for females.\footnote{Australian Bureau of Statistics Cat. No. 3302.0 and 3105.0.65.001.}

In Queensland, notification of deaths was a responsibility of ‘duly qualified medical practitioners’, but in practice some parts of the colony did not have a readily available doctor. Colonial Secretary Robert R. Mackenzie attempted to introduce a health act in 1866, asserting that non-medical people notified about a third of deaths, a situation that would obviously lead to inaccuracies.\footnote{Debates of the Queensland Legislative Assembly, 23 May, 1866, pp 294-295. See also, Q.S.A. A/45174, in-letter 03819 to Commissioner of Police, 11 February, 1903, in which Constable Gillies examined the body of a 3 year old girl who had died without medical attendance, and finding no marks of violence or suspicion of foul play, asked the magistrate for a burial order, which was given.} As late as 1914, the police could give orders for burial without a death certificate, if the cause of death was clearly apparent and in the absence of suspicious circumstances, if death occurred some miles from the nearest doctor and if a certificate of burial was issued by the Registrar/Assistant Registrar for births and deaths.\footnote{See, for example, Q.S.A. A/45174, in-letter 07640 to Commissioner of Police, 20 March, 1914. As Assistant Registrars might well be members of the police, this no doubt expedited the situation.} As the numbers of practitioners increased, so did the numbers of deaths certified by them.

\section*{2.4 Health and disease}

British colonizers to Australia from 1788 onwards brought with them their own British cultural baggage and their own approach to health and disease. Southern Queensland was perceived to be a place with a healthy and salubrious climate, abounding in fresh air and...
pure waters. Meat was plentiful and the indigenous population appeared to be free of those endemic diseases, such as malaria, that caused such morbidity and mortality in many other colonies. Epidemic diseases appeared to be almost entirely absent, so governments could perhaps be forgiven for thinking minimal intervention in public health matters was needed. In his first Annual Report, the Registrar-General commented favourably on the low infant mortality rate in Brisbane compared to Sydney, and hoped this happy state of affairs would continue. It did not. By 1878, the Registrar-General could say it was an unmistakable fact that Queensland towns were most unhealthy, with a death rate higher than in some of the towns and cities of Great Britain. Yet governments dealt slowly and ineffectually with an impending public health problem. Only in 1872 was a part-time Central Board of Health, to advise on sanitary matters, established.

### 2.4.1 The medical profession

By 1846, four years after free settlement was allowed in the former penal colony, six doctors practised in Brisbane, and one on the Darling Downs. Despite claims that the climate was almost too healthy for doctors to make a living, they came to Queensland. By 1871, one hundred and five medical practitioners were registered in the colony. A

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63 Brisbane Courier, 6 November, 1863.

64 Q. V. & P., 18th Annual Report of the Registrar-General, 1878:1; 925-1006.


66 Q.P.G. 1871:8; 13-14. Not all registered doctors necessarily lived or worked in Queensland, however the great majority did.
medical board was established under New South Wales legislation in 1860. The following year Queensland introduced its own Medical Act. Registration was open to graduates of British schools, and some foreigners on production of the appropriate certificates from their country of origin. The board had no powers to strike registrants off. Once registered, a doctor was a ‘duly qualified medical practitioner’, with sole power to sign those medical certificates and documents required by acts of parliament. The majority of doctors qualified in Britain, generally with a licence from one of the Colleges of Surgeons, sometimes with additional qualifications, of which the most common was a license from the Society of Apothecaries. The first specialist (in the modern sense) was the appointment of Doctor Edward Owens to be honorary ophthalmic surgeon to the Brisbane Children’s Hospital in 1885. Doctors were esteemed because of the perception that they were educated people, and were important for administrations wishing to recreate the structure of British society, but without a landed gentry or aristocracy. Some medical men were elected to the Legislative Assembly, or appointed to the Legislative Council. Doctors in Queensland (and other settler colonies) had higher social status than in Britain, where ‘status anxiety’ dogged the profession.

67 London, Edinburgh, Glasgow or Ireland.
68 Anonymous. Australasian Medical Gazette, vol 5, 1885, p 82.
throughout much of the nineteenth century.\textsuperscript{72} Most doctors struggled with low incomes, so many had outside interests.\textsuperscript{73} In addition the doctors experienced significant competition from an army of unregistered, irregular practitioners, who provided services for lower fees than the doctors. The Medical Board did its best to control these irregulars, but lack of resources and lack of interest on the part of government meant that mostly it failed.\textsuperscript{74} Indeed, at least one ‘irregular’ was a member of the Legislative Assembly.\textsuperscript{75} Chemists and druggists also provided significant competition\textsuperscript{76} and abortionists operated illegally.\textsuperscript{77} Local newspapers carried many advertisements for patent medicines, including, as early as 1847, Holloway’s ointment and pills.\textsuperscript{78}

\textsuperscript{72} Douglas M. Haynes. Social Status and Imperial Service: Tropical Medicine and the British Medical Profession in the Nineteenth Century. In: Warm Climates and Western Medicine: the Emergence of Tropical Medicine, 1500-1900. Ed: David Arnold, Rodopi, Amsterdam, 1996.

\textsuperscript{73} Doctor William Hobbs grew cotton, while Charles Sharpe, on the Etheridge, had interests in the goldfield;\textsuperscript{73} Joseph Bancroft invented a process for drying and canning meat, and built a factory at Deception Bay for this. Robert McBurney of Mackay was also engaged in the sugar industry.

\textsuperscript{74} see Q.S.A. COL/A219, for a series of letters to and from the Medical Board complaining of irregular medical practitioners. Also Q.S.A. A/38201 for more of the same. And, as late as 1900, HOM/A30, in-letter 02190 to Home Secretary complaining of an unqualified practitioner in Beenleigh, 12 February, 1900.


\textsuperscript{76} See, for example, the inquest on a child who died of suspected ‘leucocythemia’ (leukaemia) and the dispute between doctor and chemist, at Q.S.A. JUS/N219/93/563.

\textsuperscript{77} See, for example, the minute book of the Medical Board for 3 March, 1887, at Q.S.A. A/38178.

\textsuperscript{78} Brisbane Courier, 11 December, 1847 (Holloway’s ointment, a mixture of lard, wax and turpentine). By 1891, tea tree oil, (‘Ti Ta’) was being recommended for a variety of diseases, including consumption, syphilis, scrofula, diphtheria and ‘diseases especially peculiar to women.’ The Queenslander, 10 October, 1891.
Doctors were employed as Lodge doctors. According to William Coote, an Oddfellows lodge was operating in Brisbane in 1847, though the system was not as popular in Queensland as in Victoria due to the large distances and small populations outside the few major towns. The doctors’ income could be swelled by appointment as Government Medical Officers. In this role they cared for the police and their families, for prisoners (including lunatics, whether in gaol or a Reception House), and for Aborigines and Pacific Islanders under government control. They generally performed police post-mortems and attended court to give evidence. They sometimes acted as public vaccinators. However, each town had only one such appointment. Salaries of the Government Medical Officers ranged from £25 per annum to £500 per annum. By 1865, seven towns had a Government Medical Officer, ten years later there were fifteen, plus four Health Officers for the ports of Brisbane, Maryborough, Townsville and Cooktown. The same individual could hold both the posts of government medical officer

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79 Coote. *A History of the Colony of Queensland from 1770 to the close of the Year 1881*. Brisbane: William Thorne, 1882 Volume1, P 91 The Brisbane Courier, 8 December, 1863 noted a meeting of Oddfellows to celebrate the first anniversary of the Rose of Queensland Lodge.

80 Blainey claims that lodges existed only in Queensland’s tropical north until 1889, when three lodges opened in Brisbane. Geoffrey Blainey. *Odd Fellows A History of IOOF in Australia* Allen & Unwin, Sydney, 1991, p 83 Lodges became unpopular when doctors were perceived to be ‘sweated’ by the system.

81 Though magistrates were often reminded not to order a post-mortem if the cause of death was clear or self-evident. See Q.S.A. A/73422, unnumbered circular from Justice Department 24 April, 1890, and again, 3 March, 1894.

82 Section 15 of the Medical Act of 1867 specified the fees to be paid for giving evidence and for performing a post-mortem examination; however, salaried government medical officers would receive no remuneration for performing a post-mortem in the case of death occurring in a public hospital, gaol or other public building they normally attended.

83 Q.S.A. A/44766, Duties of G.M.Os, 22 October, 1896.

84 Otto Sasche, Government Medical Officer for Townsville in 1869 received no remuneration. This was rare.
and port health officer. The port health officer controlled the medical aspects of quarantine. By 1885, forty towns had a government medical officer. Salaried government medical officers received no extra remuneration for carrying out their official functions.

Police and government medical officers did not always see eye to eye. Doctors commonly complained about pay, while the police complained that the doctors were not always available, private practice took precedence over police work, and the doctors were, sometimes, drunk. (A report on the state of the medical profession in Australasia of 1893 commented on the unenviable life of doctors in the bush, which induced many practitioners to indulge to excess in alcohol and narcotics. These in turn led to a death rate among medical men in the colonies double that of the general population.)

\[85\] William Hobbs was both GMO and Port Health Officer for Brisbane. Richard Frost was both G.M.O (with a salary of £50/annum) and Health Officer (also at £50/annum) for Townsville in 1874.

\[86\] See, for example, Q.S.A. COL/A290, in-letter 1456 to Colonial Secretary, 11 March, 1880, from Dr F. Margetts, Government Medical Officer at Warwick.

\[87\] See, for example, Q.S.A. COL/A316, in-letter 13/80, 29 June, 1880 from Sgt Michael Dillon to Sub-Inspector Tompson at Georgetown, ‘Prisoner P. E. arrived here at 6 pm ...in a very violent state, and as the Sergeant did not know of Dr Sharpe’s appointment as health officer for the district, there being no record in this office to that effect, and as Dr Sharpe has been in a cronic (sic) state of drunkenness for several weeks previously (see Watch house record for weekending 16th May last) the sergeant at once sent for Dr Piggott...’ Sharpe subsequently mended his ways, and was commended by Inspector Tompson ‘as temperate in his ways, and clever in his profession’, in-letter 2232, to Commissioner of Police, 26 May, 1881. Drunken doctors on land were acceptable apparently, though surgeon-superintendents of emigrant ships who drank were liable to be dismissed. See, for example, Brisbane Courier, 11 September, 1865 which reported that a Board of Enquiry recommended Dr E.R. Hodgkinson of the emigrant ship Royal Dane not have charge of emigrants, ‘the Board regarding intemperance of whatever degree as a serious disqualification in a medical man.’

\[88\] Ludwig Bruck. The Present State of the Medical Profession in Australia, Tasmania and New Zealand. Australian Medical Gazette, vol 12, 1893 pp 94-98. See also, the inquest reports at Q.S.A. JUS/N391/08/99, on Doctor D.A.McVean of Boulia hospital who died from heat, drink and cocaine: JUS/N367/07/02, Doctor W.G.Rainer died at Eidsvold by morphia poisoning while drunk, 16/12/06. Brisbane Courier, 8 October, 1886 reported the death of a Dr Macartney in Townsville, quoting, without comment, that ‘after seeing a large number of patients, and having had but little sleep during the previous night, he (as was sometimes customary with him...) took a dose of laudanum and chloral...’
testimony to the Report of the Police Inquiry Commission of 1899, Commissioner of Police W.E. Parry Okeden noted that ‘in cases of notoriously drunken and incapable medical officers’, the constable could go elsewhere, but would have to apply to the Commissioner, who would put the matter before the Minister, which would probably result in the medical officer being struck off the list.89 Lori Harloe has also commented on the frequency with which doctors in north Queensland developed a reputation for drinking, while at the same time, selection committees for hospital appointments appeared more concerned about sobriety than about professional qualifications.90 If there was no Government Medical Officer in a place where police work was to be done, a fee was paid, though often the doctors complained about this. Dr Thomas of Irvinebank—a mining town in North Queensland—was asked by the police to travel some twenty miles to examine the body of a murdered man. He refused to go unless paid £20 for his efforts. The police brought the body to Irvinebank, where Thomas performed a post-mortem examination, as a result of which he was subsequently issued with a subpoena to attend court as an expert witness. He was offered 2 guineas for the post-mortem, one guinea for his appearance in court, and £2-10-0 for travel allowance, but refused to accept this, saying it was inadequate, and again asking for £20. Lawyers, the Justice Department and the Commissioner of Police all got involved in the dispute, which generated a

only 28 years of age was admitted to the Brisbane Asylum in 1887 suffering from mania due to alcohol and drugs.(Q.S.A. A/64789, entry for 17 February, 1887). See also Q.S.A. JUS/N224/94/245, JUS/N401/08329, JUS/N416/09/138, JUS/N179/90/379 etc.


considerable correspondence. Thomas was eventually offered, and accepted, a further £5.\textsuperscript{91}

After the passage of the 1884 Health Act, towns and divisions were authorised to appoint salaried health officers to advise the local councils on sanitary matters. With small but regular incomes from private practice, with supplementary salaries from colonial or local government, and with outside interests, some doctors, especially those in the larger urban centers, acquired considerable social and financial status. Doctors, especially in Brisbane, formed an important component of the membership of the Queensland Philosophical Society (1859) and the Queensland Acclimatisation Society (1862) and made significant scientific contributions.\textsuperscript{92} As in Britain, the profession tried to draw together with the formation of medical societies, the first of which, the Queensland Medical Society, was formed in 1871. Despite its name, membership was heavily slanted in favour of Brisbane. This society was short lived. In 1882, the Medical Society of Queensland was formed, but was also short lived. In 1886, the Queensland Medical Society was resurrected, with Joseph Bancroft as its first president. After disputes among members of the visiting staff of the Brisbane Hospital, an alternative Queensland Medical Association, a branch of the British Medical Association was formed in 1894. The two societies joined forces in 1900,\textsuperscript{93} forming the first truly ecumenical group in the State.

\textsuperscript{91} Q.S.A. A/45174, in-letter 001481 to Commissioner of Police, 18 January, 1907.


Medical practice was to be driven by science, a point made by the eminent Brisbane ophthalmologist John Lockhart-Gibson in 1887:

'A medical training, such as that obtained in the Universities, is only complete when it has embraced—in addition to human physiology—the study of those sciences which give us an insight into animal and vegetable life.'

The majority of white patients received treatment in their own homes. Hospitals, financed by subscription, by voluntary donations and by funds from government, were established to look after the sick indigent and for those who could afford to pay who required greater care than could be arranged at home. Hospitals established strict rules. An annual subscription of £1 allowed the subscriber to admit one free, and two paying patients, and two for outdoor relief. A donor of £10 was considered a life member and was entitled, for life, to the annual privileges of a £1 donor. However, the house committee had to approve all admissions. Larger hospitals employed a permanent medical superintendent or house surgeon while smaller ones used the services only of visiting surgeons. Hospitals refused entry to certain classes of patients, including pregnant women (unless suffering from disease), lunatics, epileptics, sometimes those with loathsome and infectious diseases, or incurably diseased. Patients guilty of

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94 The Boomerang, 3 December, 1887.
95 Q.S.A. COL/A265, Rules of the Stanthorpe Hospital.
96 Q.S.A. COL/A 717, in-letter 14459 to the Colonial Secretary, 7 December, 1892 from the Secretary of the Maryborough Hospital Committee asking that Mary Benham, ‘an unfortunate woman sent in by the police’ who was in a very bad way from the venereal, be transferred to the Lock Hospital.
97 Q.S.A. COL/A185, Rules of the Brisbane Hospital, 1871: JUS/AE8 Rules of the Walsh District Hospital.
misconduct, or disobedience of legitimate orders could be immediately discharged from the institution. Admitting Aborigines, Chinese, Japanese and Pacific Islanders could be difficult.\textsuperscript{98} Doctor D.W. Balfour Wilkie wrote to the Colonial Secretary in 1892 about an Aboriginal patient dying from an infected compound fracture of the thigh, to explain his reasons for refusing the man admission to the Gayndah hospital. ‘It would be certain death to admit him into a ward in charge of a white wardsman, depriving him of the company of his friends and other luxuries necessary to a blackfellow. He himself was very averse to the hospital.’\textsuperscript{99} These observations may have represented expediency on the part of the doctor, or were, perhaps, a culturally sensitive observation.

\subsection*{2.4.2 Disease}

Though the population of the colony showed an impressive increase throughout the nineteenth century, Queensland was not a healthy place, despite optimistic statements to the contrary made deliberately to attract British immigrants. By 1863, infant mortality rates in Brisbane equalled those of Sydney, and surpassed those of some of the worst cities of Britain, though rural areas experienced generally lower infant mortality rates.\textsuperscript{100} The principal causes of infant death included ill-defined conditions such as diarrhoea, ‘teething’, fits—presumably febrile convulsions—and specific diseases such as measles, 

\begin{flushleft}
\textsuperscript{98} In Mackay a special hospital for Islanders was established. See also Q.S.A. COL/A191 in-letter 68/1874, to Colonial Secretary, 10 January, 1874, referring to the rules of the Maryborough Hospital that Aborigines should not be admitted to the hospital as patients.

\textsuperscript{99} Q.S.A. COL/A700, in-letter 06980 to Colonial Secretary, 6 June, 1892.

\textsuperscript{100} Annual Report of the Registrar-General for the year 1863. Q.V. & P. 1864:887-912.
\end{flushleft}
scarlet fever, whooping cough and diphtheria. If children survived the first year of life, the next four years were also difficult, with deaths in children under the age of five representing almost fifty percent of all deaths. Again Brisbane fared more badly than other towns, which in turn fared less well than the rural areas. However, the situation did slowly improve in urban areas so by 1900 Brisbane and rural areas experienced similar childhood mortality rates. Children who survived the first five years of life would likely reach adulthood, but a second peak of mortality, between the ages of twenty and forty years awaited them.

The commonest causes of death in adults were consumption (or phthisis), ‘miasmatic’ diseases and violence of one sort or another. Though it is commonly assumed ‘consumption’ meant tuberculosis, other lung diseases associated with cough, fever and weight loss no doubt occurred. The Registrar-General in 1884 opined that the high rate of mortality from phthisis in Queensland was due to the influence of ‘Polynesians’, who seemed peculiarly susceptible to the disease, and the attraction for other colonists of a climate that seemed to be beneficial for consumptives. In 1881, the Registrar-General defined miasmatic disease as

‘a class of disease long called preventable, because they are the outcome, very generally, of impurity, and may be greatly lessened, if not entirely got rid of, by a rigid attention to cleanliness. They are prevalent in Australia chiefly in towns; and,

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102 Q.V.& P. Vital Statistics. 1884:2;154. For a brief review of ‘miasmatism’, see Appendix 1.
whenever there is an absence of proper drainage, good ventilation and pure water, such conditions are at once plainly marked by the presence of miasmatic disease'.

Of the miasmatic diseases, perhaps the most important was typhoid fever. The Registrar-General dealt only with death and its causes. Morbidity statistics could only be obtained by notification, and for many reasons, despite occasional recommendations by medical gentlemen, and sometimes others, for the introduction of notification for infectious diseases, this was not accepted. During times when certain diseases appeared more prevalent, the Central Board of Health might make such diseases notifiable, by the attending medical officer, or by the householder if no doctor saw the patient, but such notifications were bound to be inadequate. Diseases such as leprosy, diphtheria, plague, measles and scarlet fever might be notifiable at certain times and in certain places, but not universally until well into the twentieth century. In the absence of notification, an assessment of the prevalence of non-fatal disease can only come from hospital statistics. For many reasons, and especially in the absence of effective diagnostic criteria, such statistics were subject to serious bias. In the general topography of disease, typhoid fever was an urban disease, as was tuberculosis, while violence (murder and, especially, accidental death) was more of a rural problem. Suicide occurred at similar levels in both urban and rural areas.


In the years 1870 to 1871, the police received reports of 417 deaths resulting in an inquest.\textsuperscript{105} The inquests reveal the high toll of deaths from drowning (27.4\% of these deaths), from accidents of one sort or another, but commonly involving falls from horses, or involving horse and carts (20.9\%), while in the two years, twenty one suicides (5\%) were reported. Among the deaths from illness, or natural causes, alcohol was specifically mentioned as a contributory factor in twelve out of 154 (7.8\%), certainly a likely underestimate, but one highlighting the role of alcohol in the development of Australian culture, and of importance in the conceptualization of mental illness.\textsuperscript{106}

\textbf{2.5 Public health administration in Queensland}

Early legislators in colonial Queensland were either wary of, or indifferent to, the health needs of the colony. The New South Wales \textit{Towns Police Act} of 1838 gave the police powers to abate nuisances, but only in proclaimed towns. By 1859, only four towns in what became Queensland had been proclaimed under this act. Over the course of the next fifty years, the act would be applied to most significant towns.

Later, Queensland would follow the example set by Britain, where, after the great cholera epidemic of 1831-32 a board of health was established to advise on personal sanitary matters.\textsuperscript{107} This board expired as the epidemic waned, but Edwin Chadwick’s

\textsuperscript{105} Q.P.G. for the years 1870 and 1871.

\textsuperscript{106} See also John Weaver and Sean Gouglas. \textit{They brought their hazards with them}, 2002, who comment on the significant role of alcohol in accidental deaths, homicide, suicide and deaths from natural causes.

Report into the Conditions of the Labouring Population (1842) led belatedly to the British Public Health Act of 1848. The act conferred on local authorities powers to deal with sanitary matters in towns, including drainage and sewerage. The act was permissive, not obligatory, in character and this would prove to be its greatest fault. The act established a General Board of Health, initially for a period of five years, but did not require the establishment of local boards, unless the local populace wished for one.\textsuperscript{108}

Later legislation in the period dominated by sanitary theory of Public Health in Britain included the Local Government Board Act of 1871, which created a central department (the Local Government Board), the Public Health Act of 1872 which established a sanitary authority in every district of the country and required each authority to appoint a suitably qualified medical officer of health, and the Public Health Act of 1875 which consolidated sanitary legislation into a single statute. Notification of Diseases Acts of 1889 and 1899 made the notification of certain infectious diseases compulsory.

\subsection*{2.5.1 Sanitation and the Central Board of Health}

John Petrie, the first mayor of Brisbane, the largest city and the busiest port of the colony, asked the Colonial Secretary in 1859 for land for drainage purposes, as council was anxious to organize a thorough system of drainage throughout the municipality;\textsuperscript{109} but government was slow to respond, little money was forthcoming, and almost forty years

\begin{footnotes}

\footnote{109} Q.S.A. BRI/G1 out-letter 26 of 1859 to Colonial Secretary, 29 December, 1859.
\end{footnotes}
later, the *Brisbane Courier* could still complain about the poor state of drainage in the town\(^\text{110}\) (figure 2.2).

In April 1865 the Colonial Secretary established a Central Board of Health to make recommendations for the public health of the citizens. The board consisted of the Colonial Secretary, Robert. G. W. Herbert, as chairman, the Commissioner of Police, D. T. Seymour, the colonial architect, C. Tiffin, the engineer of harbours and rivers, J. Brady and the president of the medical board, Dr K. Cannan. William Hobbs, the Government Medical Officer was the Secretary. Two months later, it tabled its first and only report in the Queensland parliament, with sensible recommendations for the prevention of diseases of filth.\(^\text{111}\)

Later in the year, Herbert introduced a health bill, not entirely certain it was a perfect measure, but to draw the attention of members to the necessity for measures to protect the health of the population. It provided for the establishment of a Central Board of Health, and of local boards under the central board. The bill intended to invite the cooperation of the local authorities, though Herbert recognized most were hardly in a position to do all that was required. However, he categorically stated that the corporations were the proper entities to deal with nuisances and matters of this kind, and that what they needed was a bill to authorise their actions. At the same time, the bill was framed to involve no greater expenditure than would be absolutely necessary. It dealt

\(^{110}\) *Brisbane Courier*, 12 September, 1888.

\(^{111}\) Q. V. & P., Report of the Central Board of Health, 1865:2; 1313-1320.
with sewers, nuisances, unwholesome food, noxious trades, hospitals and cemeteries. Only James Taylor, the member for the Western Downs, proposed to vote against the second reading.

Figure 2.2 The Boomerang. February 4, 1882. The caption reads, “There’s Nothing Like Our Bungling Sanitary System to Give Death a Chance. And He Takes it too.’ (John Oxley Library)

of the bill, on the grounds that it was for the benefit of Brisbane and Rockhampton only. He did not believe other towns in the colony needed such a measure. If, however, other towns were brought under the act, he foresaw the possibility of numerous appointments being made, appointments that would have to be funded by the local ratepayers, already taxed at an exorbitant rate. Two months later, the Colonial Secretary withdrew the bill, stating it would form the subject of careful consideration at the next session.
The following year, R. R. Mackenzie, the Colonial Secretary in the first Macalister administration, reintroduced the bill, with slight modifications. Once again, a Central Board of Health, based in Brisbane, would be the main instrument for preserving health, while local boards, under the direction of the central board, dealt with problems in other parts of the colony. The appointment of health officers, and all other matters connected with the health of towns, such as drainage, would be under the supervision of the local board. Mackenzie included two new clauses in this bill. The first, brought about by the fact that some thirty percent of deaths were not certified by legally qualified medical practitioners, sought to remedy this matter by requiring officers of health to inquire into causes of deaths of persons whose deaths were registered without a proper medical certificate. If the deceased had been attended by or prescribed for by an unqualified person, that person would be deemed to have committed an offence, and the officer of health should prosecute. The second new clause required local boards, in the face of excessive mortality, to establish dispensaries for administering out-door medical relief to the sick poor. Objectors to the bill focused on the first of the new clauses, which some felt had been ‘smuggled’ in under pressure. There was much support for ‘unregistered’ practitioners, who sometimes provided the only medical care in rural areas, and who could now, if the patient died, be prosecuted. Due to delays in bringing the bill into committee, in June 1866 Mackenzie introduced another bill, the Sewerage Commissioners Bill, as a rider to the health bill. He proposed a commission, appointed by government, half to be members of the local authority, half appointed by the executive. Mackenzie suggested the colonial government would be prepared to pay up

112 Legally qualified Medical Officer was the term used to describe a doctor registered under the Medical Act of 1861. Queensland Parliamentary Debates, 23 May, 1866, p 294 passim.
to half the costs of essential sewerage works in view of the alarming and dangerous conditions of the towns and the amount of disease and death resulting from these.\footnote{Debates of the Queensland Legislative Assembly, 1866, p 463.} The financial panic of May 1866 led to the resignation of the government and the two important health bills failed. Dr K. I. O’Doherty made an attempt to introduce a Health Bill into the Assembly in 1871, but this was a poorly crafted bill that only received its first reading before being forgotten.

The following year, smallpox threatened the colony. O’Doherty, introducing a new health bill into the Legislative Assembly in July 1872, said it was to protect the colony against smallpox.\footnote{Queensland Parliamentary Debates,(Q.P.D.) 11 July,1872, pp 595-598.} What was required, he said, was a general Board of Health, whose duty it would be, in the event of a violent outbreak of any epidemic disease, to take the necessary steps to prevent the spread of the disease and then to stamp it out. Power would be invested in government to proclaim any district attacked by disease for a period of six months as being under the operation of the act. The main feature of the bill was the appointment of a sanitary board, which would act as sanitary advisers to the government, and be a Central Board of Health; the Board would be an honorary one, acting in perfect harmony with the Colonial Secretary, who would be its chairman. The act would also sanction the appointment of local boards of health, albeit for periods of six months only, to act under the supervision of the Central Board.\footnote{Q.P.D., 11 July, 1872, p 595.} Despite the threat of smallpox, there...
was no mention of public vaccination campaigns, even though vaccines were available and vaccinators had already been appointed in some ports. Introducing the bill into the

**Fig. 2.3 Dr K.I. O’Doherty** (John Oxley Library)

Legislative Council, Dr W. Hobbs, the Government Medical Officer for Brisbane, opined that the ‘Council of Health’ should be full time, but accepted this was unlikely at the time. On-going complaints from the Registrar-General about the dangers of miasmatic diseases, the publication of a new Public Health Act in England in February 1872, and

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the threat of smallpox all ensured the bill was passed with little discussion, and was
assented to on 12 August, 1872. The Central Board was to consist of eight members, of
whom at least two (later increased to three) would be medical practitioners, the
Colonial Secretary the Chairman and the remaining members prominent local citizens.
The Commissioner of Police was no longer a member. The functions of the board were to
supervise the working of local boards of health set up in proclaimed towns and to issue
sanitary regulations. It was not responsible for quarantine.

Twenty years later, W. F. Taylor, a member of the Legislative Council, the Central
Board, and a well known surgeon, said of the board that its functions were limited to
meeting when permitted by the Colonial Secretary, and dealing only with matters brought
forward at the meetings. Another critic compared the Queensland board to that of New
South Wales, which received an annual grant of £20,000, compared to the former’s £350.
In his opinion, the health of the human portion of Queensland received less consideration
from government than flocks and herds.

Section 10 of the *Health Act* gave powers to members of local boards of health (‘health
officers’) to enter and inspect dwellings and premises. If the owner objected, the health

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117 The first Board consisted of four medical men, Drs. William Hobbs, Kevin O’Doherty, Kearsey Cannan
and Hugh Bell.

118 William F. Taylor. Inaugural Address to the Queensland Medical Association, *Australian Medical
Gazette*, vol 12, 1893, pp 120-123.

*Australian Medical Gazette*, vol 18, 1899, pp 48-50.
officers could call in the constables to enforce the regulation. The health officer might, or might not be, a medically qualified person.

In 1874, the Central Board of Health tried to amend the Health Act, framing a bill to provide for efficient vaccination, for the regulation of boarding houses and for preventing the sale of adulterated food, but many politicians objected and the bill lapsed.\textsuperscript{120}

The act was repealed by the \textit{Health Act} of 1884, which abolished local boards of health and restored powers for dealing with sanitary matters, sewerage, closets and privies, cleansing of streets, control of lodging houses and other nuisances to the municipal and divisional councils. The conservative leader, Sir Thomas McIlwraith strongly endorsed the idea that the workings of the public health should be left entirely to local bodies elected by ratepayers.\textsuperscript{121} Most of these functions are still controlled by local authorities to this day.\textsuperscript{122} Under section 84, any person could make a complaint to the justices of the existence of a nuisance, who could then authorize any officer of police to do all that was necessary to execute any orders made under the section. The \textit{Health Act} of 1900 replaced the Colonial Secretary as chair of the board with the new full-time post of Director of Public Health, a man who had to be an expert in sanitary science.

\begin{footnotes}
\item[120] Enid J. Barclay. \textit{Fevers and Stinks}. \textit{Queensland Heritage}, 1971:2(4); 3-12.
\item[121] Q.S.A. COL/G20, out letter 83/750 from Premier, 28 April, 1883.
\item[122] Local authorities remain responsible for sewerage, cleansing, inoculations against childhood diseases etc.
\end{footnotes}
Local boards were proclaimed for periods of six months only, after which the proclamation either lapsed, or had to be renewed. This necessarily led to inadequacies, boards fearing they might be disbanded before their work was completed.

In the course of almost thirty years, the Central Board of Health issued regulations to deal with sanitary matters (1873) and earth closets (1875), to deal with the threat of cholera (1885), with scarlet fever (1890), with leprosy (1891), with smallpox (1892), with measles (1893), and with plague (1900). In 1887 the Board attempted to frame regulations for the management of diphtheria, but the Chief Secretary, Sir Samuel Griffith, thought that the proposal ‘to place all patients suffering from it in quarantine was attended by so many obnoxious objections that nothing but the clearest necessity would justify action which would cause much distress and would in many cases be absolutely cruel.’

Smallpox was a matter for the quarantine authorities, though as the disease threatened in late 1876, the board held a meeting in January 1877, making a number of recommendations, none of which were implemented. The board otherwise ignored the disease, which, fortunately, never seriously affected the colony.

In addition, the board issued a small number of reports (especially into typhoid fever in Toowoomba in 1878 and Brisbane in 1884). In occasional annual reports it was self-congratulatory and never self-critical. The board never directly involved the police in its work, though it seems likely the use of the phrase ‘with such force as may be necessary’

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123 *Brisbane Courier*, 19 November, 1887.

in a regulation of the board was a signal for police involvement. The sanitary regulations of 1873 make no reference to the use of force or the constabulary, and nor do the scarlet fever regulations, and the police showed no interest. The leprosy and plague regulations do refer to the police or the use of force, and the police acted accordingly.

During the period of the supremacy of the Central Board, from 1872 to 1900, the largest single cause of death in Queensland was tuberculosis. The board made no attempt to deal with this scourge, which was perceived to be a disease of civilization, and would therefore be defeated by increasing levels of civilization. The situation was made worse by the promotion of Queensland’s climate as beneficial for the consumptive. The board failed to undertake any proactive investigations of the social causes of disease as had been done, for example, in Sydney.125 In the absence of notification of disease, they could not make any statistical inferences about death or survival from specific diseases. Apart from the boards, no other bureaucracy was developed to oversee the public health until the early days of the twentieth century.

Some of the failures of the Board may be attributed to its lack of expertise in ‘sanitary science’, the uncertainties the Board had about the causes of disease (miasma theory was a prominent belief of some members of the Board as late as 1884), the lack of financial resources the Board possessed, its inability to force local boards of health to do its bidding and disagreement among members of the medical profession about how to deal with a specific problem. The few Regulations the Central Board introduced for dealing

with specific diseases were sensible and appropriate, and had there been well staffed local authorities willing and able to undertake the recommendations, some morbidity and mortality could have been averted. The board, however, fatally focused on diseases requiring engineering expertise (drains and sewers) or on exotic diseases of limited importance (cholera, leprosy, plague etc.). Only late in the nineteenth century did it attempt to cope with diseases of children, especially diphtheria, measles and scarlet fever.

2.6 Government

On 6 June, 1859, Queen Victoria signed the papers creating the new colony of Queensland. The first Governor, Sir George Bowen was sworn in on 10 December, 1859. In 1867, the *Queensland Constitution Act* was passed by the parliament. Between 1860 and 1867, a Queensland parliament ruled by virtue of an Order-in-Council issued by Queen Victoria, empowering it to make laws and administer justice. Government consisted of a nominated upper house (the Legislative Council) and an elected Legislative Assembly. Responsible self-government was not independent government. There were significant constraints on the actions of government, while the colonial governor played an active role, not merely guiding the ministry, but serving British imperial interests at the same time. Responsible self-government was not democratic government either. The franchise extended only to (white) males over twenty-one years of age who had been in the colony for over a month, were holders of land or significant payers of rent. In 1872, the franchise was extended to all (white) adult males. In 1884, Aboriginal people were

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specifically excluded from the franchise by the Queensland Electoral Act of 1884, a situation not repealed until 1965. The Elections Amendment Act of 1905 gave white women the vote. Government exercised its administrative duties through an executive council, chaired by the Governor and consisting of three ministers: the Colonial Secretary, the Attorney-General and the Treasurer. The Attorney-General’s department dealt with superior courts, but the magistracy (and the police) was the responsibility of the Colonial Secretary’s office. The Treasurer was responsible for institutions that generated money—customs, harbours, lands and the post office (until the post office became in 1866 a separate organization under the Postmaster-General127). The Colonial Secretary—who was generally also the premier—headed a very large department, whose functions included the office of the Registrar-General, the police and magistracy, health (including the care of lunatics), gaols, immigration, scab inspectors, the Volunteer Defence Force and other functions. The title of Colonial Secretary was changed in 1896 to Home Secretary, while the new post of Chief Secretary (or Premier) was created at the same time. The Chief Secretary assumed responsibility for the government’s legislative program, for external relations, and for defence.

From its earliest days, Queensland had a significant bureaucracy in Brisbane, though outlying areas were less well served. Police Magistrates128 and the police themselves, both appointed by Government were, outside Brisbane, the most widespread ‘civil servants’. As the Government, for the exercise of its power, sought more and more

127 The Postmaster-General was, by convention, also the leader of the government in the Legislative Council.

128 See chapter 2 for the definition and development of “police magistrates”.
information and exercised more and more control over the daily activities of life, rather than appointing specialised civil servants, which would have cost money, it increasingly came to rely on the police (the only officials to travel widely through the country), to undertake much of this work.

### 2.7 Conclusions

The colonization of Queensland led to the greatest public health crisis of the nineteenth century, the disastrous decline in Aboriginal populations as a result of imported disease, loss of traditional feeding grounds, the impact of the Native Police (and others), and the baleful effects of alcohol and opium, a crisis that received no medical response or attention. Meanwhile the European population increased at a great rate, largely due to immigration and a significant birth-rate, and despite appalling childhood mortality rates. Gold and the sugar industry stimulated the influx of large numbers of Chinese and Pacific Islanders, who were blamed for the introduction of exotic diseases, especially leprosy.

The medical profession became well-established, but showed little concern for issues of public health. Much reliance was placed on quarantine as a means of preventing the importation of diseases such as cholera that had caused so much concern in Britain. A Central Board of Health, established to advise on sanitary matters, proved to have little power. Throughout most of the nineteenth century, public health stagnated, while governments spent money on what were perceived to be more important infrastructure projects.
3.0 Policing lunatics

3.1 Introduction

Doctor Jonathan Labatt MD was a respected medical practitioner in Warwick. In December 1861, Labatt consulted a lawyer about a ‘disturbance in his domestic relations.’ The conversation became heated, and Labatt, in a rage, broke some windows in the lawyer’s house. The police subsequently arrested Labatt, and kept him in the watch-house. An application for bail was refused. Labatt was charged with being a dangerous lunatic. With the testimony of two medical witnesses to support the case, one of whom had reasons for disliking him, Labatt was sentenced as a dangerous lunatic. The police took him to the Brisbane gaol, where he was incarcerated for a month. An order from the Chief Justice eventually secured his release. That Labatt had committed criminal damage was not denied, the problem for the police was trying to determine why he did what he did, since, in most liberal jurisdictions, a plea of insanity can be a defence against a criminal charge. The police therefore have specific interests in the problems of the insane.

3.2 Lunacy legislation in Britain

Among the concerns of the evangelists and dissenters of the moral revolution that started in late eighteenth century Britain was lunacy, inspired in part by the illness of George

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1 Brisbane Courier, 28 September, 1864.

2 For the record, Labatt was appointed to be the medical superintendent of benevolent patients in 1865.
III\(^3\), which became public knowledge in 1788. During this period an increasing number of private and charitable institutions, managed by individuals—some of whom were doctors, some not—to deal with the insane came into being as Bethlem Hospital\(^4\) fell into an increasingly derelict state. The proliferation of institutions was also accompanied by increasing criticisms of the asylums, chief among which was that insane patients were being kept against their will, or the will of their families, for pecuniary gain.\(^5\) Accusations of wrongful confinement and abuse led to parliamentary investigations, which, in turn, led, indirectly, to the development of the specialisation of psychiatry. While it required no particular skill to diagnose the furiously manic, the deeply suicidal melancholic or the totally confused person with dementia (the three main diagnostic classifications of pre-nineteenth century insanity), it became increasingly difficult to diagnose either the very early stages of these conditions, or, more importantly, their disappearance. Mad-doctors increasingly set themselves up as experts. The case of James Tilly Matthews, who was incarcerated in Bethlem in 1796, is instructive. In 1809, Matthews’ friends and relatives attempted to obtain his release, saying he was now sane, which John Haslam, the apothecary at Bethlem, disputed. Outside doctors called in to examine him reported him sane apart from a few minor delusions. Haslam was outraged.

\(^3\) It is now thought that George III’s illness was due to intermittent acute porphyria. See Ida Macalpine & Richard Hunter. *George III and the Mad Business*. Pantheon Books, New York, 1969, though not all accept this diagnosis, or a later one of variegated porphyria. See T. J. Peters and A. Beveridge. The blindness, deafness and madness of King George III: psychiatric interactions. *Journal of the Royal College of Physicians of Edinburgh*, 2010:40;81-85.

\(^4\) Bethlem, or Bedlam, was an ancient hospital, founded in 1247 as a priory for the brethren and sisters of the Order of the Star of Bethlehem. It became a hospital in the fourteenth century, and purely a mental hospital some two hundred years later, and was, until the nineteenth century, the only state run institution for the insane in Britain.

‘Madness being the opposite of reason and good sense’, he wrote, it seemed astonishing to him doctors could disagree so fundamentally. Experience and observation over long periods of time must be superior to a momentary examination, and others took up this opinion.

A select committee of the House of Commons to inquire into the state of criminal and pauper lunatics in 1807 led to the *County Asylum Act* of 1808, which made provision for the establishment of county asylums for the reception of pauper lunatics and the criminally insane. The act was, for many political reasons, discretionary, that is, it gave powers, but did not commit the counties to erecting asylums so that, in the twenty years after the passage of the act, only nine county asylums were established. Accusations of wrongful incarceration and abuse continued, leading in 1815 to a further parliamentary enquiry, which exposed Haslam’s lack of care and concern for his patients. He was eventually dismissed from the Bethlem Hospital. The reports of the select committees showed that comprehensive lunacy laws, governing all types of institutions, were necessary, but the time was not yet ripe. Another select committee in 1827 led to two bills in the following year. A new *County Asylums Act* placed a responsibility on visiting justices to send annual returns to the Home Secretary of the numbers of admissions, discharges and deaths in the county asylums. The *Madhouses Act* appointed fifteen Commissioners in Lunacy with wide powers to inspect lunatic asylums and grant, or

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revoke or refuse, licences to those wishing to run private institutions. Despite these important legislative changes, continuing anomalies led eventually to the Lunacy Act of 1845. The Lunacy Act of 1845, passed in tandem with the County Asylums Act, was the culmination of this concern, becoming the basis of English mental health law until 1890.

The Lunacy Act established Commissioners in Lunacy, initially under the chairmanship of the philanthropist Lord Shaftesbury, to inspect plans for asylums, and to be responsible for the inspection of all public institutions dealing with the insane. Asylums, other than the state asylum of the hospital of St. Mary of Bethlehem (Bethlem), were to be registered with the Commission, were to have written regulations and a resident doctor. 

The Commission was to be made up of five lay, three medical, and three legal members. 

The act also provided for certification by two duly qualified and registered medical practitioners that a person was insane. On presentation of a certificate, an order for committal would be issued either by a magistrate, or by an officiating clergyman together with a Relieving Officer of the Poor Law for the Union in which the lunatic lived.

Lastly the act gave powers to the Commissioners to inspect private houses and licensed institutions. At the same time the County Asylums Act, which was passed simultaneously with the Lunacy Act, required every county and borough authority to

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10 After 1853, the majority of insane committals were outside the judicial system, part of the Poor Law Administration. Finnane. Insanity and the Insane in Post-Famine Ireland. Croom Helm London, 1981, p 87.

provide asylums for the reception of the pauper insane, to be governed by a Board of Visitors composed of local magistrates.

Prior to the act, the insane were managed in one of six ways: firstly, under the Poor Laws, pauper lunatics came under the control of the parish overseer and were housed in a workhouse, for which funding came from parish rates. Secondly they might be confined under the criminal law. Third, they could be confined under the Vagrancy Laws, generally in a local gaol. Fourthly, they could be confined in a private mad-house, an option available to the wealthier sections of the population only. Fifthly, they might be confined in Bethlem. Lastly there were the ‘single lunatics’, the large group of people who lived at home, often in appalling and squalid conditions. The family right to demand the confinement of a madman was lost by the 1845 act, when the prerogative was increasingly handed to physicians. Conditions in the workhouses were stringent and unpleasant. Michel Foucault suggests this confinement constituted one answer to the problem of economic depression which started in the seventeenth century. However, it was not mere economics that determined the need for workhouses or houses of correction, but rather, the view that poverty, unemployment and insanity resulted from a relaxation of discipline and morals. Within the house of correction, labour would function as an exercise in moral reform. Critics of Foucault point out that, in England at any rate, the great increase in confinement occurred in the nineteenth century.


3.2.1 Moral management

Insanity was thought to be mainly due to defects of reason or intellect. Early in the nineteenth century, French psychiatrists described the clinical features of antisocial personalities, recognizing that madness need not signify a deficit in reasoning powers. They called this condition *manie sans delire*—mania without delirium. Later the English alienist, James Cowles Pritchard, broadened the scope of this syndrome calling it ‘moral insanity’, a class of disorders affecting emotional and volitional capacities. Moral insanity was the first psychiatric diagnosis implying a specific lesion of the mind, that is, a psychological aetiology, comparable to the class of disorders of the twentieth century called the psychopathies.

The history of institutionalised abuse carried out in Bethlem, under the supervision and authority of medical men led, in 1796, to the establishment of the Retreat in York by the Quakers William Tuke and his son Henry. There were to be no whips or chains and no unnecessary medication, purging, bleeding and vomiting characteristic of the treatment of patients at Bethlem. ‘Moral management’—kindness, mildness, reason and humanity within a family atmosphere—was to be the regime in this nonmedical alternative to Bethlem. Tuke’s grandson Samuel described the philosophy behind the Retreat at York in his *A Description of the Retreat*, published in 1813, which not only put the institution...

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on the world psychiatric map, but also provided a stark contrast to the horrors of Bethlem exposed by the parliamentary enquiries of 1815 and 1816.\textsuperscript{17} Moral management has been described as a triumph of humanism and of therapy, a recognition that kindness, reason and tactful manipulation proved more effective than fear, coercion, restraint and the medical treatments then available.\textsuperscript{18}

Moral management gave way in Britain after the \textit{Lunacy Act} of 1845 to incarceration in the large county asylums for the insane, under the superintendence of medical men. There were many reasons for the paradigm shift—from moral management to medical management—including an increasing population, an inability of the moral managers to cope with the increasing numbers of people sentenced to incarceration, a shift in the intellectual theories of the causation of insanity, away from those of moral force, towards heredity, degenerations and defects of character and nonconformist behaviour,\textsuperscript{19} and an increasing awareness that the brain was the material substrate for mental activity. In the theory of Franz Joseph Gall (1758-1828), a German neuro-anatomist whose ideas would later form the basis of phrenology,\textsuperscript{20} the brain was the seat of some thirty ‘organs’ dealing with specific functions, each occupying specific cortical areas. His ideas were controversial since they endangered the religious conviction that the mind was part of the


\textsuperscript{20} Phrenology: Study of the external conformation of cranium as supposed index to development and position of organs belonging to the various mental faculties. The Concise Oxford Dictionary, 1975.
rational soul, and could therefore not have a material basis.\textsuperscript{21} By 1839, the American alienist\textsuperscript{22} Isaac Ray could write: ‘it is an undisputed truth, that the manifestations of the intellect, and those of the sentiments, propensities and passions... are connected with, and dependent on the brain.’\textsuperscript{23} Thomas Sutton gave the first description of \textit{delirium tremens} and related it to excessive alcohol—and especially spirituous liquors—intake in 1813,\textsuperscript{24} though it would be some years before it was realised that it was the sudden stoppage of excess alcohol that precipitated the attack.\textsuperscript{25} Since the beginning of the nineteenth century, cases had been described of brain ‘softening’, (a condition the French called ‘ramolissement’, a term used in the Woogaroo asylum in Queensland) associated with dementia.\textsuperscript{26} Finally, in 1875, the French venereologist J.-A. Fournier suggested that syphilis caused brain disease associated with insanity, though proof of this would have to wait further developments in microbiology and immunology. These developments reinforced the pathophysiological concept that lunacy was due to disease of the brain, and therefore would prove amenable to medical treatment. The ultimate result of these changes was that the state would take responsibility for the incarceration of the insane, while the medical profession tried to manage the diseased within the walls of the asylum.


\textsuperscript{22} Alienist: a person who studied and cared for the insane.


\textsuperscript{24} Thomas Sutton. \textit{Tracts on delirium tremens, on peritonitis, and on some internal inflammatory affections, and on the gout}. London, Underwood, 1813.


3.3 Lunacy legislation in Australia

Arthur Phillip, the first Governor of the colony of New South Wales, carried documents authorizing him to deal with the insane, whether convict or settler. He had authority to do this without further consultation, though subsequent governors usually passed on this authority to Justices of the Peace and magistrates. The first asylum for the mentally unsound was built at Castle Hill in 1811. Until 1843, lunatics were committed either to gaol or to the asylum. The involvement of the police led to conflicts with the doctors, who wanted control of these patients. In 1843, Captain C. Hyndman was incarcerated in Tarban Creek Asylum. He successfully sued the superintendent of the asylum for false imprisonment, a judgement that led directly to the Dangerous Lunatics Act\textsuperscript{27} of New South Wales, whose jurisdiction extended over the area which is now Queensland. The act made provision for the criminal, or dangerously insane to be confined to a gaol or public hospital and also for committal to be ordered for the non-dangerous by means of request from a relative with two independent medical certificates and agreement from a Supreme Court judge. The immediate priority was not treatment, but the preservation of the social order.\textsuperscript{28} The asylum was not a hospital. Section 4 of the act stated that a person acquitted of a crime on the grounds of insanity would be immediately held in detention at the Governor’s pleasure. The act also represented the first incursion of a set of medical priorities into the system of lunacy incarceration in Australia, which consequently


\textsuperscript{28} Stephen Garton. Policing the Dangerous Lunatic 1987, p 76.
presented the medical profession with some powers to determine who was insane. The act reflected the fear of ‘dangerousness’ and of lunacy in its language. It reflected the wording of the Irish \textit{Criminal Lunatics (Ireland) Act} of 1838, which provided that if a person were detained under circumstances suggesting their minds were deranged and had the intention of committing a crime, then two justices were empowered to call in a physician to examine the suspect. If the physician determined the person was a ‘dangerous lunatic’ he could be committed to gaol, until either discharged by order of the two justices, or removed to an asylum by order of the Lord Lieutenant.

\subsection{3.3.1 Queensland}

The police were generally the first to deal with an individual suspected to be of unsound mind, taking the individual in the watch-house, arranging for a medical visit and then taking the prisoner before the bench. Prior to Separation, those found to be of unsound mind were sent to the asylums at Sydney or Paramatta. After Separation, the situation became more complicated. Though doctors were called to deal with lunatics, hospitals generally refused to take such patients into their wards. In 1860, the Brisbane bench committed a ‘dangerous lunatic’ who had been brought before them by the police to the Brisbane Hospital, but admission was refused, on the grounds of the security of the prisoner and the safety of the other patients and staff. Colonial Secretary Robert

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\textsuperscript{29}Garton. \textit{Policing the Dangerous Lunatic} 1987, p 76.
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\textsuperscript{31} \textit{Moreton Bay Courier}, 7 July, 1860.
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Herbert pointed out that the hospital staff, by refusing a lawful warrant, placed themselves at risk of legal penalties, and ordered the admission of the patient.32 More usually, patients found to be of unsound mind were sent to the Brisbane gaol.33 In January 1860 the Sheriff of Queensland, W. A. Brown, who was responsible for prison administration, noted the need for a proper establishment for the confinement and treatment of lunatics. The Executive Council, to whom Brown’s letter was forwarded, wondered whether it would be ‘more advantageous to establish such an institution here or to forward...the patients to Sydney or Parramatta,’ but recognised that, though the need at the time was small, if the numbers of lunatics reached about fifty, then Queensland would have to build its own asylum. Governor Bowen unsuccessfully approached the Sydney authorities on behalf of the Council.34 Also in 1860, a new gaol was built on Petrie Terrace, with an asylum built within the precincts. The first principal warder of the asylum was William Harris, a police sergeant from Ipswich,35 though ultimate control of the establishment rested with Brown. Later in the year, Brown again asked the Colonial Secretary that a sum of money ‘not exceeding three thousand pounds’ be placed on the estimates for 1861 to establish an institute for the insane,36 a request to which the

32 Q.S.A. COL/A6, in-letter 60/1418 to Colonial Secretary, 10 July, 1860.
33 Q.S.A. COL/A7, in-letter 60/1570 to the Colonial Secretary, 7 September, 1860, from the Maryborough Bench describes the case of John Wilcox, who was ‘remanded from time to time for medical treatment to the Maryborough lockup’, but was finally committed to the Brisbane gaol for further medical treatment.
34 Q.S.A. EXE/E1, out-letter 60/4, 17 January, 1860.
35 Q.S.A. EXE/E2, Executive Council meeting 60/50, 30 October, 1860.
36 Q.S.A. COL/A6, in-letter 60/96 from Sheriff to Colonial Secretary, 10 August, 1860.
government later agreed. The first ‘proper’ asylum was completed late in 1864. On 11 January, 1865, the Sheriff informed the Colonial Secretary ‘the whole of the lunatics under confinement in Her Majesty’s Gaol at Brisbane, consisting of fifty-seven males and twelve females’ were conveyed to the Lunatic Asylum at Woogaroo.

There were no private institutions for the care of lunatic Queenslanders until the twentieth century (in contrast to Melbourne and Sydney, where a number of private institutions were founded in the 1860s and after) and their numbers were always small. A building was established at Woogaroo in 1866 for paying patients, ‘whose friends are desirous should not be confined indiscriminately with those of a lower grade of society.’ In January 1867, Thomas Frith was appointed the first male warder of the private wing.

Despite the opening of Woogaroo, persons under suspicion of being of unsound mind continued to be incarcerated in watch-houses until a decision about their disposal was made. The police magistrate at Maryborough, A. C. Kemball, described in 1869 the conditions under which lunatics might be held:

37 The asylum was, for many years, the largest health expense for the colonial government. It was entirely a government institution, though under the direct administrative control of a medical superintendent, in line with British practice of the time.

38 Q.S.A. COL/A63, from Sheriff to Colonial Secretary, in-letter 65/79, 11 January, 1865.


40 Brisbane Courier, 20 March, 1867.

41 Q.S.A. COL/E1, bundle 67/22, 16 January, 1867.
'Lunatics are kept in the lock-up and find this very objectionable. An insane man is sent to the lock-up and he has no mattress, no pillow and no blankets...I do not think a police cell is a proper place to put a person who is charged with lunacy.'

Inspector S. J. Lloyd, of the Gympie police, at the same commission of enquiry, commented negatively on the holding of lunatics in the lock-up, and added that constables would often help such ‘poor creatures’ who rarely improved in the lock-up.

The first Queensland legislation to touch on lunacy was contained in the Supreme Court Act of 1867, which gave the Supreme Court of Queensland jurisdiction which would be co-extensive with that formerly exercised by the Lord Chancellor of England with respect to ‘natural born fools lunatics and persons deprived of understanding and reason by an act of God and unable to govern themselves or their estates.’ The first Queensland legislation dealing specifically with mental disorder was the Lunacy Act of 1869, the main provision of which—in contrast to the New South Wales Dangerous Lunatics Act of 1843, which was the main legislation used in Queensland until the act of 1869—dealt with the setting up and supervision of reception houses. Reception houses were an alternative to gaol or hospital, places where a lunatic could be observed for up to a month. If at the termination of the period of observation, the sick person was unfit to be at liberty, the justices would send him (or her) to the Asylum at Woogaroo. (This hospital, situated between Ipswich and Brisbane, would undergo a number of name changes throughout its life. In 1885, it


became the Goodna Asylum for the Insane, in 1898 the Goodna Hospital for the Insane, and in 1940 the Brisbane Mental Hospital. These changes ‘reflected both changing fashions in psychiatric care, and a desire to escape the stigma associated with an institution for the insane.’\textsuperscript{44} The act says nothing about the police and there is no mention of the act in the Police Gazette. By an amendment act of 1871, the period of detention in the reception house could be extended for another period of one month ‘if the medical officer attending such house testify on oath that further detention was necessary for the health of the patient or would tend to his recovery; if the medical officer at the end of that period testifies accordingly, for another period of 1 month’. The reception house was to be a temporary place of incarceration, a stepping-stone between the justices of the peace and the asylum, which would in all probability be for the permanent holding of lunatics. Medical men had no power to order the arrest and transmission of a lunatic to a reception house: only the bench could do this (though apparently many police believed doctors could send a person to the Reception house without a warrant\textsuperscript{45}). However, to meet exceptional circumstances, superintendents of reception houses had the power to receive without a warrant persons brought to them by the police as insane. The responsibility for this was entirely in the hands of the police, who could only exercise the power in urgent cases where there was no possibility of obtaining a warrant in the usual way.\textsuperscript{46} 


\textsuperscript{45} Q.S.A. POL1/11/A1, Circular Memorandum from Commissioner of Police, no 53, 8 February, 1882.

\textsuperscript{46} Q.S.A. POL 3/1/1, unnumbered circular memorandum, 26 June, 1882.
Following a number of deaths at the Brisbane reception house under somewhat unusual circumstances in 1877, a Royal Commission was set up to look into the management of the asylums and reception houses in Queensland, as a result of which, new regulations were issued in 1880, and new legislation was introduced in 1884. The Insanity Act continued the existence of the reception houses and allowed the Governor to issue licences to any person for periods of up to 3 years for the reception and treatment of a certain number of patients. The act provided for the appointment of an inspector of the insane, who would inspect the asylums and reception houses and see all the patients once every six months. Section 23 allowed the justices to order a constable to apprehend a person suspected to be insane and without means of support, or wandering at large, or likely to commit an offence. A constable finding a person suspected to be insane without means of support, or wandering at large, or likely to commit an offence could apprehend him without an order and bring him before two justices. However, the police did not have the power to arrest mentally deranged persons in the control of friends or relatives. Section 41 of the act made it a misdemeanour to receive a person into an asylum or reception house without proper documentation (including medical certificates from two

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47 Brisbane Courier, 24 August, 1877. A patient died in the ‘heavy shower bath,’ another 20 minutes after the heavy shower, and a third after a large dose of the sedative chloral. The cold baths were given by untrained warders without any medical supervision.

48 Report of the Royal Commission on Woogaroo Lunatic Asylum and Lunatic Reception Houses of the Colony, Q.V. & P. 1877:1; 1095.

49 Q.G.G. 1880:26; 1030-1038. Rules and Regulations of the Asylum for the Insane, Woogaroo. These regulations were extremely detailed, and referred to every person who was employed at the asylum.

50 Statutes of Queensland. The Insanity Act, 1884, 48 Victoria, No.8.
legally qualified medical practitioners). However, if a person legally detained should escape, he could be retaken, by the superintendent or other officer, or by any constable or other person authorised by the superintendent.

### 3.4 The Queensland police and ‘persons of unsound mind’

The Queensland Police Manual of 1876 said police had a duty to apprehend and bring before a magistrate any person who was suspected to be insane found wandering about and not under proper control, ‘whether he be a pauper or not.’ However when a rural solicitor brought his twenty-year-old daughter to the police, asking that she be taken into custody as she was a nuisance, Sergeant Carmody correctly refused the request, as the girl had not been a public nuisance. The solicitor went to the local magistrates who ordered the police to arrest her. After a medical examination, the police arranged her transfer to the Reception House. One police sergeant described the case of a man who came to the lock up in December 1877:

‘He was barefoot. On talking to him, the Sergeant could not say whether he was drunk or insane, and told him to go home, but Ben would not, saying someone

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51 Despite this legal requirement, patients were sometimes admitted to a Reception House on the certificate of only one medical person, with the connivance of two Justices of the Peace. See, for example, the case of Joseph Liddell, Q.S.A. COL/A 700, in-letter 06552 to Colonial Secretary, 23 May, 1892.


53 Q.S.A. A/44741, in-letter 07037 to Commissioner of Police, 16 April, 1903.

54 Official reports from lower ranks were generally written in the third person.
was going to kill and robb (sic) him: I then took him into custody and confined him in the Lock up, where to all appearances he is insane, he is very violent.'\textsuperscript{55}

The man was subsequently remanded to Dalby for medical opinions. The police had some discretion in how they dealt with persons of unsound mind. In 1882, for example, a constable arrested a man in Morven on a charge of being of unsound mind and lodged him in the lock-up. Constable Walter King agreed that he was ‘perfectly insane’, despite which he asked the court to judge him as an idle and disorderly person under the \textit{Vagrancy Act}, for which he was sentenced to a month’s imprisonment.\textsuperscript{56} Doctor Vivian Voss, the Government Medical Officer at Rockhampton at the end of the nineteenth century, found a prisoner, sentenced to six months for an unspecified crime, to be insane and suggested ‘he appeared to have been imprisoned for the sole purpose of controlling him.’\textsuperscript{57}

The police took ‘lunatics’ to the reception houses, but also escorted patients from these to mental asylums, initially Woogaroo Asylum at Goodna, but later to Toowoomba and other asylums. The escort of patients often involved long journeys, from Normanton in the Gulf, for example, to Brisbane. The Commissioner of Police closely monitored the arrangements.\textsuperscript{58} Female lunatics being escorted to asylums had to be in the care, not only

\textsuperscript{55} Q.S.A. B/3489, Deposition Book for Taroom Police Magistrate, entry for 17 December, 1877.

\textsuperscript{56} Q.S.A. B/3248, Deposition Book, Morven, 27 January, 1882.

\textsuperscript{57} Q.S.A. A/19930, in-letter 03292 to Department of Prisons, 12 October, 1894.

\textsuperscript{58} Lunatics were also taken to Goodna from the Northern Territory and Papua New Guinea.
of a constable, but also of a female nurse, but not one who was a relative of members of the police force. If no nurse was available, the police were instructed to employ a female attendant, paying what was considered a reasonable wage plus a return train fare. Police acting as escorts were to be in plain clothes at all times. Even short journeys could have problems. The Colonial Secretary complained to Commissioner Seymour of the unpleasantness caused to passengers travelling by mail coach from Ipswich to Brisbane if accompanied by prisoners or lunatics, and asked that steamer rather than coach convey the patients under escort. The police sometimes gave the names of lunatics being transferred to the local newspapers, a practice which the Commissioner deplored in a note of 19 May, 1905. Dr Ernest Humphrey, a government medical officer in Townsville originally complained to the Police Inspector, asking that the number could be given, but the names suppressed when ‘giving information to the local rags: not that I care a jot, but I don’t like to think of the feelings of the relations,’ the doctor wrote, though Sergeant O’Sullivan thought publishing names might sometimes be a useful way for people to find ‘missing friends.’ It was essential, when transferring a patient to the asylums, for the paper work to be complete and accurate, otherwise the police escort would find itself with a mental patient on their hands and nowhere to go. In January 1902, the same Dr Humphrey certified a patient for admission to Goodna. When the

59 Q.S.A. A/44741, in-letter 08554 to Commissioner of Police, 5 June, 1901. The Commissioner admitted that there did not appear to be any ‘orders’ on the subject, but thought that the practice was correct and should be continued.

60 Generally five or ten shillings per day.

61 Q.S.A. A/44742, in-letter 24341, 25 October, 1911. Though there was no traceable instruction for this custom, it was apparently hallowed by long usage, and allowed to continue.

62 Q.S.A. COL/ Q5, out letter, 24 January 1893 from Colonial Secretary to Commissioner of Police.

63 Q.S.A. A/44741, in-letter 06828 from Humphrey to Inspector of Police, Townsville, 20 March, 1905.
patient, under police escort, arrived at the asylum, the Superintendent of the asylum, Dr Hogg, refused to take him in since Humphrey’s certificate merely said the patient was of unsound mind, but did not specify the symptoms observed by Humphrey himself. Humphrey’s explanation was simple and not unkind. He considered the patient was not fit to be at large. He was a chronic epileptic, had threatened suicide, and had neither money nor friends. Humphrey did not know what else to do with him. This particular patient was then returned by the police to the Brisbane Reception House and after a few days there was sent to the Dunwich Benevolent Asylum. Another patient was refused admission to Goodna since the doctor who signed the certificate was not properly registered with the Medical Board. Patients from north Queensland were either shipped to Brisbane, or shipped to Gladstone, finishing their journey by train. Lunatic patients occasionally threw themselves overboard, and this always generated a great deal of police questioning and correspondence (see section 3.4.3 for more details of these). Relations with Station Masters were not always easy. In 1887, a special police van was commissioned from the Railways Department, which was ready for use in July of the following year. This van would be regularly used to transport prisoners, lunatics, and later, leprosy patients. Inspector Meldrum of the Rockhampton Police reported in March 1899 that a request had been made several days previously for the prison van to be sent to Gladstone to convey five lunatics to Brisbane. The escort arrived at Gladstone, with six, not five, lunatics, to find the van was not there, and instead a carriage had been

64 Q.S.A. A44764, in-letter 10270 to Commissioner of Police, 20 May, 1907.

65 Q.S.A. A/44741, in-letter 05009 of 11 July, 1888 from Railways Traffic Manager to Commissioner of Police

66 Q.S.A. A/44741, in-letter 04184 from Inspector Meldrum to Commissioner of Police dated 10 March, 1899.
reserved, which the constable in charge thought was far too small for two constables, a nurse, five male lunatics and one female lunatic. There was also no lavatory in the carriage, something much needed. The station master was unhelpful, but the situation was resolved peacefully after other passengers agreed to change carriages.\textsuperscript{67} Station masters acted sometimes in a high-handed manner, ignoring the needs of the lunatics and the police who tried to control them, while doing all they could to soothe the concerns of the travelling public. Station Master Murphy at Roma Street Station objected when Constable Dewhurst took a male lunatic who was being difficult into the ladies’ toilet, the only place that could be locked. The dispute led to considerable correspondence.\textsuperscript{68} Sometimes, the travelling public was helpful to the escorts, sometimes not.

In December 1903, Sergeant Robert Bell of the Emerald police arrested a suspected ‘dangerous lunatic’, a railway worker armed with a butcher’s knife, six miles from Comet, in the Central Highlands of Queensland. Using his initiative, he gave the railway gangers at the camp a written request to take him and his prisoner, who was unable to walk, to Comet. The gangers agreed, taking them by hand car, an exercise that irritated the Chief Engineer of Railways, who complained bitterly; but Commissioner Seymour rejected his complaints.\textsuperscript{69}

\textsuperscript{67} Q.S.A. A/44741, in-letter 04184 to Commissioner of Police, 4 March, 1899.

\textsuperscript{68} Q.S.A. A/44741, in-letter 09543 to Commissioner of Police, 17 September, 1892. In this file are other cases of conflict between railway authorities and the police, for example at Gympie, Charters Towers and Bundaberg.

\textsuperscript{69} Q.S.A. A/44741, in-letter 24351 to Commissioner of Police, 24 December, 1903.
The Commissioner of Police was determined that all activities relating to the *Insanity Act* of 1884 should be carried out according to the letter of the law. Constable Adams, escorting a patient from Warwick to the Willowburn Asylum in April 1908, arrived without the necessary papers with him, so admission to the asylum was refused. The unfortunate woman was returned to the Toowoomba watch-house. Acting Sergeant Leech admitted he forgot to give the necessary certificates to Adams. The extra cost devolving on the police department was 9/2½d which Sergeant Leech was ordered to refund.\(^{70}\) Patients were turned away if the certificate accompanying the request for admission to the asylum was more than fourteen days old, leading to a circular on the subject from the Commissioner.\(^{71}\) (In the first such case the patient, from Mount Morgan, was taken from the asylum to the Brisbane Reception House where Inspector White arranged for the Government Medical Officer to see her, re-certify her, and returned her to the asylum the same day.\(^{72}\))

The police attempted to show ‘community spirit’ by being helpful to citizens trying themselves to get their relatives to Goodna. A lady was released from Goodna on permit in early July 1905, but rapidly relapsed. Her husband asked the Gympie Police to provide an escort when he took her back to Goodna. Sergeant Bell wrote to his Inspector in Maryborough asking for instructions, as ‘during all his experience he had never known a similar case or application and was very doubtful whether he could be justified in

\(^{70}\) Q.S.A. A/44742, in-letter 05859 to Commissioner of Police, 7 April, 1908.

\(^{71}\) Q.S.A. A/44742, circular memorandum 447, 27 April, 1907.

\(^{72}\) Q.S.A. A/44742, in-letter to Commissioner of Police, 27 April, 1907.
sending a constable in charge of a female who was out on permit and in the custody of her husband and children.’ The Commissioner of Police had no doubts, and wired back ‘Comm (sic) instructs you to send a constable to accompany Mrs. M. to Goodna Asylum.’

Despite the presence of reception houses and the machinery to deal with persons of unsound mind, the management of the insane, especially in small towns, did not always follow the correct path. The returns of prisoners discharged from principal gaols in the colony, published in the Police Gazette throughout the second half of the nineteenth century, recorded numerous prisoners being discharged whose offence was ‘being of unsound mind.’ This situation continues to the present time, when it is reported that a significant proportion of prison inmates are people with mental health disorders, and, equally, a significant proportion of people with mental health problems are imprisoned.

However, alleged insanity can also be used to get out of prison. In 1923, the Comptroller of Prisons asked the police to return to the prison four men who had been sent to the Goodna Asylum on suspicion of insanity, but turned out, according to the hospital authorities, to be malingerers, and no doubt other similar cases occurred.

From the Annual Reports of the Commissioner of Police between 1877 and 1916, 9826 men and 1766 women were arrested by the police on suspicion of being of unsound mind.

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73 Q.S.A. A/44741, in-letter 12262 from Inspector Andrew Driscoll to Commissioner of Police, 29 August, 1905.


75 Q.S.A. A/19561, out-letter 3155 from Comptroller of Prisons, 24 October, 1923.
representing respectively 2.5% and 4.0% of all charges during this period. Men were significantly more likely to be discharged by the courts than women, perhaps a reflection of the effects of alcohol on men, and the hard and restricted lives that many women led.76

3.5 Police and doctors

Government Medical Officers who examined lunatics in police custody received no extra remuneration as this was part of their duties. The Insanity Acts however specified lunatics could only be sent away on the certificate of two medical officers. As towns only had the one G.M.O, the other doctor would have to be paid. General Order 674 of 1896 specified the fees to be paid to medical officers, including 10/6d for a visit between 8am and 8pm, and one guinea for an examination and evidence in lunacy. The police generally paid the doctors’ fees and then attempted to recover the costs from families or the Curator in Insanity. Again, the police had to trace, interview and persuade families to pay the doctors’ fees. There were difficulties about the fee itself. The doctor was sometimes paid £1-11-6d for seeing the patient and giving a certificate of lunacy. This was incorrect, the authorities said: one guinea covered both the examination and the certificate, in which case the police had this time to persuade the doctor to refund the 10/6d. A hospital surgeon signed a certificate for an in-patient of the hospital, then asked the local police to pay him his guinea. The police forwarded the request to the Commissioner, who stated that only if the patient was in the hands of the police would

76 46.6% of men, but only 27.6% of women brought before the courts on suspicion of being of unsound mind were discharged by the courts, a statistically highly significant difference.
the fee be paid.77 These investigations generally took considerable time since not infrequently relatives lived in other colonies or states, and police in these then became involved. One case involved a patient who was discharged from the Toowoomba Hospital (Willowburn) in October 1913. In February 1914, he went to Western Australia. The man owed the police £1-16-0d for medical examination and cost of conveyance to Willowburn. His sister told the police, when interviewed, that he had inherited £700 from the sale of his share in his father’s estate, and she therefore refused to pay the debt. Requested by Commissioner Parry-Okeden to find him and collect the money, the West Australian police in due course informed their Queensland colleagues that he had left the state, and was thought to be in South Australia. The Commissioner then wrote to his counterpart in Adelaide, asking him to locate the man. Constable Hicks of the South Australia police informed his commissioner he had ‘made diligent enquiries at the Government Labor (sic) Exchange, Labor offices, public houses, boarding houses, restaurants, electoral offices, G.P.O. mental hospital and other hospitals, and various other places,’ but could find no trace of the man.78 The debt remained unpaid.

The doctors themselves complained about the remuneration. Doctor Phillip Clarke in Mount Molloy objected to being paid only a guinea for a medical examination, expert evidence, and signing a certificate. He demanded an extra 10/6d, otherwise he would decline to attend any police case. Shortly after, an alleged lunatic was brought to Mount Molloy, so Clarke refused to see him. Acting Sergeant Welsh wired his inspector in

77 Q.S.A. A/44764, in-letter 15913 to Commissioner of Police, 1 October, 1904.
78 Q.S.A. A/44764, in-letter 19340 to Commissioner of Police, 13 July, 1914.
Cairns for instructions. Inspector William Brett replied that if Clarke would provide a statement of his views, he would forward it to the Commissioner of Police, but if Clarke still refused to examine the lunatic, Welsh was to bring him to Cairns. Clarke then wrote a letter to Brett, giving his side of the story (and after examining the new case and accepting a fee of one guinea!), which Brett forwarded to his Commissioner. The Commissioner forwarded all this correspondence to the Home Secretary, and in due course, Clarke was paid an extra 10/6d.\(^79\) Police occasionally inadvertently used the services of an unregistered medical practitioner for a certificate (despite a notice in the Police Gazette warning police against this action\(^80\)). Vouchers for payment to the doctor would be refused.\(^81\) Government Medical Officers sometimes attempted to sidestep their responsibilities since there was no extra remuneration for them in giving certificates of insanity. In October 1901, the Brisbane Hospital Secretary wrote to the Commissioner of Police to ask whether a Government Medical Officer should be called in to give a second certificate in the case of insanity in the hospital. The G. M. O., he told the Commissioner, said this did not apply to Brisbane, but the Commissioner assured him it did.\(^82\) Vouchers for payment of doctors’ fees could only be forwarded to Police Headquarters and would only be paid after the police had made diligent efforts to extract payment from the estate, family or friends.\(^83\) The Home Secretary also instructed the

\(^79\) Q.S.A. A/44764, in-letter 01984, copies of correspondence to Commissioner of Police, 30 January, 1908.

\(^80\) Q.P.G., 2 February, 1906.

\(^81\) Q.S.A. A/44764, in-letter 008483 to Commissioner of Police, 16 May, 1907.

\(^82\) Q.S.A. A/44764, in-letter 14632 to Commissioner of Police, 7 October, 1901.

\(^83\) Q.S.A. POL11/A1, unnumbered memorandum from Commissioner of police, 1 February, 1894.
police that it was not advisable, under section 32 of the *Lunacy Act* of 1884, to obtain two certificates from doctors who were ‘in a relationship’, presumably either married or working together.

Expenses incurred in escorting patients who had been arrested by the police as being of unsound mind (to either a reception house or the Lunatic Asylum) generally fell on the police. The police were then instructed to attempt to recoup all or some of the costs, from relatives, or from the Curator in Insanity if the patient had, or was suspected to have, funds. If relatives refused, either through genuine hardship, or obstinacy, there was little the police could do.

### 3.6 Insanity in Aborigines

In 1889, the Intercolonial Medical Congress held in Melbourne included for the first time a section on Psychological Medicine. The president of this section was F. Norton Manning, a well-known psychiatrist from Sydney, a noted reformer of the New South Wales asylums and the first inspector of the insane in that colony.

He reported on ‘Insanity in Australian Aborigines, with a Brief Analysis of Thirty-Two Cases.’

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84 Q.S.A. A.44764, in-letter to Commissioner of Police, 15 July, 1907.

85 see, for example, the case quoted in Q.S.A. A/44741, in-letter 08359 to Commissioner of Police, 16 April, 1903.


opinion, insanity was rare among the Aboriginal population in ‘their primitive and uncivilised condition’ prior to colonization. He believed that violent lunatics were slaughtered, while melancholic ones were allowed to commit suicide. After contact with white people, insanity increased dramatically among the Aborigines, so Manning could say ‘we have…passed from a period in which insanity was almost unknown among the native race, to one in which it is almost twice as common as among the European race.’ Manning’s opinion, based on inadequate research, was extensively quoted in America, Europe and Britain for the next thirty years.\(^8\) According to Manning, the Aborigines themselves claimed there was more insanity than previously, which they attributed to the use of intoxicating liquors and their new disregard for their laws of consanguinity of marriage.\(^9\)

I have looked at the admission books for the Brisbane asylum between 1866 and 1907. Over 1,500 individuals were admitted to the asylum. Of these, only 12 (less than 1%) were said to be Aboriginal, nine men and three women. Seven were said to be suffering from dementia, and four from mania. Opium was specifically mentioned as a cause of disease in two men.

The reports on inquests held in Queensland State Archives included, between 1890 and 1900, twenty-four inquests on Aborigines. Eight of the deaths occurred at Goodna or Goodna.

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\(^9\) Manning. *Insanity in the Aborigines of Queensland*, 1889.
Woogaroo Asylum. Clearly, Aboriginal patients were incarcerated as lunatics, though there is surprisingly little information on the subject.

### 3.7 Suicide

One of the issues the police had to deal with was the question of suicide and attempted suicide, which increasingly throughout the nineteenth century came to be seen as problems of mental ill health.

#### 3.7.1 English law and custom

Statistical studies of suicide are fraught with difficulties, and tend to underestimate the actual rates. Comparisons of suicide rates between countries are impossible for many reasons including the effect of religion (Catholic and Muslim countries report low rates of suicide), inadequate registration, difficulties in deciding between suicide and accidental death, and other reasons. Rates within a country are more reliable, but remain subject to many problems, including different inclinations to render a ‘courtesy’ finding of cause unknown or accidental. Despite these difficulties, European, British and American authors from the eighteenth and nineteenth centuries perceived a rising problem of suicide, especially in men. The perceived increase was related to the decline

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90 Q.S.A. See various inquests.

91 Erwin Stengel. *Suicide and Attempted Suicide*. Penguin Books, Harmondsworth, England, 1964, p 19 See, also, Q.S.A. JUS/N211/93/174 and 175, the depositions of two inquests, where the bench was unable to decide whether, in the first case, the overdose of laudanum was accidental or suicidal, and in the second, whether the drowning was accidental, suicidal or homicidal.
in the social and moral order brought on by the growth of the city. Adherence to traditional family values was seen as the best protection against suicide, and explained the apparent low risk of women committing the act of self destruction.

Globally, attitudes to suicide have ranged from horror (for example, the Catholic Church) to community acceptance (the practice of ‘suttee’ by Hindu wives in India, the captain who remains at his post in the sinking ship, the Japanese samurai who committed hara-kiri when faced with dishonour), to a reasoned and intellectual way of death, as Diogenes Laertes supposedly counselled it to the brave and the wise. In England before the nineteenth century suicides were tried posthumously by a coroner’s court and if found guilty, could be judged either felones de se (self-murderers, the most common verdict) or non compos mentis (not of sound mind). Those found guilty of felo de se were posthumously punished by forfeiture of property and profane burial at cross roads with a stake through the heart. The English Enlightenment brought a transformation, with coroners’ courts increasingly returning a verdict of non compos mentis. An 1823 act made it illegal for coroners to order burial in a public highway. However, such remains

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93 H. Robin Fedden. Suicide, 1938. p 9 (Paragraph 130 of Diogenes’ Book 7, in discussion of Stoic philosophy, actually says ‘They ((the Stoics)) tell us that the wise man will for reasonable cause make his own exit from life, on his country’s behalf or for the sake of his friends, or if he suffers intolerable pain, mutilation or incurable disease.’ From an English translation of Diogenes by Robert D.Hicks, 1972 Fedden’s book gives a detailed account of the history of suicide throughout the ages.

94 The stake was to prevent the emergence of restless ghosts.

were still to be buried without Christian rites, and between the hours of 9 p.m. and midnight.

As suicide increasingly became a sign of madness, so attempted suicide was also evidence of madness. However the stricture of a criminal offence persisted, and those who unsuccessfully attempted suicide might be sentenced to either imprisonment or a lunatic asylum. The advent of London’s New Police in 1829 made it possible to routinely treat attempted suicide as an offence, and though committal for trial was unusual (except for repeat offenders or those of known bad character\(^{96}\)), many were remanded for a week with daily visits from a chaplain and a surgeon.\(^{97}\) Attempted suicide only ceased to be an indictable offence in England and Wales in 1961.

The American alienist Isaac Ray divided suicides into two classes, those who kill themselves for moral causes, and those affected by some pathological condition of the brain.\(^{98}\) Examples of the first included the intrepid Roman who fell on his sword to prevent dishonour, under the second class, he mentioned suicide associated with a melancholic disposition, widely recognised as a form of ‘monomania’.\(^{99}\) But he then confused his own classification by admitting there was a large class of cases in which no insanity had been observed, though there was good reason to believe in its existence. The


English surgeon Forbes Winslow, in his *Anatomy of Suicide*, published in 1840, attributed suicide to medical causes such as depression, physical pain or insanity.\(^{100}\) Most modern scholars ascribe to at least one of three explanations for suicide and attempted suicide, namely social causes, psychiatric causes, or psychological causes.\(^{101}\) In reality, a combination of two or more causes is likely to account for most cases. Modern practice is also to exclude the police from the management of suicide or attempted suicide, though there will always be some role for the police. Deciding whether the cause of death was suicide, not murder or accident, can be difficult. The police also remain interested in the management of assisted suicide, successful or not.

### 3.7.2 Suicide in Australia

A detailed statistical study of suicide rates in Australia between 1858 and 1910 was made by the Commonwealth of Australia statistician G. H. Knibbs, in 1912.\(^{102}\) He noted the constancy of the measure of the suicidal tendency, the constancy of the relative number of the sexes and the periodicity of the overall trend. He noted the higher suicide rates than for England and Wales (and much higher than for Great Britain, owing to the low rates for Ireland and Scotland), but a much lower rate than France. The higher sex ratio,

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4.92 male suicides for each female case, compared to 2.98 for England and Wales. He noted that suicide was more common in the summer months. Among men firearm deaths were far more common in Australia than in any European country, while hanging was less common. Women were more likely to take poison, or throw themselves into the river. He made no comment on race, country of birth, religion, domicile or occupation; not surprisingly, he also said nothing about alcohol abuse, mental health or any other predisposing factors. He attributed the periodicity—the suicide rate appeared to rise during difficult economic times—to social and economic conditions.

3.7.3 Suicide in Queensland

On October 8, 1848, William Munton, a sheep overseer, committed suicide by cutting his throat. This was his second attempt: on each occasion he was said to be suffering from an aberration of the mind brought on by intemperance. While probably not the first case of suicide in Queensland, William was to be a forerunner of many. In 1862, the population was estimated to be about 34,000 and nine suicides were recorded. Unfortunately the sex ratio is not given. Subsequent statistics did differentiate the sexes, and showed the excess of male suicides, with a ratio of one female suicide to nearly six males. Between 1863 and 1870, the male rate was 16.7/100,000 of male population; in the next decade 16.9; in the 1880s 21.1 and in the 1890s 24.4. The female rate of suicide, though much lower than the male rate, also showed an increase throughout the nineteenth century, from 4.7 in the sixties to 6.1 in the nineties. An unusual feature of suicide in

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103 Moreton Bay Courier, 21 October, 1848.
Queensland, and in apparent marked contrast to the European situation, was the relatively low rate in Brisbane, the capital city. Though making up almost a third of Queensland’s population, suicide rates in Brisbane comprised about one twelfth of the whole colony rate. As in Britain, where suicides were more common during spring and early summer, suicides in Queensland predominated during the hot summer months, reaching their nadir in the month of May. It was the job of the police to make an assessment of the cause of death and provide evidence to an inquest. Police evidence would also include evidence of mental state and alcohol or drug use or abuse. Some suicides left notes which not only assisted the police, but also reflected the banality and hardship of their lives. Inquest records reveal the causes of suicide in Queensland to have been, indeed, social, psychiatric or psychological, or a combination of these. A miner who killed himself by setting off dynamite in his mouth told a friend he could not work, and had no money to sustain himself with, he was living on celery water. Another, without work for six months, and addicted to drink, cut his throat with a razor, dying in the Brisbane Hospital six hours later. A Japanese man starved himself to death in the

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104 These statistics are derived from Annual Reports of the Registrar-General.


106 See for example, Q.S.A. JUS/N222/94/111 George Stroud, died 9/3/94; suicide note says he took his life because he had no money and did not want to trouble his family in Tasmania for money. ‘It is just six weeks today since I landed here in search of work and up to the present time can see no chance of getting a situation of any kind and being stone broke I have decided (rather than trouble my people in Tasmania for money) to make away with myself’; or JUS/N205/92/40 Marianne Jull committed suicide at Toowoomba, 1/1/92; left note to her daughter, which said ‘Let me beg of you once more never to marry Willie Cooke. He is not worthy of you or any other respectable girl, the district trollop from the slums of Toowoomba is good enough for Billy the loafer and if you wed him you will regret it all your life. JUS/N281/00/49 Edward Cott (farmer) hung himself at St George, 16/1/00; his daughter was married on the day before his death; he said to his wife, while drunk, ‘Which of us is going to die. One of us must die, you or me’, to which she replied ‘I am not going to die, die and be blessed’. And others.

107 Q.S.A. JUS/N197/92/44.

108 Q.S.A. JUS/N/326/04/336.
Thursday Island gaol where he had been locked up for his own protection. Dr Salter, the G. M. O., said he was demented, violent and refusing to eat unless forced. A former police magistrate for Maryborough cut his throat with a pen knife. He was said to have been in a very despondent state for some weeks previously.

In addition to such cases, a number of individuals committed suicide while being held by the police, sometimes on suspicion of being of unsound mind, sometimes for other reasons. Some examples include a man, accused of a sexual assault on a two year old girl, who hanged himself in the Gladstone lock-up with a belt and towel. In evidence, the police said he had shown no suicidal tendencies, but was very despondent. In 1892, Kate Harris jumped overboard while under escort from Townsville to the Asylum, leaving behind two small daughters. John Brooks, arrested on suspicion of being of unsound mind, jumped overboard while on his way from Cairns to Brisbane under police escort. A white woman, charged with the attempted murder of a Japanese man, and while under escort of the police, jumped overboard from the steamer taking her to Townsville for trial. Joseph McCarragher, a labourer, attempted to kill himself by cutting his throat with a razor. On his discharge from the Beaudesert hospital a month later, he was arrested by the police on a charge of attempted suicide. In the lock up, a

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109 Q.S.A. JUS/N211/93/151.
110 Brisbane Courier, 3 January, 1863.
111 Q.S.A. JUS/N/219/93/555.
112 Q.S.A. JUS/N204/92/365.
113 Q.S.A. JUS/N316/03/294.
114 Q.S.A. JUS/N376/07/309.
doctor certified he was insane. The following day, while his case was in court (the patient remaining in his cell), the prosecuting policeman changed the charge from attempting suicide to being of unsound mind, and the man was remanded to the Brisbane Reception House. However, by the time the police returned to the cell, McCarragher had hanged himself with a piece of rope used to tie up his swag, which, contrary to orders, had been left in his cell. In addition to suicide, there existed cases of murder-suicide, mainly, but not uniquely, men who killed a female victim. Such cases were obviously of great interest to the police.

Attempted suicide was a crime that could be punished by up to a year’s imprisonment with hard labour or to incarceration in the asylums, while the crime of aiding and abetting a suicide could attract a life sentence. Figures for attempted suicide are extremely hard to compute. The psychologist Erwin Stengel estimated that, in the 1960s, attempted suicide was six to eight times more common than actual suicide. Between 1877 and 1914, 610 men and 140 women were charged with attempted suicide in Queensland. Men were significantly more likely to be convicted of the offence than women, though many were given minor and non-custodial sentences. Figures published in the Police

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115 Q.S.A. JUS/N396/08/216, and other cases.


117 Queensland Criminal Code, 1899, S.311 and 312.

118 Figures are derived from the Crime Statistics of the Annual Reports of the Queensland Commissioner of Police. No statistics were produced in 1878. From 1915 onwards, statistics were produced for the financial year, not the calendar year.

119 Of the 610 men, 43.7% were discharged, while 63.64% of women were discharged by the courts, a statistically highly significant difference ($\chi^2 = 17.9$, with 1 degree of freedom, $p< 0.0001$).
Gazette show that five people (four men and one woman) were released from the major Queensland gaols between 1867 and 1886 after serving time for attempted suicide. After 1886, the Gazette also published figures of prisoners brought before the circuit or district courts and the results of these. A man who attempted to commit suicide in Rockhampton was sentenced to ‘rising of the court’. Three months later he repeated the offence, for which he was sentenced to twelve months imprisonment. In general, however, the courts were much more lenient. Of 117 cases coming before circuit or district courts between 1886 and 1899 and reported in the Police Gazette for those years, thirty-six received a sentence of ‘rising of the court’, twenty-one were discharged, a small number with a financial recognisance (a bond to behave, otherwise they would be brought back to court to face the original charge), eighteen to imprisonment for one minute and one to imprisonment for ten minutes. In twenty-one cases ‘no true bill’ was filed (no true bill refers to a situation where a person is committed for trial but it is not intended to proceed with the trial), or the prosecutor filed ‘nolle prosequi.’ Fourteen individuals, male and female, received terms of imprisonment ranging from one day to three months. These results indicate either considerable leniency on the part of the courts, or genuine uncertainty about an individual’s intentions. A number of individuals who attempted suicide ended up in Woogaroo, usually after a period of time in the local reception house. Sub-Inspector Graham described the case of a Japanese cook who unsuccessfully cut his throat in October 1906. He was arrested by Constable Cullen on

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120 Q.S.A. A/44764, in-letter 29832 to Commissioner of Police, 11 November, 1913.

121 Q.S.A. A/45600-45602, Case books of the Woogaroo Asylum. During the period 1865 to 1874, over 600 people were incarcerated in Woogaroo but only 2 women and 7 men were admitted for suicidal attempts, suicidal melancholia or suicidal mania.
suspicion of being of unsound mind and brought to the Charters Towers watch-house. During the journey he attempted to remove the bandage from his neck, but was prevented by the police escort. In Charters Towers, two doctors certified that he was of unsound mind. He was committed by the local bench to Goodna (the new name for Woogaroo) Asylum, the order suspended for thirty days, during which time he was to be detained in the Reception House in Townsville. A man who tried to cut his throat with glass from a broken bottle was sentenced to one month’s imprisonment ‘for (his) own sake only.’

It is likely that a number of individuals who attempted suicide had a similar passage to the asylum. Interestingly, the admission diagnosis for the unfortunate Japanese was mania, not melancholia. By way of contrast, a thirty-seven year old bus driver who attempted suicide, also by cutting his throat in 1907, was diagnosed as melancholic, despite also admitting to hearing abusive voices ‘overhead’ and having a poor memory. Some who attempted suicide while in prison on other charges appear to have not been brought before the courts. M.G. Abrahams cut his throat with a dinner knife while on remand in the Brisbane gaol. Dr Wray, the Government Medical Officer saw him, found no severed arteries or windpipe, and sent him in to hospital. No other action seems to have been taken.

There are five possible explanations for the low rate of arrest for attempted suicide in Queensland. Firstly, it was not reported to the police. Attempts made in public places

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122 Q.S.A. A45648, copy of letter from Sub-Inspector R.M.Graham to Commissioner of Police. 2 November, 1906.

123 Q.S.A. CCT7/N75, in-letter 01065 to Attorney General, 16 February, 1903.

124 Q.S.A. A/45647, Admissions Book, Goodna Asylum, 1907.

125 Q.S.A. A/19930, in-letter 10101 to Colonial Secretary from Comptroller of Prisons, 1 September, 1894.
clearly came to police attention while attempts made at home might be hushed up. Secondly, the means of suicide (shooting, poison—especially strychnine—hanging and drowning) were so effective most attempts succeeded, whether the victim hoped this would be the case or not. Thirdly, the police considered the matter of relative insignificance or felt themselves sufficiently overburdened by other extraneous duties that they ignored some attempted suicides. Fourthly, police, perhaps with the connivance of magistrates, ‘covered up’ attempted suicides to save families from shame. Lastly, those attempting suicide were treated as being of unsound mind. Attempted suicide was expunged from the Criminal Statutes in 1979.

### 3.8 Alcohol and mental disorder

The penal settlement of New South Wales was unique among all colonial enterprises in that it was fuelled by alcohol, and rum in particular. As historian Manning Clark noted, many of the civil and military officers in the early days of the convict settlement became dealers in spirituous liquors, while rum was sometimes used to pay convicts working for settlers during the time they were not employed on government work.\(^{126}\) Numerous observers of the Australian colonies in the nineteenth century have commented on the amount of alcohol consumed. ‘Hazardous levels of alcohol consumption have been part of Australian social life from first settlement,’\(^ {127}\) and ‘the Sydney of the 1880s was

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Hogarthian in its cheerful brutality…political and social histories of Australia …neglect to point out that life… was all too frequently lived in a muddle of alcohol, street brawling and domestic shirking.'\textsuperscript{128} Yet historian Milton Lewis believes the actual alcohol consumption in New South Wales before 1830 was comparable to England’s, or after that date, only slightly more, and believes many of these stories were the stuff of legend.\textsuperscript{129} After 1840, alcohol consumption declined throughout the nineteenth century, with only occasional reversals of the trend associated with, for example, the gold rushes. In Lewis’ opinion, the reasons for this decline, which occurred in both New South Wales and Victoria, were urbanization, increasing public education, and the success of the Temperance Movements. Rural areas perhaps remained less continent. The long serving Victorian police officer J. Sadleir described the process of ‘lambing-down’ in the 1850s whereby shearers, once the shearing was finished, brought their cheques to the local publican and then settled down to drink until the money ran out. Such orgies, he wrote, often ended in delirium tremens, insanity or death.\textsuperscript{130} Lewis writes very little about Queensland, where a frontier mentality remained an important component of cultural development.\textsuperscript{131} Inquests on men who died in suspicious circumstances always focused


\textsuperscript{129} Lewis. \textit{A Rum State}, 1992, pp 8-14.

\textsuperscript{130} John Sadleir \textit{Recollections of a Victorian Police Officer}. George Robertson and Company, Melbourne, 1913, p 108.

\textsuperscript{131} See, for example, the \textit{Cooktown Courier}, 2 January, 1875; commenting on the committal of a man to the Townsville Reception House, the editor noted that the many men who undergo hardships of no uncommon character, when they come to town have no other resource for killing time but drink, and asks that a Reception House be established in Cooktown for the management of delirium tremens. The volume of alcohol consumed also led to predictions of increasing insanity rates.
on drinking habits, and death was sometimes attributed directly or indirectly to alcohol.\textsuperscript{132} Whatever the social effects of alcohol, all the Australian colonies supported its consumption, since it provided a significant source of revenue, from excise duty to licences to sell alcoholic drinks. Lewis estimates that in 1859, total New South Wales revenue from the manufacture and sale of liquor amounted to 31.6\% of total government revenue, falling gradually to 10.9\% by 1900.\textsuperscript{133} Alcohol consumption, judging from the number of arrests for public drunkenness in small country towns, was high. Though public drunkenness is generally a victimless ‘crime’, alcohol can fuel violence, as well as generating other more complex neuro–psychiatric morbidities (Wernicke-Korsakow’s psychosis, delirium tremens etc.). Dealing with the effects of the abuse of alcohol was to be an important part of the work of the police. For much of the nineteenth century, alcohol abuse was perceived as harmful because sinful, but towards the end of the century, a medical model of alcoholism emerged,\textsuperscript{134} though the shift from moralism to medical model was never complete. In modern times, alcoholics are seen by many physicians as ‘undesirable patients.’\textsuperscript{135} A report published in 1899 claimed that in Belgium, alcoholic indulgence caused ‘74 per cent of criminal convictions, 45 per cent of

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\textsuperscript{132} See, for example, Q.S.A.JUS/N310/02/374. James Lambert died near Richmond from heart failure after drinking; he had previously cut off his own hand during a drinking spree: JUS/N367/07/02 Dr W.G. Rainer died at Eidsvold by morphia poisoning while drunk, 16/12/06.

\textsuperscript{133} Lewis. \textit{A Rum State}, 1992, p 17.

\textsuperscript{134} Matthew Allen. ‘From sin to risk: a brief history of the changing paradigms for understanding alcohol and health in Australia.’ Paper presented at the 11\textsuperscript{th} Biennial Conference of the Australian and New Zealand Society of the History of Medicine, Perth, 2009.

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the lunacy, 79 per cent of the pauperism and 80 percent of the suicides.\textsuperscript{136} The association with suicide appears to be a genuine one.\textsuperscript{137} Norton Manning estimated that ten percent of cases of insanity in Sydney were alcohol related.\textsuperscript{138} No doubt similar beliefs existed in Queensland.\textsuperscript{139} Lori Harloe comments that heavy drinking led in many instances to fights, sickness and suicide, while every year alcohol related deaths occurred in almost every (northern) community.\textsuperscript{140} Successive Queensland governments took no interest in the problem of alcoholism,\textsuperscript{141} believing, as was common at the time, that health problems were individual responsibilities, and anyway alcohol was an important source of revenue.

Inebriety was historically linked with lunacy administration.\textsuperscript{142} Patients suffering from psychiatric syndromes associated with alcohol were frequently admitted to reception houses. Of seventy men admitted to the Townsville reception house between October

\begin{footnotes}
\item[136] Quoted In: Report of the Howard Association, October 1899, which also mentions, in relation to Britain, the great amount of Crime, Pauperism and Vice produced by Intemperance. This report is available at Q.S.A. COL 297.


\item[139] See, for example, an article on drunkenness as a cause of mental ill-health published in the Brisbane Courier, 8 February, 1867.


\item[141] The term ‘alcoholism’ was introduced in 1849 by the Swedish physician Magnus Huss, to describe the ill effects of excessive alcohol consumption.

\item[142] Q.S.A. A/45600-45602, case books of the Woogaroo Asylum show that during the years 1865 to 1874 over 600 people were admitted to the institution. Intemperance, dypsomania or the effects of alcohol were described as the primary or contributory cause for admission in 5.8% of female, and 14% of male admissions.
\end{footnotes}
1886 and April 1889 (whose records are sufficiently complete), twenty five were thought to be suffering from alcohol related syndromes.\textsuperscript{143} The 1896 \textit{Inebriates Institution Act} provided for the establishment of proclaimed houses or places for the reception, control, care and curative treatment of inebriates. Inebriates could apply (when sober) to the courts for voluntary admission, or family or friends could apply to the courts. Two medical practitioners could certify a person needed admission, if the person had not less than five prior convictions for offences under the \textit{Licensing Act} of 1885. The police were not involved in obtaining admission of inebriates, but could recapture persons committed to the institutes who escaped before their time. An inebriate’s institution was erected at Dunwich, the first resident being admitted in November 1899. In 1910, the institution was moved to Peel Island, then back to Dunwich in 1916. The Brisbane General Hospital was also proclaimed an institution for inebriates in 1898.\textsuperscript{144} There is little evidence the institutes had much success. Treatment, according to the Home Secretary, was dietary and hygienic.\textsuperscript{145} Psychiatrists maintained (and continue to maintain) an interest in alcoholism, because they believed alcohol was a cause of insanity, though there remained much confusion about cause and effect. In 1899, J. P. T. Caulfield, a newspaper editor, claimed to have a cure for dipsomania. He opened a private institution in Sydney, using as treatment injections of strychnine and atropine, a good tonic, and occasionally apomorphine and whiskey as a nauseant, should strychnine fail. He claimed a high

\textsuperscript{143} Q.S.A. A/64789, Reception House Townsville. Of 70 men, 25 had alcohol related problems and 45 no alcohol related problems. 5/25 patients with alcohol related problems were sent to the Brisbane Asylum, compared to 37/45 of the others. An unnumbered and undated table in the file refers to admissions to the Townsville reception house between 1886 and 1891. There were 177 males and 71 females. Alcohol related problems occurred in 45(25.4\%) of men, and 3 (4.2\%) of women.

\textsuperscript{144} Q.S.A. A/45258, bundle 539M.

\textsuperscript{145} Q.P.D., Legislative Assembly, 8 November, 1899.
success rate, and attempted to open a similar institute in Brisbane if the government would pay him twenty-five guineas per person for a four week course of treatment to prove the success of his treatment. He wanted twenty drunkards to prove his theory. Both the Sunday Review and The Street supported Caulfield, but Home Secretary Foxton was not persuaded.\textsuperscript{146} Caulfield’s proposal was of interest, since he claimed alcoholism was a disease, not a problem of moral turpitude.

The Temperance Movements were of American origin. The first Australian temperance society was formed in Hobart in 1823, followed by New South Wales in 1824. Early temperance movements aimed at achieving moderate temperance, which meant no consumption of spirituous liquor, though beer was permitted. Total abstinence movements started in Sydney in 1838 and Melbourne in 1842, followed by Friendly Societies such as the Rechabites and the Templars which paid death and funeral benefits to abstemious members. The temperance movements waned briefly then became increasingly active in the 1880s and 1890s.\textsuperscript{147} The temperance movements used three methods to promote their cause. They developed alcohol free hotels and coffee palaces, pursued an aggressive educational program, and they pushed for political reform. In 1884, a Local Option League was formed in Brisbane, to push for ratepayers to have a say in the issuing of licenses to sell alcoholic liquors.\textsuperscript{148} The following year, the

\textsuperscript{146} Q.S.A. COL 297, contains a bundle of papers dealing with the Caulfield claims.

\textsuperscript{147} See Lewis. A Rum State, 1992, pp 49-71 for a detailed account of the nineteenth century temperance movements in Australia.

\textsuperscript{148} Brisbane Courier, 24 November, 1884 (Local Option had been promoted initially in the 1850s, but became more political in 1881, with the adoption by the House of Commons of a motion to take legislative action on the principle of local option with respect to the liquor industry.)
Licensing and Local Option Act came onto the statute book, giving ratepayers powers to either prohibit the sale of alcohol, reduce the number of licenses to sellers of alcohol, or forbid the granting of new licenses.

Violence, however, is not only associated with alcohol, but may also be part of a disordered mental state. The relationship between violence and mental disease is far from clear, though at least one expert noted an association between the two, and violence of any sort, in public places particularly, was of concern to the police.

3.9 Conclusions

The Queensland police were more active in the management of persons of unsound mind than their English counterparts, but the absence of significant infrastructure to deal with such unfortunate people left no alternative. Furthermore, the use of insanity as a defence in cases of criminal activity meant the police would always be interested in this branch of medicine. Lunatics, as in England, were managed by confinement under the criminal law, or under the Vagrancy laws: in private mad-houses (though these were not significant in colonial Queensland), in state institutions (a reception house, or Woogaroo Asylum), or, probably the largest number, at home. The English workhouse was not replicated in Queensland, and the Benevolent Asylum at Dunwich does not appear to have been used as an alternative to Woogaroo.

Police and family members were generally the first people to deal with those suspected to be of unsound mind. Doctors were called to certify, and sometimes offered treatment to individuals held for a few days in lock-ups, though treatments, apart from sedation, were largely ineffective. Numerically, the number of cases the police prosecuted as ‘being of unsound mind’ was small, representing 2.5% and 4.0% of all charges in men and women respectively. No doubt others were held in the watch house and sent home without being charged if they settled quickly. Much of the acute disturbance was associated with alcohol, and the management of public drunkenness occupied a great deal of police time. General Paralysis of the Insane, a late manifestation of syphilis, was not diagnosed as a major cause of insanity in Queensland. Suicide was slightly more common than in England and Wales, and was particularly associated in men with firearms. Attempted suicide was more common in men than women, but women were more likely to be discharged by the courts than men.

An important role of the police was to escort persons of unsound mind to the reception houses, or to the asylums, trips that had their own peculiar problems, such as attempting to escape or attempting, and sometimes committing, suicide. Once an individual was incarcerated in an asylum or reception house, the police were responsible for recapturing any who escaped.

The nexus between the police and insanity continues into the twenty-first century, with police repeatedly being called to deal with people who are putting the lives of others—or

150The first non-narcotic drug to be widely used as a sedative was chloral hydrate, from 1869 onwards. Though the barbiturates were discovered in 1864, their sedative properties were not recognized till early in the twentieth century.
their own—at risk. The problem is also sometimes resolved by police shooting and killing persons of unsound mind if they feel themselves to be threatened, something that does not seem to have been reported in earlier times.

The role of the police in the management of the insane was, and is, largely a matter of public order. This role was extended by the *Contagious Diseases Act* of 1868, which gave police powers over women they assumed might be infected with venereal diseases. This forms the subject of the next chapter.

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151 See, for just one example, the *Courier-Mail*, 16 June, 2009.
4.0 Policing the venereal

4.1 Introduction

In contrast to the perceived licentiousness of the Georgian era, proponents of the moral revolution preached sexual Puritanism as the desirable norm. One solution to the problems of society was to strengthen the role of the family. Marriage, instituted by God, was of fundamental importance. Infidelity was destructive to both partners, was an affront to the divine institution of marriage and was, therefore, a threat against good order.\(^1\) The desirable norm of sexual Puritanism epitomized married women as ‘good’ while those who provided extra-marital sexual favours, the prostitutes, came to be categorized as the ‘very bad’ and the subject of police concern. The problem of prostitution in the second half of the nineteenth century was discussed under the sobriquet of ‘the social evil.’ These changes, replicated in Australian society, came about as transportation was coming to an end, the immigration of free immigrants was accelerating and the professionalism of the police was increasing. The first sign of the moral change in Australia was the formation, in Tasmania in 1842, of a Society for the Prevention of Vice.\(^2\) The police, in Australia as much as in Britain, were the agency to deal with prostitution, but the situation was complicated by the perceived association between female prostitutes and the venereal diseases.

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4.2 The ‘Social Evil’

From about 1850 onwards, the venereal diseases became subjects of intense scrutiny in the western world, and excited the attention of an extraordinary number of people, not merely physicians and politicians. The principal cause of the interest lay in the perceived role of women, and especially prostitute women, as transmitters of infection. The period marked a shift of emphasis from the idea that all female sexuality was inherently dangerous to the idea that some women were dangerous by virtue of being prostitutes. Dr A. Parent-Duchatelet characterised Parisian prostitutes as a class apart, outside civilisation, a subterranean counter culture representing a moral, social, sanitary and political threat. In line with developing theories of sanitation, prostitutes came to be perceived in much the same way as a sewer. Morality and theology, medical expertise, law, politics and the police came into increasing contact in a quite unique way. The social disease, syphilis, was bred of the social evil. The French venereologist Auguste Theodore Vidal opined that subjects of syphilis should be sought and isolated, in order to withdraw from society active agents of contagion. Hence, he said, the idea of subjecting prostitutes to a sanitary inspection. He noted several police officers in late 18th century France wished to promote this idea, but were deterred by a fear their authority would be diminished in the eyes of the public by appearing to make sex safe. However, this project was put into operation around 1800 since when in France a true ‘medical police’

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developed, whose authority was not confined merely to the suppression of vice, but also included sanitary considerations. ⁶ Men were exempted from blame since they did not seek out prostitutes, rather they were ‘lured’ by the women. ⁷ The problem of venereal disease therefore became one, not of both sexes, but of women, and prostitute women in particular.

At the same time the medical profession was taking an unhealthy, almost prurient, interest in human, and especially female, sexuality, despite an embarrassing absence of knowledge. A consensus was developing that men should not impose their animal desires upon their wives more than once a month (and never during pregnancy or menstruation), while they were entitled to a greater rate of intercourse. ⁸ The problem lay in resolving the imbalance. Masturbation, for both males and females, was widely believed to cause an extensive range of conditions, including insomnia, exhaustion, moral insanity and insanity. ⁹ Seminal fluid, seen as a national resource for the future of Australia, was not to be ‘wasted’ through the uncontrolled activity of masturbation. ¹⁰ Gadgets and mechanical restraints of one sort or another were devised to prevent this unhealthy activity. As late

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⁷ Philippa Levine. *Prostitution, Race and Politics*. Routlege, New York, 2003, p 178 See also Q.S.A. CPS1/AW22. The deposition book for Brisbane’s police court for 1876 gives a number of examples of couples charged with indecent conduct in public places. The men received three months imprisonment, the women six months. In one case, both were fined £5, but the woman was given 3 months imprisonment in default, and the man 1 month.


⁹ See appendix 2.

as 1916, a Commonwealth Government report suggested ‘every boy at a certain stage should be taught … that the continent life is the right life. Nature has provided for the escape of any accumulating secretions, and the acts…of involuntary emissions are perfectly harmless…this statement … (does not apply to)… masturbation…which is a great evil.’\textsuperscript{11} The imbalance was resolved by access to prostitutes, who would at the same time be criticized for providing the service\textsuperscript{12} and would threaten the health of future generations by the threat of syphilis. The Queensland \textit{Contagious Diseases Act} would bring police and medicine into close cooperation. It is this cooperation that forms the basis of this chapter.

\textbf{4.3 Venereal diseases}

\textbf{4.3.1 Gonorrhoea}

Gonorrhoea (from the Greek, \textit{gonos}, semen and \textit{rhoia}, flux), generally a non-fatal, but distressing disorder, was named in the first century of the common era by the Greco-Roman physician Galen. It is an acute bacterial infection caused by the organism, \textit{Neisseria gonorrhoea}, discovered by the German bacteriologist Albert Neisser in 1879. In men, after a short incubation period of three or four days, infection leads to the appearance of a purulent discharge from the urethra, associated with extreme pain on


passing urine. In women the initial symptoms are generally much milder and may be absent. Untreated, the symptoms generally disappear, though the infection may persist, especially in women, for long periods. Repeated attacks in men may lead to strictures (narrowing) of the urethra. This complication necessitates the repeated use of instruments (‘urethral sounds’) to keep the urethra free from blockage. In the absence of regular dilatation of the urethra, the individual with a urethral stricture is at risk of developing renal failure, a risk enhanced by the use of improperly sterilized ‘sounds’. In women, gonorrhoea may also lead to infection and subsequent narrowing of the Fallopian tubes, leading to infertility. Pregnant women who carry *N. gonorrhoea* in the vagina may pass the infection to the infant during birth. The commonest manifestation of this event is a purulent infection of the conjunctiva, which may be severe enough to lead to blindness. Occasionally, gonorrhoea may become a systemic disease, and spread to other organs, particularly the joints, though this is a relatively rare situation.

### 4.3.2 Syphilis

Syphilis is a more serious, chronic and potentially fatal disease caused by the organism *Treponema pallidum*, discovered by the Germans Fritz Schaudinn and Eric Hoffman in 1905. In untreated cases the infection proceeds through a series of well defined stages. The primary stage becomes symptomatic after an incubation period (the time between exposure to the infection and appearance of clinical signs) of about three weeks. The initial lesion generally consists of a single ulcer (the hard chancre\(^\text{13}\)) at the site of

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\(^{13}\) A ‘soft’ chancre is a symptom of another sexually transmitted infection, chancroid, caused by the bacterium *Haemophilus ducreyi*.  

inoculation, generally, but not invariably, in the genital area. Within a period of about six weeks the chancre heals spontaneously. Soon after, the secondary stage appears. The infection is now generalised throughout the body. Rashes, mucosal ulcers, enlarged lymph glands, fever, headaches are common symptoms. Again, the symptoms generally disappear spontaneously, within a period of weeks, or rarely months, but may recur at intervals. Once the secondary stage has settled, a prolonged latent period ensues. After a number of years, the symptoms of tertiary syphilis may develop, though not all will necessarily develop tertiary symptoms. These may occur in the skin, the cardiovascular system, or the central nervous system. In the cardiovascular system, syphilis may give rise to aortic aneurysms, ballooning and thinning of the aorta, which often rupture and lead to sudden death. Syphilis of the spinal cord causes tabes dorsalis, a condition characterised by a wide-based and unsteady gait. If the brain is affected, the condition of General Paralysis of the Insane results. This generally occurs, in untreated patients, 15 to 20 years after the initial infection.\textsuperscript{14} The patient becomes increasingly immobile and demented, while grandiose hallucinations and delusions also occur, interspersed with episodes of mania. General Paralysis lasts from a few months to four to five years before death. This late complication was of considerable interest to the psychiatrists of the late nineteenth century. The long interval between the secondary and tertiary stages explains some of the difficulties earlier researchers had in attributing late stage complications to an earlier experience of syphilis. General Paralysis was originally described in 1822 by Sparling P.F., Swartz M.N., Musher D.M. & Healy B.P. Clinical Manifestations of Syphilis, In: \textit{Sexually Transmitted Diseases}, 4th Edition, Ed Holmes King K., Sparling P.F., Stamm W.E., Piot P., Wasserheit J.N., Corey L., Cohen M.S. & Watts D.H., McGraw Hill Medical, New York, 2008 pp 668-670.
the French physician A. L. Bayle.\textsuperscript{15} In 1875 the French venereologist J. A. Fournier suggested both \textit{tabes dorsalis} and General Paralysis resulted from a preceding syphilitic infection.\textsuperscript{16} In 1894 he showed that 65\% of patients with General Paralysis had a past history of syphilis, against only 10\% of other mental patients. But final proof would not be available till the first decade of the twentieth century, when serological tests\textsuperscript{17} for syphilis became widely available.

Women who contract syphilis up to a year or so before becoming pregnant, or during pregnancy, may transmit the infection to the foetus, resulting in death \textit{in utero}, stillbirth or congenital syphilis.\textsuperscript{18} Children with untreated congenital syphilis have a significantly reduced life expectancy and rarely lived long enough to pass the infection on to subsequent generations.

Syphilis is highly infectious during the primary, secondary, and early latent periods. After this, infectivity disappears. Treatment in the nineteenth century consisted of the use of salts of the heavy metal mercury.\textsuperscript{19} This highly toxic metal not only damaged the

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\textsuperscript{17} Tests based on detecting antibodies to specific organisms in blood, indicative of exposure to the organism.


\textsuperscript{19} Mercury was originally recommended by Ibn Sina in the Canon of Medicine of 1025. Mercury salts were used as ointments and as oral medication. There is no evidence that these compounds cure syphilis, though temporary symptomatic improvement was recorded in some cases. Assessment of efficacy was
kidneys, but also caused severe abdominal pains, produced excessive salivation, and damage to jaw bones, leading to loss of teeth. Doctors sometimes spoke about ‘salivating’ their syphilitic patients. Thomas Sydenham, the great eighteenth century English physician, recommended salivating his patients up to four to six pints per day—which meant giving the patient enough mercury to generate this quantity of saliva.\(^{20}\)

In addition to syphilis, the *Treponemata* may also give rise to a number of clinical syndromes that are not sexually transmitted, of which the best known is yaws. Yaws in particular has a chronic stage that, like syphilis, may affect bones, and is therefore of considerable interest to palaeopathologists. The differences between palaeologic non-venereal yaws and venereal syphilis are subtle but sufficient to distinguish the two diseases on the basis of skeletal remains.\(^{21}\) The late Cecil J. Hackett, an Australian authority on the treponematoses, suggested on the basis of skeletal appearance that yaws was endemic in northern Australia prior to European colonisation, while endemic syphilis, a non-venereal infection often of children, was endemic in Central Australia.\(^{22}\) These infections appear to have bypassed both the Tasmanian and the coastal Queensland

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Aboriginal populations. Paleopathologist Stephen Webb thinks it unlikely that venereal syphilis existed in Australia before colonisation, but admits it is possible some disease transmission occurred from trepang fishermen, or from the occasional European contact in the decades before the arrival of Captain Cook. The distinction between yaws or endemic syphilis and venereal syphilis would not have been evident to the average policeman patrolling the northern or western frontiers of Queensland.

4.4 Attitudes to syphilis

The geographic origins of syphilis are sketched briefly in Appendix 3. The Neapolitan epidemic of 1494 and 1495 soon spread to other countries, and quickly provoked complex social and political responses. Syphilitic patients quickly became stigmatized. By the nineteenth century, historian Richard Davenport-Hines reported, syphilis was appropriated to ‘inspire sordid terror…and distorted, not only to degrade those with the disease, but to frighten people away.’ Dread of venereal disease was stimulated as a matter of public policy. The sexual act was forced to connote danger. The English medical journal, the Lancet, expressed this view well, saying syphilis ‘was a disease

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24 Webb. *Palaeopathology of Aboriginal Australians*, 1995, pp 146-147. Webb thinks the Indonesian contact is less likely as a source of syphilis, since yaws was common in Indonesia and syphilis is rare where yaws is common.

25 Richard Davenport-Hines. *Sex, Death and Punishment. Attitudes to sex and sexuality in Britain since the Renaissance*. Fontana Press, 1991, pp 26-39. The pioneer demographer John Graunt, while compiling the *London Bills of Mortality* in 1662 noted the apparent paucity of reports of death from ‘the French Pox’. He concluded that only hated people or grossly disfigured individuals were reported by his searchers to have died of the disease.

always repulsive frequently disgusting: moreover it was an ailment of our own seeking and only obtained after the infraction of both moral and physical laws. Fornication was contrary to all ordinary, much more to Christian morals, and promiscuous sexual intercourse was opposed to (unstated) physiological laws. Ideas about a racial hierarchy, commonly underpinning imperialism, were expressed by those who blamed Indigenous populations for the ongoing spread of sexually transmitted diseases, which then threatened, not only the individual, but also the unborn generations of the colonizing powers. Dr William Taylor said, in discussion of the Queensland Health Amendment Bill of 1911, ‘the subject [of syphilis] was fraught with so much danger to the race it should be grappled with sternly and effectually’. The racial component would be used by eugenicists, particularly in the United States of America, mandating the use of pre-marital Wasserman tests.

The result of the changing perceptions of the social evil and the social disease was to conflate prostitution and venereal disease into a single ideological debate, the ramifications of which continue to this day.

4.5 Prostitution in Australia

Legislators acted on the assumption that it was impossible to eradicate the ‘social evil.’ This opinion was exemplified by the fact that, in English law (and Australian law derived

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28 Q. P. D., 1911-12: 1’10, 2777-2789.
from this), prostitution itself—the sale of sexual favours—was not a criminal offence. Criminal offences associated with prostitution—soliciting, brothel keeping and living off the immoral earnings of prostitutes—were generally dealt with under the Vagrancy Acts.\textsuperscript{29} The police in Australian tolerated the presence of brothels so long as there was no public outcry against them, and so long as they were not a source of disorder. They regarded prostitution as ‘a necessary evil’—without their services innocent girls and women would be at risk—seeing their role as the control, not the suppression, of prostitution. In the 1880s and 1890s prostitutes were gradually driven out of the central business districts of all the Australian capital cities, and into the back lanes and inner suburbs. At the same time, the police increasingly showed less tolerance for disorderly behavior, drunkenness, swearing and obscene displays of nudity, again dealing with these offences under the catchall vagrancy laws.\textsuperscript{30} The Queensland \textit{Contagious Diseases Act} of 1868 provided a further opportunity for police control of prostitution. Despite these changing perceptions, brothels were widespread throughout the colonies, including New South Wales and Victoria,\textsuperscript{31} until the First World War, and were widely tolerated in Queensland. The eventual closure of the brothels was not due to moralism, but rather to increasing concern about venereal disease.\textsuperscript{32}

\textsuperscript{29}The English Vagrancy Act of 1824 stated, (section 3) that ‘every common prostitute wandering in the public streets or public highways, or in any place of public resort, and behaving in a riotous or indecent manner…shall be deemed an idle or disorderly person within the true intent and meaning of this Act.’

\textsuperscript{30}Frances. \textit{Selling Sex}, 2007, p152.

\textsuperscript{31}Geoffrey Serle. \textit{The Rush to be Rich: A History of the Colony of Victoria 1883-1889}. Melbourne University Press, Melbourne, 1971, p 167. He says that in 1884, 69 brothels were known to the Melbourne police, whose policy was to remove prostitutes from the main streets and suppress the disorderly brothels.

Historian Raelene Frances has written extensively on the issue of prostitution in Australia. She believes prostitution did not exist in Indigenous, pre-convict Australia, and that convict women were transported in part to service the male convicts. She also believes Aboriginal women were widely prostituted in the frontier regions, and that the social evil\(^\text{33}\) flourished in every significant town during the nineteenth century.\(^\text{34}\) The supply of women came principally from the working class. The medical profession perceived prostitutes as women with ‘very strong sexual passions, especially when drunk’.\(^\text{35}\)

In colonial Queensland prostitution flourished. In 1863, one journalist wrote, ‘a sight fit to make angels weep...the young, the once good looking, perhaps beautiful, the much loved and lost one, abandoned to all sense and female modesty, walking the streets in flaunting dress, with loud impertinent talk.’\(^\text{36}\) In 1865, a newspaper correspondent wrote about places in the city where ‘barefaced effrontery and prostitution is [sic] carried out.\(^\text{37}\) Brothels were widespread.\(^\text{38}\) Moral laxity and sexual disgrace, rather than domestic

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\(^{33}\) The first use of the term in the Queensland context appears to have been an article in the *Brisbane Courier*, 4 October, 1865. See also *Brisbane Courier*, 13 December, 1865.


\(^{35}\) Debates of the Queensland Legislative Council, 1912, p 2893. Dr Sandford Jackson, in evidence to a committee of the Legislative Council, 13 December, 1912.

\(^{36}\) *Daily Guardian*, 11 July, 1863.

\(^{37}\) *Brisbane Courier*, 20 July, 1865, and 13 December, 1865.

\(^{38}\) *Brisbane Courier*, 13 January, 1868.
abandonment and economic impoverishment, were seen as the cause of prostitution.\textsuperscript{39} In 1884, the \textit{Brisbane Courier} noted the municipal council was grappling with the problem. The writer thought there was a strong repugnance to do anything which appeared to recognise regulation of the evil, but he recommended the confinement of the evil to ‘certain localities’, while keeping a careful register of those places, and punishing severely those who established unauthorised houses.\textsuperscript{40} In 1899, Chief Inspector Stuart wrote to Police Commissioner Parry-Okeden in support of an idea that all brothels should be under the control of the police, but the Home Secretary rejected the suggestion.\textsuperscript{41} It was a problem for local authorities, not the police. The police were, however, involved in controlling prostitutes who behaved in a disorderly manner, using section 2 of the New South Wales \textit{Vagrancy Act} of 1851, which stated that ‘every common prostitute wandering in any street or public highway or being in a public place who behaves in a riotous or indecent manner...’ could be liable to a term of imprisonment of three months with hard labour. Between 1877 and 1900, disorderly women were categorised in the annual crime statistics as ‘disorderly characters’ or, separately, as ‘disorderly prostitutes.’\textsuperscript{42} During this period, 3,163 charges of disorderly behaviour were laid against women, 1,932 relating to women alleged to be prostitutes. The prostitutes were

\textsuperscript{39} Evans. \textit{Soiled Doves}, 1984, pp 131-132  The Select Committee of the Legislative Assembly of New South Wales appointed in 1866 to inquire into the causes of distress among the Working Classes recognized that the lack of opportunities for women and girls had resulted in a large amount of prostitution. (\textit{Brisbane Courier}, 11 December, 1866).

\textsuperscript{40} \textit{Brisbane Courier}, 30 September, 1884.

\textsuperscript{41} Q.S.A. A/45284, in-letter 15191 to Commissioner of Police, 22 September, 1899.

\textsuperscript{42} See the Annual Reports for the Commissioner of Police, from 1877 to 1900. After 1900, all women were grouped together.
significantly more likely to be convicted by the courts than other women (87.5% vs. 70.9%).

The majority of female prostitutes of concern to the police were white women. That Aboriginal women were prostituted was recognised, but ignored by the police. In the last decade of the nineteenth century, an influx of Japanese women—said to be mostly prostitutes—into northern ports occurred, but as they were orderly, they were also of little interest to the police. The status of the alien prostitute as an undesirable person in society was cemented by the Commonwealth *Immigration Restriction Act* of 1901. This act, commonly considered to be the start of the so-called ‘White Australia’ policy, prohibited the immigration into Australia of certain classes of people: firstly, those who could not write out a dictation of fifty words *in an European language* (my italics) directed by an officer; those likely to become a charge on the public, or public or charitable institutions: idiots and insane persons: persons suffering from an infectious or contagious disease of a loathsome or dangerous character: and lastly, any prostitute\(^{43}\) or person living on the prostitution of others. The contagious disease was widely assumed to be syphilis.\(^{44}\)

### 4.6 The Epidemiology of venereal disease in Queensland

After an extensive review of the venereal diseases in early Australia, and especially in

\(^{43}\) Even though prostitution, the act of selling sex, was not then a crime.

\(^{44}\) In a radio interview, historian Alison Bashford specifically mentions syphilis as a disease of exclusion for the purposes of this act. As there was no specific test at the time for syphilis, immigration officials presumably had to rely on history and appearances. [ww.abc.net.au/rn/rearvision/stories/2007/1902562.htm](http://ww.abc.net.au/rn/rearvision/stories/2007/1902562.htm).
Queensland, physician B. A. Smithurst concluded that gonorrhoea and syphilis came to the continent with the British. He described both convicts and crews of the First, Second and Third Fleets as ‘a poxy lot’, and claimed the problem of venereal diseases in the early days was largely ignored in the face of greater threats to health in the forms of scurvy, malnutrition, fevers and dysenteries. Just how important syphilis was in colonial Queensland is hard to assess. Mortality figures for ‘enthetic diseases’ suggest syphilis caused the death of only a handful of people. There are many social and medical reasons why deaths from syphilis are likely to be improperly enumerated. A late stage of syphilis is the disease known as General Paralysis of the Insane or GPI. The relationship between GPI and syphilis was initially doubted, and even denied by some observers. But general paralysis was rare in Brisbane. In 1872, General Paralysis caused only three out of twenty deaths in the Woogaroo Hospital for the Insane. Clearly, GPI was neither an important cause of death in an institution that might be expected to have large numbers of such cases, nor an important cause of admission to the institution. Alternatively, the disease was not being diagnosed. The Townsville reception house admitted 248 patients between 1886 and 1891, but only one was due to GPI. At Callan Park Asylum in Sydney, between 1878 and 1907, GPI caused 39% of male deaths, and 8.7% of female. In 1904, a post-mortem study carried out in Melbourne suggested 34% of hospital deaths


46 Q.S.A. COL/A 188, in-letter 2360 of 31 December, 1873. See also Appendix 2 for more details about admissions to the Woogaroo (later the Goodna) Asylum.

47 Q.S.A. A/64789, admissions to the Townsville reception house, 1886-1891.

showed clear signs of syphilis, while a further 19% showed doubtful signs. In a study in 1910 of new admissions to Callan Park Asylum in Sydney 14.4% had a positive Wasserman reaction,\textsuperscript{49} while in 1916 a government report estimated 12 to 15% of the population of Australian cities was syphilitic.\textsuperscript{50}

Regrettably, in Queensland, neither syphilis nor gonorrhoea had to be notified until the Health Act Amendment Act of 1911. There were many reasons for this unsatisfactory state of affairs, not the least being the perception that men with symptoms of the venereal would not seek medical attention if the diseases had to be notified. There are regrettably few reliable hospital statistics. Statistics from the Moreton Bay Hospital, between October 1848 and June 1850, show that of 312 admissions, seven (2.2%) were for syphilis and three (1%) for gonorrhoea. In the thirteen months September 1872 to October 1873, of 542 admissions to the Brisbane General Hospital, nine (1.7%) were for syphilis and twelve (2.2%) for gonorrhoea.\textsuperscript{51} In the eleven weeks January to mid March 1887, of 463 admissions to the same institution, thirteen (2.8%) were for syphilis, and only two (0.4%) for gonorrhoea. These statistics are likely to underestimate the true incidence of venereal diseases, since the registers do not categorize other conditions which might have had a venereal origin—orchitis\textsuperscript{52} for example, or urethral strictures.

\textsuperscript{49} Q.S.A. HOM/J80, Report of the Committee of the Australasian Medical Congress, 9th Session on Syphilis, 10 June, 1910 The Wasserman Reaction test, or W.R. was the first serological test for syphilis, introduced in 1907.

\textsuperscript{50} Q.S.A. COL 163, Commonwealth of Australia, Department of Trade and Customs, on Invalidity in the Commonwealth, 1916 Report on Venereal Diseases, p 7.

\textsuperscript{51} But hospital rules for many colonial hospitals specifically denied admission to patients suffering from the ‘venereal’.

\textsuperscript{52} Orchitis: an inflammation of the testicles.
‘bubo’\textsuperscript{53} or aortic aneurysm—according to cause. In 1874 and 1881, at the Sydney Hospital, venereal diseases represented 6.9 and 3.8\% of total admissions.\textsuperscript{54}

In November 1866, Dr W. Hobbs, a medical doctor and a member of the Legislative Council, pointed out that a daily average of 12\% of the men of the 50\textsuperscript{th} Regiment, the Queens Own, based in Brisbane after a tour of duty in New Zealand, attended the sick parade. He found this number astonishing, given the site of the barracks and the healthiness of the climate, and, coyly, attributed this primarily to the frequency of ‘chronic disease.’ Modesty forbade him naming this.\textsuperscript{55}

Venereal diseases certainly existed in early colonial Queensland, and were most likely underestimated, as a result of deliberate hiding of symptoms, of misdiagnosis, and of unwillingness on the part of doctors to embarrass their patients.

4.7 The Contagious Diseases Acts in Britain

Though legislation to deal with venereal diseases and/or prostitution had been in existence in some parts of the Empire (for example, in Bengal since 1807\textsuperscript{56}) before the

\textsuperscript{53} Bubo: Swollen and inflamed glands, often in the groin.

\textsuperscript{54} Milton Lewis. \textit{Thorns on the Rose} 1998, p 66.

\textsuperscript{55} Q.S.A. GOV/A2, in-letter 87 of 8 November, 1866 from Hobbs to O.C. 50\textsuperscript{th} Regiment.

British Contagious Diseases Act of 1864, it was this and the two subsequent acts of 1866 and 1869 in particular which set the scene for much of the debate in the English speaking world on sex, morality, venereal disease and prostitution for the next forty years or so. It is essential to look at the British acts before turning to the situation in Queensland.

In Britain, the Crimean War stimulated official interest in venereal diseases when these were reported to have depleted troop strengths almost as much as tuberculosis and dysentery.\textsuperscript{57} Prior to this date, few physicians suggested venereal diseases had any social consequences. In the early 1860s a large outbreak of venereal disease occurred in the home army as troops from India, where the problem was severe, returned home after the suppression of the Indian Mutiny.\textsuperscript{58} In colonial India, sexually transmissible diseases always threatened to deprive the British army of many of the rank and file (and all diseases killed more men than war). More than thirty percent of European troops were hospitalised at any one time because of venereal diseases, making control of these a strategic as well as a medical imperative. The unfortunate soldier was portrayed as the innocent victim of Indian prostitutes, women of low caste, unable to control their sexuality, even acceptant of genital examination with nonchalance.\textsuperscript{59} Equally, in Britain in 1862, a third of the British Army rank and file was hospitalized for venereal diseases. A number of solutions were tried, including the provision of improved leisure facilities, education, regimental libraries, punishment etc. to control or prevent the problem, but the

\textsuperscript{57} Davenport-Hines. *Sex, Death and Punishment* 1990 pp 156-209.


ultimate solution was legislation, in the form of the *Contagious Diseases Acts* of 1864, 1866 and 1869. The term contagious disease was adopted directly from the *Contagious Diseases (Animals) Act*. It has been suggested that opinions about the eradication of cattle diseases directly shaped many of the opinions about venereal diseases in prostitutes.\(^{60}\) While those who supported the Contagious Diseases legislation—the government, the medical profession and the military—argued the legislation was an important public health measure, opponents did not agree. In brief, the act of 1864 attempted to control venereal disease through the control of female prostitution. The act was only to be enforced in proclaimed garrison and naval towns and was designed to be limited to a period of three years. On the sworn evidence of a superintendent of police, a woman believed to be a common prostitute (the descriptive adjective is never explained) who lived within five miles of a military facility could be committed for examination by a military surgeon, and if found diseased, she could then be incarcerated in a special hospital for up to three months for treatment. The act was passed late at night, in a thinly populated House, after little debate. An amending act in 1866 extended the life of the first act; it. This amending act also allowed the magistrate to order fortnightly, rather than monthly, inspections of women, and permitted detention in a lock hospital for up to 6 months. Moral and religious instruction was also to be provided in the lock hospitals. William Ewart Gladstone, then the Chancellor of the Exchequer, and a man who had taken an unusual interest in prostitutes,\(^{61}\) supposedly thought the 1866 act applied to

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animals.\textsuperscript{62} A select committee of the House of Lords, set up in 1868 and loaded with supporters of the acts, argued that these had been a success from both a moral and sanitary point of view. It recommended extending the range of the act from five to fifteen miles, and detention for up to nine months. Pressure from the Association for the Extension of the Contagious Diseases Acts, a group founded in 1868, and backed by powerful establishment figures in Britain, including the Royal Colleges of Physicians and Surgeons, bishops, army and naval authorities and most of the Members of Parliament in the Conservative Party, ensured the successful passage of the amended legislation through the House of Commons in 1869.\textsuperscript{63} This amending act included the recommendations of the Select Committee.

Concurrently, a campaign against the CD acts started to take shape and gain support. It was the nexus between disease and female prostitution which would make the CD acts, not only in Britain but also in many of the colonies, a passionately debated subject.

\textbf{4.7.1 The Queensland Contagious Diseases Act}

Most colonial jurisdictions passed Contagious Diseases Acts, sometimes even in advance of the British Acts. In British India, the Bengal Government sanctioned the establishment of lock hospitals for the treatment of women at stations of the Bengal


Army in 1807, an experiment ceasing in 1830, probably for financial reasons, though the government claimed they had failed in their purpose.\textsuperscript{64} Apart from the situation in India, colonial legislation tended to focus more on the civilian population than the military. Those colonies that did not pass such acts were generally small, recently acquired, or possessing only small European populations.\textsuperscript{65} New South Wales\textsuperscript{66} and Victoria stand out as important exceptions to the rule, though Victoria did, in 1878 pass a Public Health Conservation Act, one aspect of which was an ineffective attempt to compel female prostitutes to undergo medical treatment.\textsuperscript{67}

The first attempt to introduce a \textit{Contagious Diseases Act} (CD) into Queensland was made in May 1867 in the Legislative Council. The Hon. Western Wood said the act passed in England had been sent by the Secretary of State to the Governors of the different colonies with a request they induce their government to bring in similar bills. (This was not correct. The suggestion came from the Senior Medical Officer of the British Army Medical Department based in Melbourne, who in April 1867 asked Brigadier-General George Carey to persuade Governor George Bowen, and other colonial governors, to introduce the measure.\textsuperscript{68} Bowen put the proposal to the members of his Executive

\begin{itemize}
\item \textsuperscript{64}Peers. Soldiers, Surgeons and the Campaigns to control Sexually Transmitted Diseases in Colonial India \textit{Medical History} vol 42, 1998, pp 137-160.
\item \textsuperscript{66}In April 1875, a Contagious Diseases bill was introduced into the New South Wales parliament, but it failed to move beyond its second reading.
\item \textsuperscript{67}Serle. \textit{The Rush to be Rich} 1971, p 168.
\item \textsuperscript{68}Q.S.A. GOV/A2, Governor’s Letterbook. Letter from Brigadier General Commanding Troops in the Australian Colonies, and copy of a letter from Surgeon-Major A.E. Carte of 20 March, 1867, p 129.
\end{itemize}
Council, who, though lukewarm about it, did as he asked.\textsuperscript{69}) It is not clear why Bowen went along with the request. He was not a military man, but neither were Sir John Young in New South Wales, nor Sir John Manners-Sutton in Victoria. It was not loyalty to a military ethic that persuaded Bowen’s Executive Council to introduce the legislation. Parliament unfortunately was prorogued a week later and the bill lapsed. At his second attempt, in October, Wood again had to withdraw his bill as it contained financial implications and by convention, the Council did not introduce bills with financial implications. But Charles Lilley, the Attorney General, lost no time in introducing the bill to the Legislative Assembly, where it immediately caused uproar. The legislation was copied almost word for word from the British act of 1864, though much shorter than the original. The powers of the act pertaining to the police were: if an inspector or other officer of police laid information on oath before a justice of the peace that a woman was a common prostitute and resident within a proclaimed town, the justice was empowered to order the woman to undergo a medical examination by the visiting surgeon in order to ascertain whether she was suffering from a contagious disease. If she was found to be infected, the surgeon would sign a certificate naming the hospital in which she was to be treated. Duplicates of the certificate were to be given to the female and to the chief of police in the town. If she failed to attend the hospital, then a constable, acting under the orders of the chief police officer, could arrest her and take her to the hospital. If any female subjected to an order from a justice refused, or absented herself, or quit the hospital without a certificate, she would be guilty of an offence under the act, and for leaving the hospital without a certificate, she could be taken into custody without warrant.

\textsuperscript{69} Q.S.A. EXE/D33, 24 April, 1867, Governor lays Carte’s letter before Executive Council.
by any constable. If a woman left hospital with a certificate which said she was not cured of a contagious disease and conducted herself as a common prostitute, she could be imprisoned for up to one month for the first offence, and up to three months for each subsequent offence.

Clearly, the act gave great powers to the police to control prostitution and, indirectly, to control women. As Mary Spongberg has said, ‘the sexualized body of prostitutes was viewed as a health problem, in much the same way as a cesspool or badly planned sewer.’ Objections to the act in the parliament generally did not involve the role of the police. The very idea of such a bill outraged the member for Maryborough, Mr. H. Walsh, who objected that it would legalize prostitution and assist those who supported it.

The first reading of a new bill in the Assembly is to alert members to the broad substance of the bill, debate is reserved for the second reading, by which time the members have had time to read and assimilate the contents of the bill. At the second reading, five days later, Walsh said if the thrust of the bill was limited to the neighbourhood of the barracks, he might withdraw some of his objections but if it were made general in its application, it would become merely a measure for the protection of prostitution. He thought the proposed act was un-English, indecent, unnecessary, and in its character, unworthy of Englishmen. More than that, he looked with horror on the Englishman who would consent to become a (medical) officer under such a measure, who would so far forget his

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manhood and his country as to take the odious, the frightful office for which provision was made in it.\textsuperscript{71}

Two medical members of the Assembly, Drs Kevin I. O’Doherty and Henry Challinor supported the bill. O’Doherty thought the outrage was misplaced.\textsuperscript{72} He talked fervently about ‘as frightful a form of venereal disease as there was in the world, stalking abroad among those unfortunate females, unseen and unknown to those who had dealings with them.’ It was, he said, ‘a quite dreadful form of the disease, though it was quite possible to be cured,’ while ‘those unfortunate women were walking centres of the most frightful disease to which the human body could be subject’. As a result there were a number of young men in Brisbane with the disease, and not only would it never leave them, but it would affect their children and their children’s children. (Now, there was no more talk of cures, as far as the unfortunate male victims were concerned.) Challinor\textsuperscript{73} said the purpose of the bill was for the protection of the innocent, to prevent the dissemination of the disease (no one spoke the names of this shameful disease) rather than the control of prostitution. He recognized the legislature had, on occasions, to interfere with personal liberty, and this was such a case. Furthermore, the English act had been found to have a moral benefit, and the same would surely apply in Brisbane—despite the fact the act did not include specific instruction to provide moral education to the women. Challinor worried the certificate of cure given to those lucky enough to be cured of the evil might be converted into a licence. But the Queensland act stated the certificate would not be

\textsuperscript{71} Q.P.D., 1867, p 420.

\textsuperscript{72} Q.P.D. 1867, p 471.

\textsuperscript{73} Q.P.D. 1867, p 471 passim.
given to the individual, but to the police, so the woman who wished to pursue a course of vice would not have the certificate to exhibit. Only A. M. Francis, the member for East Moreton, thought a measure such as this was liable to great abuse. It would, he opined, legalise vice, and expose an unfortunate portion of the community to the exercise of a species of tyranny.

In reply, Lilley said he thought the act would diminish prostitution. He had sought the opinion of the local clergymen on the subject, and found them all fully supportive. The proposed act was not, he said, opposed to the moral sense of the community. ‘The consequences of the disease’, he said, ‘as they descended from generation to generation were of so dreadful a nature and were so fearful to contemplate, that no one should hesitate to pass the bill.’ Instead of the bill providing a licence for prostitution, he thought, conversely, it would act to prevent it. ‘When those females who followed the profession of prostitution – and it was a profession – knew they were under police surveillance, for this was purely a police measure, (my italics) he ventured to say there would be fewer of them to be found upon the streets.’

The best argued case against the bill came from Joshua Bell, the conservative member for West Moreton, who said he intended to oppose the bill all the way. He believed women were the victims of the men, not the other way around, and thought there should be provision in the bill for dealing with men as well as women. He did not think it ‘fair that females should have the whole of the legislation hurled against them’ while the men got

74 Q.P.D., 15 October, 1867 p 473.
away scot-free. He also believed fear of infection was a powerful prophylactic and worried that the act might remove that prophylactic fear. Walsh, having had time to collect his thoughts, thought the bill would legalise vice, and thereby expose an unfortunate portion of the community to the exercise of a species of tyranny. In the Legislative Council, in January 1868, Albert Norton said he would object to the bill, as it would not lessen the crime of prostitution in females, nor would it remedy any of the injurious effects of the social evil, but rather would encourage licentiousness, since it would give knowledge of less danger of contagion. Wood repeated his claim he was merely trying to prevent an infectious disease, while the Hon. G. R. Gore thought if the British House of Lords, with a full bench of Bishops, including the Bishop of Oxford, were unanimous in its favour, there could be little reason to oppose the Queensland bill on religious grounds.

Despite a careful search, there is no evidence available in the records held at the Queensland State Archives that Police Commissioner Seymour was ever asked for his opinion on the proposed bill.

The bill passed and became law in February 1868. In contrast to the British act, the Queensland law did not apply to garrison or dockyard towns, but to proclaimed towns, and thus had a wider reach than the British act. Nevertheless, the act did not apply to the entire colony and that proved to be an important limitation. Brisbane was the first town

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75 Samuel Wilberforce, son of William, best known for his opposition to Charles Darwin.

76 Q.P.D., 15 January, 1868, p 855.
to be proclaimed, in July 1868, followed by Rockhampton and Maryborough in 1869 and Cooktown in 1876. The suburb of Rockhampton North was proclaimed in 1881. In 1899 the Mackay Town Council asked to be proclaimed under the act. Here there had been an influx of Japanese women, though Commissioner W. E. Parry-Okeden thought ‘coloured aliens needed a suitable outlet for their sexual passions, and the supply by Japanese women for the Kanaka demand is less revolting and degrading than if provided by white women.’ The police favoured the proclamation, while Chief Inspector Stuart thought the act should be extended to all towns with a health officer. The Central Board of Health recommended the act should be extended, not only to Mackay, but to all seaports and any towns where alleged Japanese prostitutes congregated, but nothing came of these recommendations. At the same time, the police saw no necessity to extend the act to Childers, where a significant number of Pacific Islanders dwelled. Shortly after, the Townsville authorities also asked to be proclaimed under the act, after the Government Medical Officer had noted adversely the rising incidence of syphilis and allied diseases in the town. Despite seeking for a site, and drawing up plans for a lock

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77 David C.S. Sissons. Karayuki-San: Japanese Prostitutes in Australia. *Historical Studies* vol 17, 1977, pp 323-341. Australia was opened to limited Japanese immigration after the passing of the Treaty of Commerce and Navigation signed between Great Britain and Japan in 1894; there was much opposition from colonial governments, but reassurances from the Japanese government that no excessive immigration would be allowed paved the way. Q.S.A. PRE/102 includes a letter from the Townsville Presbytery to the Colonial Secretary drawing attention to the large number of Japanese women arriving in North Queensland for “immoral purposes”. In-letter 08158, 21 June, 1897. POL/J1 contains numerous reports on the presence of Japanese alleged prostitutes in northern towns.

78 Q.S.A. HOM/A24, unnumbered memorandum 23 March, 1899.

79 Q.S.A. HOM/J80, unnumbered and undated memorandum.

80 Q.S.A. HOM/B3, in-letter 8735 to Home Secretary, 6 June, 1899.

81 Q.S.A. HOM B3, in-letter to Home Secretary, 2 October, 1899 What factors were considered when making these determinations is unclear.
hospital, nothing further eventuated. Despite some initial administrative consideration, this request was also rejected. The reasons for these failures are not stated but it seems likely costs (of medical officer and construction of Lock Hospital), coupled with opposition from the local citizens, contributed.\(^{82}\) It was pointed out in the Legislative Assembly as early as 1869 that the act led to rising costs (in Rockhampton, the medical officer’s salary had risen from £90 to £200 as a consequence of the provisions of the act being extended to the town.)\(^{83}\)

Within a short time the British garrison of Queensland was to be reduced to only a single company, and would be completely withdrawn by early 1869.\(^ {84}\) As a solution to venereal diseases in the military, the act was irrelevant. Mackay, in 1906, and Bundaberg, in the following years asked to be proclaimed under the act, but again, the request was refused. Other towns with potential problems of venereal disease, such as mining towns like Maytown, were never considered for proclamation, presumably because of the problems of finding medical officers willing and able to undertake the required examinations.

Like the British act, the Queensland act gave powers to the police to report a woman to the police magistrate on suspicion of being a common prostitute. If the suspicion was confirmed she could be taken to ‘a special place’ and there be examined by a government medical officer, and if found to be suffering from a venereal disease, was to be held in ‘a

\(^{82}\) Q.S.A. HOM/J80, unnumbered and undated memorandum. See also HOM/J80, in-letter 13363 from Inspector Douglas to Commissioner Parry-Okeden, complaining of the proposal to site a lock hospital in Townsville in the old gaol, where it would be close to his quarters, and therefore objectionable to his wife.

\(^{83}\) Q.P.D., 30 March, 1869, p 249.

\(^{84}\) Q.S.A. GOV/35, Despatch to Earl Glanville, 28 January, 1870.
special place’ and treated for periods of up to three months, or longer if the chief medical officer of the hospital and the visiting surgeon both certified her continued detention was necessary. The special place was to be a special hospital, called a Lock Hospital, to be set up in each proclaimed town for the incarceration of infected prostitutes from within the proclaimed town.

4.8 Lock hospitals

The origin of the word Lock, for a venereal diseases hospital, is uncertain. According to one author a leper hospital called Les Loques (derived from the French word for rags) existed at Kingsland on the northern approach to the City of London since the thirteenth century. This was run by the governors of St. Bartholomew’s hospital. As leper houses became redundant with the decline in cases of the disease, those in need of mercury treatment for the French Disease were transferred to this facility, now known as Kingsland Lock (or Loke). A similar establishment was run by St. Thomas’ hospital in Southwark.85 In 1746, a new Lock Hospital was established in London.86

In September 1868, Hobbs, the Government Medical Officer for Brisbane, (and therefore responsible for the medical component of the Contagious Diseases Act), informed the Colonial Secretary that, after many unavoidable delays, he had commenced his duties. He explained that women charged under the act were initially examined on Saturday

85 Benjamin Golding. An Historical Account of St. Thomas’s Hospital, Southwark. : Longman, Hurst, Rees, Orme & Browne, Pater-Noster Row, London 1819, p 133.

afternoons at the Central Police Office, in a room set apart for that purpose and furnished with screens to secure as much privacy as possible. He complained that the limited accommodation available at the General Hospital for women being treated under the act was inadequate, and the following month the Colonial Secretary agreed to erect an additional nine bedded ward, the Brisbane Lock Hospital, for these patients. By 1879, the number of beds had increased to twenty. In 1886, following complaints that the women held in the hospital were out of control, the government approved regulations for the Brisbane Lock Hospital. Section 32 of the regulations provided for inmates to be kept in solitary confinement, to be kept at hard labour, or to be deprived of food, indulgences or comforts for breaches of the regulations. Despite the regulations the police complained in 1891 the place was not a lock hospital— they apparently assumed the term ‘lock’ was synonymous with ‘lock up’—as there was no fence to keep in the women whenever they chose to leave. In 1897 the police again complained to the Commissioner that the gate of the Lock Hospital was continually left open, leading to escapes and consequently extra work for the police. Parry-Okeden asked that the matter be brought under the Minister’s notice, adding that the lock hospital should certainly be under police control. This, however, did not eventuate. In 1893, a ‘registered prostitute’ absconded from the Lock Hospital. She was married by the Rev. James Stewart to a South Sea Islander, an event leading to a police investigation. Stewart, it was claimed,

87 Q.S.A. COL/A111, in-letter 2872 to Colonial Secretary, 10 September , 1868.
88 Q.S.A. COL/Q5, out-letter 68/657 from Colonial Secretary 5 October, 1868.
89 Q.S.A. POL/J35, from Sergeant Taylor to Sub-Inspector of Police at the Roma Street Police Station, 8 August, 1891.
90 Q.S.A. POL/J35, to Chief Inspector Stuart, in-letters 08378 July 28, 1891, 08946,8 August, 1891 and 12211, 15 October, 1897.
had officiated at the marriage of at least seven common prostitutes. When interrogated, the woman said she thought, incorrectly, that by so doing she would be freed from attending for medical examination. Stewart promised to be more careful in future.\textsuperscript{91}

The police were aware of ambiguities in the act. In 1891 Sergeant Taylor pointed out that a woman given a certificate to go to the hospital could not be taken there by the police unless she refused to go, in which case she was allowed her liberty, and sometimes that liberty was abused. Commissioner Seymour noted that since no period of time for her to go to the Lock was stated in the act, if not admitted to hospital on the same day, she should be taken by force. The police however were aware that many women knew they could not be taken to the Lock Hospital without a warrant.\textsuperscript{92}

The Lock Ward eventually became part of the Brisbane Hospital, but inmates still escaped. In 1900, a new Lock Hospital was built on the gaol reserve in Boggo Road, South Brisbane. After its completion, the building was used as a Reception House for the insane, until a new Reception House was built in 1902. Dr Elspeth Dods, then the Brisbane Government Medical Officer urged the need for opening the new Lock, as the old one, in the grounds of the Brisbane Hospital, was ‘pervious to rain’ and its fence was falling to pieces. He pointed out that since January 1901, twenty-eight women had escaped from the place, and eight in August 1902. He thought it more sensible to

\textsuperscript{91} Q.S.A. COL/A754, in-letter 09598, 19 August, 1893, to Colonial Secretary, and subsequent letters.

\textsuperscript{92} Q.S.A. POL/J35, in-letter to Commissioner of Police, 11 November, 1891.
improve the Lock. The new Lock Hospital was opened in June 1903, and closed in September 1911 after the rescission of the *Contagious Diseases Act* in Brisbane.

Like the Asylums for the Insane, the Lock Hospitals were a charge on the government, which paid for the buildings, paid the salary of the wardswomen, paid half the salary of the Lock doctor and the dispenser, and gave the hospital authorities three shillings per day for each in-patient.

An outpatient clinic was established in Countess Street, Springhill, where, every Thursday, the Government Medical Officer examined women registered under the *Contagious Diseases Act*. A police constable was responsible for the running and maintenance of this clinic. He employed a poor woman every three months to scrub and wash the rooms, closets, verandas and seats, for which he paid the woman five shillings. In the intervening weeks he or his assistant swept the floors and dusted the building.

The *Contagious Disease Act* required the establishment of Lock Hospitals in proclaimed towns. In March 1869, the Rockhampton authorities received £100 from the Colonial Secretary to convert the old Rockhampton Hospital into a Lock. This hospital appears

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93 Q.S.A. COL 360, in-letter 13092 to Colonial Secretary, 22 August, 1902.

94 Though G.M.Os did the clinical examinations, for which he received no extra remuneration, a hospital doctor was also responsible for the management of the women held in the wards.

95 Q.S.A. COL/A306, in-letter 386 to Colonial Secretary, 25 January, 1881.

96 Q.S.A. A45367, a number of letters dealing with the management of the Countess Street rooms.

97 Q.S.A. COL/A120, in-letter 69/1058 to Colonial Secretary 15 March, 1869. In 1881, a new Lock Hospital was built in Rockhampton in the grounds of the District Hospital. (COL/A306, in-letter 386 to
to have been quite busy, admitting, in the first quarter of 1871, eleven women\textsuperscript{98} and in the three months ending in December 1879, nine women.\textsuperscript{99} A similar hospital was built in Maryborough, but was little used. The annual report of the Maryborough Lock for 1879 noted there were four women on the police list (of prostitutes) and during the year, three women had been admitted to the Lock, all for ‘vaginal discharges.’\textsuperscript{100} Hobbs recommended that this hospital be closed and patients treated in the Maryborough hospital.\textsuperscript{101}

It seems likely that women suffering from venereal diseases could be admitted on a voluntary basis to the various Lock Hospitals. The medical officer in charge of the Rockhampton Lock noted in 1871 the admission, ‘at the request of ladies of the Benevolent Society’, of a 41 year old woman suffering from long standing secondary syphilis, who subsequently died in the hospital.\textsuperscript{102}

Once the problem of the venereal among the Aborigines —discussed in section 4.11— had caught the attention of the authorities the question of a Lock Hospital for this population was raised. In 1906, the Superintendent of the Barambah Aboriginal Reserve

\textsuperscript{98} Q.S.A. COL/A155, in-letter 1005 and report to Colonial Secretary, 6 April, 1871.

\textsuperscript{99} Q.S.A. COL/ A289, In-letter 530 to Colonial Secretary, 10 January, 1880.

\textsuperscript{100} ‘Vaginal discharges’ may be physiological or pathological. In the absence of bacteriological investigations it is difficult to separate the two categories. Clearly, syphilis was not a problem in Maryborough.

\textsuperscript{101} Q.S.A. COL/A289, in-letter 530 to Colonial Secretary, 10 January, 1880.

\textsuperscript{102} Q.S.A. COL/A155, in-letter 1005 to Colonial Secretary, 6 April, 1871.
recorded a number of Aborigines suffering from venereal diseases, especially syphilis. The Chief Protector of Aborigines ordered the building of a camp ‘at a distance from all other natives’ and ‘the erection of a large slab hut to be known as The Hospital. He suggested a building, surrounded by several strands of barbed wire and having a lockable gate, ten by twenty feet would be adequate for patients suffering from venereal disease.  

In 1913, the secretary of the Normanton Hospital, which claimed to be at the centre of an Indigenous epidemic of venereal disease, suggested the need for a Central Lock Hospital (and extra funds). The funds failed to arrive, but the idea of a Lock for the Aboriginal population received serious consideration. An unnumbered government memorandum from 1913 said a Central Lock had been under consideration on several occasions, and there was a current proposal to establish one on Fraser Island. There would be no provision for a medical superintendent, but a visiting medical officer would be appointed. The Chief Protector of Aborigines estimated there were about two hundred cases eligible for admission, while the Health authorities estimated three hundred and fifty.  

The following year a plan was devised to build a lock on Fitzroy Island, off the coast of Cairns, but the plan was abandoned with the outbreak of the First World War. In 1928, a Lock Hospital for Aboriginal patients opened on Fantome Island. 

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103 Q.S.A. A/58676, out-letter 06/1863 from Chief Protector of Aborigines J. Howard to Superintendent at Barambah, 8 December, 1906.

104 Q.S.A. SRS1043/1/228, un numbered memorandum 18 June, 1913. Neither of these estimates was based on any sound epidemiologic investigation.

105 In 1901, Archibald Meston, had suggested building a sanatorium on Fitzroy, but nothing came of this. (Q.S.A. HOM/J in-letter 12785 to Home Secretary, 12 August, 1901. The island was also used as a penal station by the managers of the Yarrabah Mission and for an Aboriginal Hospital (Q.S.A. HOM/J162, out-letter 07536 from Postmaster- General’s Department, Commonwealth of Australia to Dr B. Tyrie, G.M.O at Cairns, 15 June, 1911.

The Police Gazette, published monthly at first, but later weekly, gives details of people about to be released from Queensland jails, their offences, the place of trial and the length of sentence. From about 1875, offences under the *Contagious Diseases Act* led to the imprisonment of an increasing number of women. Such offences included escaping from the Lock hospital and refusing to undergo medical examination, which carried penalties ranging from two weeks to one month for a first offence, with increasing penalties for subsequent offences (Table 1). The majority of women imprisoned under the act came from Brisbane. Rockhampton dealt with fewer than ten, while Cooktown and Maryborough appear to have ignored this aspect of the act.

**Table 4.1**

Women discharged from prison for offences under the *Contagious Diseases Act*

<table>
<thead>
<tr>
<th>Years</th>
<th>Number of women</th>
</tr>
</thead>
<tbody>
<tr>
<td>1870-74</td>
<td>5</td>
</tr>
<tr>
<td>1875-79</td>
<td>19</td>
</tr>
<tr>
<td>1880-84</td>
<td>35</td>
</tr>
<tr>
<td>1885-89</td>
<td>44</td>
</tr>
<tr>
<td>1890-94</td>
<td>35</td>
</tr>
<tr>
<td>1895-99</td>
<td>39</td>
</tr>
<tr>
<td>1900-04</td>
<td>84</td>
</tr>
<tr>
<td>1905-09</td>
<td>42</td>
</tr>
</tbody>
</table>

Few women were incarcerated under the act compared with the numbers incarcerated for drunkenness, obscene language and indecent exposure, as reported in the annual reports.

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107 Parsons. Fantome Island Lock Hospital, 2008.
of the Commissioner of Police. A significant proportion was imprisoned on more than one occasion. The Police Gazette for 1902 reported that one woman discharged from prison for an offence under the CD act had thirty-six prior convictions, though it does not say whether these were all prostitution related, and her name does not appear in the prison discharge records. In 1909, only one woman was incarcerated for offences under the Contagious Diseases Act, and in the following two years, none were. The figures do not truly represent the ‘criminal’ status of these women. Between 1877 and 1909, 936 women were charged with offences under the Contagious Diseases Act, of whom only 20.9% were discharged by the courts, the others receiving cautions, fines and, a minority, imprisonment.

The police continued to be involved for many years. In 1919, the Health Department continued to send notices to the Brisbane city police for them to serve on women to attend the William Street (Venereal Diseases) Clinic. In his Annual Report for 1923, the Health Commissioner noted one hundred and fifty persons received warnings for failure to continue treatment for venereal diseases. The police interviewed one hundred and thirty of these. They could find no trace of forty-seven people. Eight had left Queensland, twenty-three had the required certificate, forty reported back to the clinic for treatment, and in twelve cases, enquiries were still continuing. The exercise involved a considerable amount of work. Effectiveness of the act, in the eyes of the police and the

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medical profession, depended on its ability to keep prostitutes ‘clean for hire’. The focus of the act was clearly on both prostitution and disease, because both were intimately linked in official eyes. However, the Queensland Police Manual of 1876 stated a woman could not be taken into custody just because she was a prostitute. The police had no power to interfere with men and women talking together in the streets, therefore a woman had to commit some offence in order to be arrested. Soliciting for paid sex was such an offence. This was an exact copy of an order of 1869 from the Chief Commissioner of Metropolitan Police Sir Edmund Henderson in England. The Queensland manual also said a general register of common women was to be kept, and sergeants and constables on the beat were to be provided with pocket registers that would contain a complete list of all common women. Evidently there was a difference between a common prostitute and a common woman. A Police Magistrate wrote to the Colonial Secretary in 1882 of a woman who was ‘of bad character, but not a common prostitute’ who was suffering from syphilis, and asking for permission, which was granted, to send her to the Rockhampton Lock Hospital ‘as a pauper.’

The Brisbane Courier had little to say on the subject of the act, but did publish letters supporting and opposing the act. A Citizen (sic) thought the bill should properly be called a ‘Bill for the Encouragement of Dissipation, and for the Protection of Debauchery’.

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113 Q.S.A. COL/A337, in-letter 2714 to Colonial Secretary, 15 May, 1882.
The action of the bill would be that accommodation for the patrons of brothels would be kept clean, so that they could ‘violate every moral and social law with safety, while they wallow like swine in animal indulgences and gratify their craving for the seduction of more innocent creatures of the weaker sex.’\textsuperscript{114} A.B.C. (sic), though he would have preferred a system of licensing of prostitutes, as in some European countries, recognized the legislature had a duty to prevent the many virulent diseases associated with prostitution. An anonymous correspondent, denying the role that fear of infection may have in preventing vice, wrote, ‘the worm that never dies, and the fire that never shall be quenched are awful realities, yet the fear of enduring such torments does not operate to keep men from sinning; nor is the virtue worthy the name that is to be distinguished by the fear of consequences.’\textsuperscript{115} In August 1870, two years after Brisbane was proclaimed under the CD Act, an anonymous correspondent, G, wrote: the ‘great sin stands bold and defiant in our midst.’ G recognized the association between vice and intemperance in respect to intoxicating liquors, but also blamed the act for legalizing sin. He begged for a society such as existed in Victoria, for the promotion of morality, the dissemination of pure literature, and the suppression of books of an immoral tendency.\textsuperscript{116}

The act gave great power to the police, yet during the colonial years, neither Commissioner (Seymour and Parry-Okeden), in annual reports to the Legislative Assembly, ever commented on the workings of the act, or gave statistics. The police kept

\textsuperscript{114} Brisbane Courier, 22 October, 1867.

\textsuperscript{115} Brisbane Courier, 23 October, 1867.

\textsuperscript{116} Brisbane Courier, 30 August, 1870.
a register of common prostitutes, presumably those who had been arrested at some point in time. Despite a diligent search I have been unable to find this register in the State Archives. Whether a name was ever removed from the register is unclear.

In summary, the role of the police in proclaimed towns was to arrest women they suspected might be common prostitutes and take them to a Government Medical Officer. If the G.M.O. diagnosed a venereal disease, the police were to take the women to a lock hospital. If they escaped from the lock, the police were to recapture them.

4.9 The Hobbs Report

In reply to a request from the Colonial Secretary of New South Wales in 1878 to John Douglas, his counterpart in Queensland, for his views on the working of the Queensland Contagious Diseases Act, Jordan asked Hobbs to prepare a report, which was later tabled in parliament. With increasing immigration from 1864 onwards, in Hobbs’ opinion, ‘a large number of loose women ... landed in Brisbane, whose gross conduct and behaviour in the public streets in broad daylight betokened that they had come to the colony to earn their livelihood by prostitution’, though the figures he gives for the numbers of prostitutes on the police register do not suggest a ballooning problem. A grave deficiency of the act, in Hobbs’ opinion, was the clause demanding women be given two weeks’ notice by the police to attend for examination. The result was, Hobbs

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117 Q.S.A. COL/G7, from Colonial Secretary to Hobbs, 2 January, 1879

said, many women left Brisbane (and presumably, other proclaimed towns later on), either for towns that had not been proclaimed, or more commonly, for southern capitals.

**Fig 4.1 Dr William Hobbs** (John Oxley Library)

However, prostitutes did still visit Brisbane, especially on festive occasions, such as the National Exhibition, or race meetings. By avoiding the police, such visitors were capable of propagating the disease for a long time. Hobbs thought an amendment of the act should shorten this period. He claimed no innocent woman had ever been summoned to appear before the examining surgeon, showing ‘with what care and prudence the police carried out their delicate duty’. Hobbs repeated the adage about syphilis being dangerous even to the third and fourth generations, and then challenged opponents of the act. It had
been argued, he said, that the act made vice easy, sin safe and thereby increased licentiousness. The real effects of the act were to control vice, disarm its baneful effects and protect the innocent offspring from inheriting the disease contracted by the vicious indulgence of its parents. Hobbs finished by commending the actions of the Queensland government and stressed the need for the other Australian colonies to follow Queensland’s lead.

In his report, Hobbs noted that in 1868 77 prostitutes lived in Brisbane, for a population of 14,265, i.e. one prostitute to 185 people. By 1878, the number had increased to 114 prostitutes, when the population had increased to 24,608, or almost one to 216 people. This was, in Hobbs’ opinion, satisfactory evidence of the success of the act in reducing the vice. Hobbs ignored the fact the years 1866 to 1870 were years of economic depression, while 1878 was a year of boom. Prostitution is a market institution, used by women with no other viable occupational choices,\(^\text{119}\) which is also more likely to flourish in communities with significant gender imbalance, as Queensland was at the time. Regrettably, Hobbs says nothing about the ages of the women. In New South Wales, it had been earlier reported that a third of the Sydney prostitutes were children, with a significant number aged nine to twelve years.\(^\text{120}\) No official specifically mentions children, but the area of childhood sexuality was one of considerable ambivalence. Hobbs also quoted admission figures to the Brisbane Lock Hospital, and gave the numbers affected by venereal diseases (table 4.2). Diagnosis was clinical, depending


upon the presence of a hard chancre, or generalized skin eruptions with or without enlarged glands in a person with a history or clinical evidence of a hard chancre.

It would be almost thirty years before the Wasserman test was introduced and reduced some of the diagnostic confusion about the causes of genital ulceration. No reliable conclusions about the effectiveness of the CD act can be obtained from Hobbs’ data, but clearly women were admitted to the Lock who did not suffer from venereal disease.

A good diagnostician could probably diagnose primary and early secondary syphilis without too much difficulty and with a reasonable degree of accuracy. Gonorrhoea in women is often clinically silent. Diagnosis depends on bacteriology, which was not then available. Clearly, gonorrhoea in women would have been grossly underestimated. Other clinical syndromes, such as genital herpes infection, or venereal warts, now understood to be sexually transmissible infections, would most likely have been ignored.

Table 4.2

<table>
<thead>
<tr>
<th>Year</th>
<th>No. on Police Register</th>
<th>No. admitted*</th>
<th>No. with syphilis**</th>
</tr>
</thead>
<tbody>
<tr>
<td>1869</td>
<td>74</td>
<td>105</td>
<td>9 (8.6%)</td>
</tr>
<tr>
<td>1870</td>
<td>65</td>
<td>59</td>
<td>7 (11.9%)</td>
</tr>
<tr>
<td>1871</td>
<td>67</td>
<td>35</td>
<td>4 (11.5%)</td>
</tr>
<tr>
<td>1872</td>
<td>70</td>
<td>46</td>
<td>0</td>
</tr>
<tr>
<td>1873</td>
<td>76</td>
<td>49</td>
<td>0</td>
</tr>
<tr>
<td>1874</td>
<td>85</td>
<td>58</td>
<td>9 (14%)</td>
</tr>
<tr>
<td>1875</td>
<td>87</td>
<td>71</td>
<td>13 (18.3%)</td>
</tr>
<tr>
<td>1876</td>
<td>92</td>
<td>90</td>
<td>8 (8.9%)</td>
</tr>
<tr>
<td>1877</td>
<td>115</td>
<td>109</td>
<td>19 (17.4%)</td>
</tr>
<tr>
<td>1878</td>
<td>114</td>
<td>109</td>
<td>16 (14.7%)</td>
</tr>
</tbody>
</table>

* Some women were readmitted several times in the same year
** The diagnostic category includes Syphilis, ulcers and eruptions.
4.10 Opposition to the Contagious Diseases Acts

Opposition to the British *Contagious Diseases Acts* started during a meeting of the Social Science Congress in Bristol in late 1869, at which the National Association for the Repeal of the Contagious Diseases Acts was launched. Feminists led by Elizabeth Wolstenholme and Josephine Butler soon after formed the Ladies National Association. On New Year’s Day 1870, their first manifesto was published making eight specific charges against the acts and demanding repeal. The charges being that the acts were passed in secret, they changed the legal protection previously afforded to women, the offence was not clearly defined, the laws punished only one sex for vice, the ‘path to evil’ was made easy, the implementation of the laws was cruel and degrading, the acts would not remove disease, but rather tended to increase it and the cure was moral, not physical. A long and bitterly fought campaign led, first, to suspension of the acts in 1883, then their repeal in 1886. In the spring and summer of the following year, Sir Henry Holland, the British Colonial Secretary, instructed most colonial possessions to repeal their CD acts. India, Ceylon and the Straits colonies resisted, eventually gave way, but maintained some aspects of the system in a clandestine fashion. Uniquely, Queensland retained its law without compromise. Whether the function of the acts was to control disease, or control vice remained an uncertain point.

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Either way, it was sexualised women who bore the brunt of the force of the act, and it was this, especially, which galvanised opposition to the act.

The suspension of the British acts was noted in Queensland, but ignored by the politicians.\textsuperscript{124} The editor of \textit{The Telegraph} had no doubts the Queensland act was utterly alien to the sense of freedom and justice innate in English people.\textsuperscript{125}

Opposition to the Queensland act was slow to develop. The white population, by then just over one hundred thousand people, was predominantly (63\%) male, and less than 20\% of the white population lived in Brisbane. The first shot appears to have been fired by the \textit{Queensland Freeman}, a Baptist newspaper which in 1883 expressed the hope that as a result of a men only meeting, the \textit{Contagious Diseases Act} would be blotted from the Statute Book,\textsuperscript{126} a plea repeated eighteen months later.\textsuperscript{127} The \textit{Brisbane Courier} drew attention in 1884 to the pitiful wages young girls starting out in employment received, and the often appalling work conditions they endured,\textsuperscript{128} with the obvious implication of descent into prostitution. In the same year, the Presbyterian General Assembly took up the issue of the Queensland Act. Rev. S. Robinson wrote to the \textit{Brisbane Courier} to bring to the attention of the public the rampant social evil on the streets of Brisbane to an extent unparalleled in any other English-speaking city (later it was generally said

\textsuperscript{124} \textit{The Telegraph}, 10 May, 1884.

\textsuperscript{125} \textit{The Telegraph}, 10 May, 1884.

\textsuperscript{126} \textit{The Queensland Freeman}, 16 April, 1883.

\textsuperscript{127} \textit{The Queensland Freeman}, 15 December, 1884.

\textsuperscript{128} \textit{Brisbane Courier}, 11 February, 1884.
Brisbane was not as bad as Sydney or Melbourne, but hyperbole was common. He suggested that one answer to the problem was for the ladies of Brisbane to visit the girls in their homes, to speak and plead with them on the streets, to be prepared to take a girl in temporarily and to raise funds. A Social Purity Society was formed. ‘The House of Commons has declared against the Act,’ Mr. E. Moons, the new honorary secretary of the society wrote, adding he hoped the Queensland legislature would follow suit.’

The Brisbane Courier, though a staunch supporter of the act, published a letter from Mrs E. Pottie of New South Wales, which strongly condemned the Queensland act based on the horrors of physical examination of women by male doctors, and the role of men in the transmission of venereal disease.

‘Do you know that there is a dark blot on the legislation of your land in the shape of the Contagious Diseases Acts? That these acts operate on women only, and that they are the means of degrading women who are already fallen, so that they sink lower and lower...women...are subject to a horrible examination at the hands of men, fortnightly, an examination so brutal in its nature that the very black women in a country where it has recently been the outcome of a victorious war on the part of the English, rather than submit to it at the hands of the doctors, were found lately in hundreds at the bottom of wells,, and at the foot of precipices ...yet this indignity girls by hundreds are regularly subjected to in your own city of Brisbane...And why? Yes, forsooth, why? That men, bad men, who break the laws of God and man may be protected against an evil—a dreadful evil— but an evil that these men do not scruple to destroy virtuous

129 The Telegraph, 13 November, 1884.
women with, and for the cure of which your Government keeps open a special hospital.’

The letter set the tone for the hyperbole and exaggeration that would characterize debates over the act, by both abolitionists and non-abolitionists. The *Brisbane Courier* responded by saying the act was not intended to protect men from the consequences of indulging in vice, but rather to protect the health of the thousands and hundreds of thousands of children, who, but for the act, might be born with a taint of the disease. The editorial also set the tone for debate, because there remained great confusion about the exact function of the act. Was it to diminish prostitution, or to legalise it, or to make it safe for men to indulge their illicit passions? Was it purely a public health measure, as Lilley had suggested, designed to reduce the burden of disease on this and subsequent generations? The medical profession certainly thought it was. J. Ashburton Thompson, who later became President of the New South Wales Board of Health, wrote to point out the errors in Mrs Pottie’s letter. Supporting the position of the *Brisbane Courier*, he quoted English experience in favour of the acts. On one point was there certainty, especially, but not only, on the side of the abolitionists. The act was unfair to women. A ladies branch of the Social Purity movement was founded in Brisbane in 1884, which stressed that the one sided character of the act of itself rendered it a failure. The women also stressed that the act was clearly an attempt to frustrate one of ‘the laws of God’s immutable providence by which, awful and stern though it be, the path of the transgressor was made, in mercy as

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130 *Brisbane Courier*, 26 July, 1884.

131 *Brisbane Courier*, 6 August, 1884.
well as in judgment, hard and perilous. Christian ladies clearly perceived venereal diseases as a just and divine punishment for those who strayed from the straight and narrow path.

In November 1884 and again in October 1886, Henry Jordan, previously the Registrar-General of Queensland and a Wesleyan missionary, now the member of the Legislative Assembly for South Brisbane, introduced a motion to repeal the Contagious Diseases Act. On each occasion, the house divided equally, and twice the Speaker cast his vote with the ayes. Significantly, no one used Queensland Police statistics or information, though there is mention of one hundred common prostitutes being on the police register. At the conclusion of the 1886 debate the Premier, Sir Samuel Griffiths, said that since the vote was only carried by the casting vote of the Speaker in a thinly attended House (exactly as had happened in 1884), the government would not feel justified in acting on the resolution as the definite opinion of the House. He proposed, at the next session, to introduce a measure to better protect women and girls and to suppress brothels. Phillipa Levine insists that it was the racial arguments used by the premier in 1886 which prevented the act being repealed. ‘Does (Mr. Jordan) know how many black men in Australia and Polynesia there have been whose blood is upon our heads for allowing this disease to go among them? Does he know that nearly half of the black population of

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132 Brisbane Courier, 15 August, 1884.

133 For details of the debates, see Debates of the Queensland Legislative Assembly, 21 November, 1884, pp 1523 and onwards, and 1 October, 1886, from pp 1043.

134 Q.P.D., 11 November, 1884, and 1 October, 1886.

135 Levine, Prostitution, Race and Politics, 2003 p 101. Levine also states that the premier at the time was Sir Hugh Nelson. This is incorrect.
Australia has perished from it … it has affected the whole of the aboriginal population, or almost all of it, except in those parts of the colony where they have been free from contact with the whites, but where they have their deaths occur – 50 per cent of them – from that cause alone.’ The spectre of black venereal disease being transmitted to whites was an effective ploy against repeal, Levine believes. Yet a close reading of the debate suggests the racial issue was of little significance, and was referred to only by Mr. John Macfarlane, the member for Ipswich, who believed that if syphilis was as common among the blacks as the Premier said, then it was the more shame on the white men of the colony. Furthermore, the act applied only to proclaimed towns, and Aborigines with significant problems lived, not in these, but in the bush. The 1886 failure of the abolitionists occurred at the same time as, in Britain, the acts were repealed after a three-year suspension. Both sides in the Queensland debate knew this had happened, and used what little evidence there was of the effect of the suspension to bolster their case.

The *Brisbane Courier* supported retention of the Contagious Diseases Act, and also suggested, in line with the Premier, that ‘not one in a hundred probably knows more about the subject matter of the petition (to parliament in support of repeal) than about the internal politics of the republic of Guatemala.’ Sentimentality, not hard facts, the paper suggested, motivated opponents of the acts. No one denied syphilis was a problem, or that the scourge needed to be stamped out. Abolitionists focused especially on the hypocrisy of the double standard which condemned women but allowed men who used their services to remain blameless. Much was made of the danger of syphilis to unborn

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136*Brisbane Courier*, 2 October, 1886.
generations. ‘From generation to generation, even to the third or fourth, evidence of its existence may be seen in families…no other disease we know lies dormant for ten, fifteen or even thirty years and then manifests itself,’ Hobbs wrote in his 1879 report.137

In July 1887, Attorney-General Rutledge introduced a Criminal Law Amendment Bill, designed to raise the age of consent for a female from twelve to fourteen years. He believed the sum total of the ‘social evil’, prostitution, was augmented by reason of the comparative immunity from punishment ‘which persons have enjoyed who sought to overthrow the virtue of young and innocent girls.’ It would therefore be a felony to have illicit intercourse with a girl under the age of fourteen, and various punishments, with or without whipping, were suggested for the offence. Section 6 also made it a misdemeanour to unlawfully and carnally know a girl between the ages of fourteen and sixteen. The Attorney-General believed that, in Queensland, girls of comparatively tender age attained an amount of physical development which might lead a man to consider them older. This would be a reasonable defence if the girl was between fourteen and sixteen years of age. The amendment also made it a misdemeanour to procure women or girls for the purposes of prostitution, while keeping a house, or allowing a house, or letting a house, to be used for immoral purposes would also be an offence. The Brisbane Courier pointed out the proposed bill had nothing to say about the Contagious Diseases Act, which remained unchanged. The editor thought the clauses dealing with girls between the ages of fourteen and sixteen to be unworkable. ‘The sad fact must be

137 Report on the Working of ‘The Prevention of Contagious Diseases Act of 1868.’ The Hobbs Report. Syphilis may infect children, but such children are usually sickly and die young, without the opportunity to pass the disease down further generations, a point made by Mr.J. MacFarlane in the Legislative Assembly in October 1886, when he supported repeal of the act.
remembered that numerous girls embark on a professional dissolute career under the age
16. It is impossible to protect these girls from themselves by any act of Parliament.\textsuperscript{138}

Though Sir Henry Holland instructed the colonies to repeal their Contagious Diseases
laws in 1887, there is no evidence this message was received in Queensland,\textsuperscript{139} and the
Queensland government had no intention of so doing, having dealt with the objections of
Jordan and his repealers. In January 1887, Premier Griffiths travelled to London for a
Colonial Conference. It is possible that at some point in the proceedings, he told Holland
of the result of the Jordan amendment. It is also possible that, from Holland’s point of
view, Queensland, though large in area, was in population only a small part of the
empire. It was, moreover a loyal and supportive component of the empire, her people
had achieved responsible self-government, and her laws received the Royal Assent unless
they breached imperial or international laws. The repeal of the British acts was not
imperial legislation. The British government and the abolitionist lobby were powerless to
change the system in Queensland.

In 1907 a deputation of the Woman’s Christian Temperance Union met Premier William
Kidston to demand repeal of the Contagious Act. After listening to the delegates, he said
‘in the course of a guarded reply delivered almost in an undertone... that though he would
like the act to apply to both men and women, it would need forty or fifty women in

\textsuperscript{138} \textit{Brisbane Courier}, 27 July, 1887 The Criminal law was only amended in 1891 when an Act to make
better Provision for the Protection of Women and girls, and for other Purposes came onto the Statute Book.

\textsuperscript{139} A close look at Queensland State Archive material has failed to reveal any evidence of a despatch, or a
response to one, dealing with the CD act, during the period 1886-1888. GHR.
parliament to do so.\textsuperscript{140} There were no women in parliament at the time, women voting for the first time in a state election in May 1907.\textsuperscript{141} Over the course of the next four years, Women’s Associations, Temperance Societies, church groups and even some doctors made numerous efforts to force the repeal of the act, with success finally coming in 1911.\textsuperscript{142}

4.11 Venereal disease and Aboriginal populations

Believing the Aboriginal population faced extinction no doubt influenced colonial attitudes towards perceived venereal disease and prostitution in that population. Historian Raelene Frances has pointed out that wherever white colonizers intruded on Aboriginal lands, sexual contact, often violent and coercive, occurred between white men and Aboriginal women.\textsuperscript{143} The settler population also promoted alcohol abuse among Aboriginal women as it became a common commodity in return for sexual favours.\textsuperscript{144} In 1873, Sub–Inspector Douglas noted that a Mr. Gilder, ‘who acts as a doctor in St. Lawrence’ complained about the Aborigines being ordered out of town, as it deprived him of the income derived from treating men with venereal diseases contracted from

\begin{flushright}
\textsuperscript{140} \textit{Brisbane Courier}, 29 October, 1907.
\end{flushright}

\begin{flushright}
\textsuperscript{141} \textit{Brisbane Courier}, 18 May, 1907. The franchise was extended to women of 21 years or over in 1905.
\end{flushright}

\begin{flushright}
\textsuperscript{142} Dr Helen Shaw, who was offered a post of medical officer at the William Street Clinic in 1913 turned the offer down because she felt that the compulsion or regulation of prostitutes did not achieve what it set out to do; she considered regulation a danger since it encouraged clandestine prostitution, and created a false sense of security. Dr A. Jefferis Turner thought the main defect of the act was that it applied to such a small proportion of the possible carriers of infection. Both these may be seen at Q.S.A. HOM/J80.
\end{flushright}

\begin{flushright}
\textsuperscript{143} Frances. \textit{The History of Female Prostitution in Australia}. 1994 See also Henry Reynolds \textit{Nowhere People}, 2005, p 102.
\end{flushright}

\begin{flushright}
\textsuperscript{144} Lewis. \textit{A Rum State} 1992, pp152-153.
\end{flushright}
Aboriginal women.\textsuperscript{145} The Reverend Duncan Macnab noted in 1879 that, ‘frequently the whites seize the black gins and after keeping them for a few days let them go’.\textsuperscript{146} Sergeant P. Walsh noted in 1898 that, at Birdsville, the female Aboriginals in the district, as well as the town, were ‘utilized’ as prostitutes, by men of all nationalities.\textsuperscript{147} Another report for the Longreach police suggested ‘all the gins in the area are common prostitutes’.\textsuperscript{148} Sergeant I. Williams reported (Aboriginal) females could be found ‘knocking about’ travellers’ camps for purposes of prostitution; they used the money they made to buy opium.\textsuperscript{149} Other reports claimed the money made from prostitution was used to buy ‘spirituous liquors’\textsuperscript{150} A Mr. Purcell, concerned for the welfare of the Aborigines, claimed that hotel keepers in Western and Northern regions kept Aboriginal women, who were in a terrible state from the venereal, for the purposes of prostitution. Inspector Alec Douglas, asked by the Commissioner of Police to investigate the claims, said the report was incorrect, at least for the Northern region, where he had considerable experience.\textsuperscript{151}

\textsuperscript{145} Q.S.A. COL/A188, in-letter 3747 to Commissioner of Police, 2 December, 1873.

\textsuperscript{146} Q.S.A. COL/A316, Notes on the Condition of the Aborigines of Queensland, 24 October, 1879. Gin’ is a racist and offensive term used to denote female Aborigines.

\textsuperscript{147} Q.S.A. COL 144, letter to Inspector of Police at Longreach, 12 December, 1898. Also COL 143, in-letter 18283 to Commissioner of Police 18 November, 1900.

\textsuperscript{148} Q.S.A. COL 144, letter to Inspector of Police at Longreach, 10 December, 1898 Numerous similar reports can be found in the bundle.

\textsuperscript{149} Q.S.A. COL 140, letter to Inspector of Police at Longreach, 12 March, 1902 (in-letter 04419, Home Secretary) Numerous similar police reports can be found in this bundle, reporting prostitution, particularly for tobacco.

\textsuperscript{150} Q.S.A. A/58764, out-letter 69/01 from Constable McKenna, at Mossman, to Protector of Aboriginals, Cairns, 23 August, 1901.

\textsuperscript{151} Q.S.A. COL/A 717, in-letter 12407 to Commissioner of Police.
The problem of venereal diseases in the Aboriginal population started to exercise the minds of the police and others in the 1880s. In May 1887, Sub-Inspector Frederick Urquhart—hardly an expert in medical diagnosis—estimated that ‘contagious disease’—syphilis—infected about half the adult male blacks and a full 90% of women in the Cloncurry region. He said that he had seen many children with it. He recommended placing restrictions on the unrestrained intercourse between black and white, but without saying how to achieve this end. Archibald Meston, appointed Southern Protector of Aborigines in 1897, repeated the emphasis that syphilis came from the white population in a report on the Western Aborigines. Opium and syphilis, in his opinion, were destroying the western Aboriginal population. In a subsequent report, he emphasized the only remedy was the total isolation of the population from the whites. In an earlier report Meston, not a physician, noted European diseases appeared to assume an aggravated or virulent form among ‘primitive races’. ‘Syphilis’, he wrote, ‘is far more poisonous and deadly among the aboriginals than the whites, because it is new with the one race and old with the other.’ Inspector James Lamond in 1897 made a sensible suggestion that, ideally, might have come from the Central Board of Health.

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152 Q.S.A. POL/ J19, in-letter 03759 to Inspector Carr, 5 May, 1887.

153 Q.S.A. COL144, Report on The Western Aboriginals by Archibald Meston, 15 June, 1897.


155 Q.S.A. COL 142, Report on the Aboriginals of Queensland, by Archibald Meston. W.E.Roth said of syphilis in Aboriginals that ‘unfortunately, this disease takes on very often a malignant or galloping form, running a rapidly destructive course.’ (Annual Report of the Northern Protector of Aboriginals for 1900, Q.V. & P. 1901: 4; 1329-1338

156 James Lamond, a Scot, was appointed to the Native Police in 1879 where he played an important administrative role in the later years of the Native Police. Quoted from Jonathan Richards, The Secret War, 2008, pp 96-97.
Nearly all the blacks in this district are more or less diseased and it seems almost useless curing isolated cases. What is really necessary is a Doctor to go round amongst the tribes – he would see how much they suffered and would be able to prescribe and show them how to cure themselves – it is a big undertaking, but unless something is done, they will become a festering reproach to us. Syphilis seems to have been introduced everywhere amongst the blacks and Doctors...have told me fully 70% of the lock hospital cases are the result of intercourse with blacks.\footnote{Q.S.A. POL/ J19, in-letter 14093 to Commissioner of Police dated 24/11/1897.}

Two years later, Lamond wrote to the commissioner about syphilitic aboriginals in Burketown, who were a danger to the health of the town. He decided to give them rations and sent the whole clan back to their old hunting grounds, where he thought their health would improve. He also stipulated that no one was to employ blacks except under permits.\footnote{Q.S.A. HOM/A27, in-letter 12697 to Home Secretary, 9 September, 1899.}

In 1892 the Bowen Magistrate complained to the Colonial Secretary of the amount of syphilis in the district, and asked for a sum of money to be placed at the disposal of the bench for supplying food and medicine. Colonial Secretary Boyd D. Morehead asked the police commissioner to get the local police to bring in such cases for the attention of the Government Medical Officer.\footnote{Q.S.A. POL/J19, in-letter 05478 to Commissioner of Police, 3 April, 1889.} Sergeant James Whiteford reported he had seen some four hundred and fifty Aborigines while on a tour of Cape York and found them all ‘more
or less suffering from venereal diseases’. The apparent epidemic of syphilis did not exempt children. Constable John Cassidy reported the case of an Aboriginal boy of about 11 years of age who he thought had hereditary syphilis, as he was too young to ‘have contracted the disease himself’. He went on to say some might think the child had leprosy, but he, Cassidy, had seen several lepers and thought it was not that disease. In a letter to his inspector at Longreach, a constable described the condition of the ‘walk-about Blacks both male and female’ who ‘were nearly all suffering from venerial (sic) diseases and were horrible to look at, through being covered in sores’. Even the Commissioner got into the act. W. E. Parry-Okeden reported in 1897 that, on a trip to North Queensland he saw a female Aboriginal who was ‘in a fearful state from syphilis.’ He drafted a proposed Aboriginal Protection Act, section 14 of which stated, ‘when the Protector reports that venereal or other contagious or infectious diseases prevail among the aborigines of any locality, the Commissioner of Police may cause all affected aboriginals to be mustered and removed to some island or other place, there to be detained until cured.’ This section was not included in the Aboriginal Protection Act of 1897, but the idea was accepted. In 1900, Northern Protector of Aborigines and physician Walter E. Roth stated that, at Camooweal, almost all the blacks were ‘more or

160 Q.S.A. POL/J19, in-letter 13401 to Commissioner of Police, 8 November, 1897. Sergeant James Whiteford was the last man to have served his entire police career in the Native Police of North Queensland. Richards “A Question of Necessity” 2005, p 150.

161 Q.S.A. POL/J19, in-letter 13405 to Commissioner of Police, 6 September, 1897. Confusion between syphilis and leprosy was common, and will be discussed in the next chapter.

162 Q.S.A. COL 144, in-letter 2830 to Inspector of Police at Longreach, 18 December, 1898.

This curiously inexact statement from a physician perhaps describes some of the problems of making a firm diagnosis of syphilis in this population. Roth recognized the role of the police: ‘the local police... have been very good at supplying them with remedies. As I have advised the Police, the most merciful thing ... to be done is to give all those who are crippled by the disease, both food and tobacco.’ He alleged syphilis was not sexually transmitted in this particular population, but was spread by the common use of pituri\textsuperscript{165} which was chewed and passed from mouth to mouth. Roth also stated the Aborigines of Northern Queensland believed sorcery caused a rapidly destructive form of syphilis. Roth noted the high prevalence of the venereal in the north western districts, along the Peninsula coast line, especially on the lower gulf shores and close to white settlements, so putting whites at risk. He claimed to know of two European children accidentally infected with syphilis from their Aboriginal nurses.\textsuperscript{166} Dr Herbert Brownrigg reported several cases of Europeans suffering from venereal disease allegedly contracted from ‘black gins’.\textsuperscript{167} Constable Carl Hansen, of Normanton, examined one hundred and seventy-six Aborigines in company with Dr Richard Rendle, in whose opinion, ‘about half the blacks were suffering slightly from the venereal.’\textsuperscript{168} Inspector David Graham forwarded to the police commissioner a note from

\textsuperscript{164} Q.S.A. A45209, in-letter 10527 to Home Secretary, 27 June, 1900.

\textsuperscript{165} Pituri - \textit{Duboisia hopwoodii}, a native shrub containing high levels of nicotine (and other alkaloids), the cured leaves of which are chewed.

\textsuperscript{166} Walter E. Roth. Annual Report of the Northern Protector of Aboriginals for 1900 Q.V.&P. 1901:4; 1329-1337.

\textsuperscript{167} Q.S.A. POL/J19, in-letter 05928 forwarded to Commissioner of Police, from Dr Herbert Brownrigg to Officer in Charge of the Police at Winton, 3 June, 1892.

\textsuperscript{168} Q.S.A. POL/J19, in-letter 17651 to Commissioner of Police 23 August, 1900. Rendle also wrote that ‘something must be done to isolate and treat contagious disease among aboriginals, for the safety of our
Sergeant Patrick Quain who worried about a ‘black gin’ dying in a fearful state from syphilis, and wanting to know if he could ration the woman until she died at the cost of about a shilling a day.\textsuperscript{169}

Though the police had taken note of the problem of venereal disease in Aboriginal populations prior to the passage of the act, following the \textit{Aboriginal Protection and Prevention of the sale of Opium Act} of 1897, the Commissioner of Police was appointed Chief Protector of Aborigines. In this role, the police came to take an increasing interest in all areas of Aboriginal health.

Aborigines were alleged to be sexually promiscuous. The secretary of the Torres Straits Hospital wrote to the police commissioner about a girl—(‘quite a child’)—suffering from severe venereal disease for whom a cure was more than improbable. This child was said to have contracted the infection sexually.\textsuperscript{170} The question of the sexual abuse of Aboriginal girls would prove a difficult one, since most did not have a birth certificate. The \textit{Aboriginal Protection and Prevention of the sale of Opium Act} of 1897 had nothing to say on the question. Within eighteen months of this act being passed, Home Secretary Justin Foxton introduced an amendment before parliament aimed at preventing the violation of young girls. Foxton wished for the onus to be placed on the offender to

\textsuperscript{169}Q.S.A. POL/J19, in-letter 04223 to Commissioner of Police, 1 January, 1898. Parry-Okeden minuted that he should do what was necessary.

\textsuperscript{170}Q.S.A. POL/J19, in-letter 00735 to Commissioner of Police, 3 January, 1898. The possibility of sexual abuse was not raised.
prove the victim was above the legal age of consent (fourteen years) but was met with stiff resistance from parliamentarians who insisted a man could readily mistake the maturity of ‘native’ girls of nine or ten years old, because they ‘ripened’ earlier in tropical areas. The final decision would rest with medical opinion that the girl had reached puberty\textsuperscript{171} (and was, therefore, assumed to be old enough to have intercourse.) As late as 1939 the Chief Protector of Aboriginals wrote to the Superintendent at Yarrabah Mission:

\begin{quote}
Regarding the marriage of girls under 18 years of age, the act does not fix any minimum marriage age for aboriginals but provisions concerning moral offences fixed the age of consent for aboriginal females at the proof of attainment of puberty. Under the marriage laws aboriginals under 21 years of age must have the consent of parents, legal guardians or of a Justice authorised to consent to the marriage of minors. This latter authority is vested in the Chief Protector of Aboriginals. As a matter of practice, this office regards females 16 years of age as old enough for marriage if some medical, nursing or other responsible authority certifies that the females appear to be sufficiently developed physically".\textsuperscript{172}
\end{quote}

The Central Board of Health was aware of the problem of venereal disease in Aboriginal communities. Instead of organizing a proper investigation by competent medical authorities, the board relied on police reports, and did nothing else.\textsuperscript{173} However, the

\textsuperscript{171} Quoted In: Rosalind Kidd. \textit{The Way we Civilise}. 1997, p 50 How puberty was to be defined was not discussed. Puberty in girls is a prolonged physiological period, often lasting several years. The earliest stages, breast development and the appearance of pubic hair do not necessarily mean the girl is ‘mature’.

\textsuperscript{172} Jonathan Richards. Personal communication, 2009.

\textsuperscript{173} See, for example, Q.S.A. POL/J19, in-letter 04402 from the Central Board of Health to the Police Commissioner, asking for reports from his officers, 22 April, 1892.
situation was complicated by independent reports from places the police believed were infected with syphilis, suggesting the Aborigines were, in fact healthy and free of contagious diseases, for example, the Lower Diamantina region. A similar conclusion was reached by Sub-Inspector Michael Dillon, who after a journey through this area, said he had seen no blacks with any significant disease except a few women with syphilis. He remarked that twenty years ago, cases had been more common. The Wasserman test for syphilis was introduced in 1906, yet no epidemiologic surveys were undertaken in the period covered by this study.

The police, of course, were amateur diagnosticians. Acting Sergeant George Smith in 1897 described a case he calls syphilis which sounds very much like donovanosis—still a venereal disease, but one with a quite different prognosis from syphilis. He also described a case he calls syphilis in which the patient’s testicles were greatly swollen and covered in warts. This does not sound like syphilis. Equally, in 1900, Acting Sergeant John Casey in Mitchell, receiving a report from the local chemist about a case of venereal in an Aboriginal man, sent for the man, and ‘made an examination. The right groin (is) a mass of ulcerated sores and his penis (is) in a state of decay beyond description.’

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174 See for example a letter from a Presbyterian minister, Alex Barr, who travelled through the Lower Diamantina area saying reports of syphilis in the area were quite untrue. Q.S.A. POL/J19, in-letter 05999 to Commissioner of Police, 9 June, 1892.

175 Q.S.A. POL/J19, in-letter 05927 to Commissioner of Police, 4 June, 1892.

176 Q.S.A. POL/J19, in-letter 14092 to Commissioner of Police, 11 November 1897 Donovanosis, or granuloma inguinale is a chronic bacterial infection of the ano-genital region caused by Klebsiella granulomatis. The lesions generally remain localised, but may be quite destructive. The progress of the disease is slow, often measured in months, and sometimes years. It is assumed to be a sexually transmitted infection from the distribution of the lesions, though extra-genital lesions may occasionally occur.

177 Q.S.A. COL/145, in-letter 13148 to Commissioner of Police, 31 August, 1900.
Again, this sounds like donovanosis, not syphilis, raising an important point. What was ‘the venereal’ from which so many Aboriginal people apparently suffered? Urquhart’s report on the prevalence of disease in Cloncurry called attention to the large numbers of children affected, yet syphilis is not a disease of children (except, occasionally, congenital syphilis in which the clinical lesions are different from those of the sexually acquired form) but yaws and endemic (non-venereal) syphilis are. Physician Ernest Hunter suggests venereal diseases were probably relatively uncommon, and further suggests that many so called cases of syphilis were, in fact, yaws. Inspector Andrew Driscoll informed the authorities of an Aboriginal man, ‘rotten with syphilis’ who was discharged from care a month later, apparently fully recovered. This is not the normal prognosis for someone with advanced syphilis treated with mercury. Equally the police sometimes argued that a skin condition was not syphilis, though it might be. Constable Daniel Whelan described a common disease among the Aborigines at Ayton, near Cooktown, that might, in his opinion, have come from the Chinese, where he noted skin lesions ‘on the parts where skin meets such as the lips, and under the arm pits.’ This is classic secondary syphilis. Some of these patients died, which is uncommon in ordinary syphilis, but Meston may have been right in suggesting that a new disease in a population behaved differently. No doubt the doctors made similar errors also. The significance of diagnostic error resides, not necessarily in incorrect treatment, but in the moral stigma attached to venereal diseases. Urquhart preface his remarks with the statement that it

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179 Q.S.A. POL/J19, in-letter 02328 to Commissioner of Police, 22 February, 1898.

180 Q.S.A. POL/J19, in-letter 03576 to Commissioner of Police, 13 December, 1896
was a difficult subject to write about and no doubt other police personnel felt the same reluctance when talking about the subject.\textsuperscript{181}

In contrast to the casual indifference of some doctors, the police attempted to make life easier for some of their charges. The case mentioned by Inspector Graham has already been referred to. On another occasion, a sergeant, without consulting his inspector, gave an alleged syphilitic aboriginal blankets from the watchhouse. The Commissioner of Police thought this was most improper and dangerous, and hoped the blankets had been boiled after use.\textsuperscript{182} Inspector Lamond appears to have given the problem of venereal disease in Aboriginal communities a considerable amount of thought. On a number of occasions he said that what was needed was a doctor to look after the Aborigines, especially a doctor with experience of venereal diseases. He recommended, after a number of Aboriginal people with the venereal were found around Normanton, the establishment of a small hospital camp within the police paddock, where the sick could be treated by the government medical officer until cured.\textsuperscript{183} The idea was approved, but the final outcome is unknown. In 1892, the Under Colonial Secretary wrote to the Commissioner of Police, stating the medical officers at Winton and Cloncurry had been asked to furnish the police in the districts with supplies of mercurial ointment (mercury was the standard treatment for syphilis at the time) for distribution to the blacks and to give the police such directions as would enable them to instruct the blacks as to the use of

\textsuperscript{181} Q.S.A. POL/J19, in-letter 03759 to Inspector Carr, 5 May, 1887.

\textsuperscript{182} Q.S.A. POL/J19, in-letter 02871 to Commissioner of Police, 3 March, 1898.

\textsuperscript{183} Q.S.A. POL/J19, in-letter 13683 to Commissioner of Police, 16 September, 1899.
the ointment. Yet another duty to add to their ever lengthening list, they were now to become dispensers of medicine!

Roth, who was also an amateur anthropologist (although he called himself an ethnographer) said the indigenous population believed sorcery or non-observance of rules to be the cause of syphilis. If native treatments failed, he claimed, many lay down to die, a condition he called ‘suicidal mania.’ Some doctors did what they could for their Aboriginal patients, but there was always the problem of money. One doctor in Burketown said he would visit the Aboriginal camp to give medicines and directions to a syphilitic patient, if the police ordered him to do so, and signed a voucher for payment for this service.

Hospitals often refused to admit patients with the venereal, though rural hospitals appeared less rigid than the larger, city hospitals. Aboriginal patients with syphilis were doubly disfavoured. Constable Thomas McGrath brought a very sick man to the Townsville Hospital but the surgeon, Dr Wuth, refused to admit him on the grounds he had been treating the man as an outdoor patient for syphilis. After the man died four days later, McGrath made a complaint against Wuth. The hospital committee sided with the doctor, saying the rules forbade his admission, but, given the dire state of his health, they had purchased a house where he could receive his ‘special treatment’.

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184 Q.S.A. POL/ J19, in-letter 05698 to Commissioner of Police, 4 June, 1892.
186 Q.S.A. COL 144, unnumbered letter to Police in Burketown, 8 May, 1899.
187 Q.S.A. COL/A290, in-letter 1043 to Colonial Secretary, 10 February, 1880.
Aboriginal patients might be treated in a hospital, or the police might be ordered to erect a tent in the grounds of the police paddock for such people.\(^{188}\) In 1913, the secretary of the Normanton Hospital Committee wrote to Premier Digby F. Denham about the state of the Aborigines suffering from syphilis: ‘The Aboriginal Department, represented by the police, have on several occasions brought to the hospital aborigines suffering from advanced syphilis’ and claiming the patients could not be treated as outpatients as they were irregular in their treatment, and as inpatients, they required lengthy treatment and generally absconded before treatment was completed. The letter also said that if the Normanton District was ‘the criterion’, then venereal diseases must have made extensive ravages among the Aborigines leading eventually to both the extinction of themselves, and to disease and deterioration among the white population.\(^{189}\) To prove the point, the secretary enclosed hospital statistics showing twelve syphilitic patients stayed in the Normanton hospital a total of 1,007 days, (an average of eighty-four days per person), while 205 non-syphilitic patients stayed a total of 2578 days (12.5 days per person). The Assistant Superintendent at Barambah (now Cherbourg) noted the Nanango Hospital refused to admit an Aboriginal patient suffering from ‘venereal disease’, while the doctor refused to do anything for him.\(^{190}\)

\(^{188}\) Q.S.A. POL/J19, in-letter 102328 to Commissioner of Police, 22 February, 1892.

\(^{189}\) Q.S.A. SRS 1043/1/228, in-letter 06318, 24 May, 1913 from Normanton Hospital Committee to Home Secretary.

\(^{190}\) Q.S.A. A/58676, unnumbered letter to W.E.Roth, 27 June 1906
4.12 Further police involvement

Historian Raelene Frances wrote that from the 1870s to the start of the First World War, the Australian colonial legislatures made concerted efforts to ‘clean up’ their streets.\(^{191}\) Increasingly, the police became involved in the suppression of houses of ill-repute, or brothels. Section 167 of the *Local Government Act* of 1878 gave powers to councils to make bye laws for the suppression of nuisances, houses of ill fame and gambling houses, but local government seemed uncertain of its powers. In 1899, the Brisbane Town Clerk wrote to Commissioner Parry-Okeden about a petition signed by over six hundred citizens, asking for the removal of brothels from the city centre. The law, he said, was unsatisfactory. Parry-Okeden asked his Chief Inspector for his opinion. Chief Inspector Stuart thought the problem of illegal brothels was the city’s most difficult social problem. He recognized the total inadequacy of the legal powers of both police and municipal authorities to deal with the situation, and recommended all brothels should be under the control of the police, so they could shut those that became a nuisance or were obnoxious to the general public.\(^{192}\) Nothing was done. Four years later the Town Clerk again wrote to the Commissioner of Police to canvas his assistance in suppressing houses of ill fame, but Parry-Okeden seemed uncertain how to set about the task.\(^{193}\)

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\(^{192}\) Q.S.A. A/45284, in-letter 15191 to Commissioner of Police, 1 August, 1899.

\(^{193}\) Q.S.A. A/45284, in-letter 06926 to Commissioner of Police, 14 May, 1903.
Frances attributes these moves on the part of the police to the growth of an urban middle class creating a ‘class of leisured wives and daughters who sought to use urban spaces in new ways, most notably by shopping and promenading in the central business districts.’ The sensibilities of these genteel people might be polluted by the presence of prostitutes, or even worse, they might be mistaken for one.\textsuperscript{194}

Finally, it seemed little was done. As they had always done the police ignored quiet and orderly brothels, and suppressed the disorderly ones.\textsuperscript{195} At the Police Inquiry of 1899, when questioned about houses of ill-fame, Sub Inspector J. Nethercote stated that under the \textit{Contagious Diseases Act}, officers visited the houses, looking not only for disease, but for disorder as well. How they looked for disease is not stated,\textsuperscript{196} but raises suspicions. The \textit{Contagious Diseases Act} came into force in February 1868. The proclamation declaring Brisbane to be under the provisions of the act was rescinded in Brisbane in August 1911\textsuperscript{197} and in Rockhampton in 1917.\textsuperscript{198} Following the rescission in Brisbane the police reported a decrease in soliciting in the streets of Brisbane,\textsuperscript{199} though the medical profession objected. \textit{The Observer} reported,

\textsuperscript{194} Frances. \textit{History of Female Prostitution in Australia} 1994 pp38-40.

\textsuperscript{195} see, for example, Q.S.A. A/45284, in-letter 15381 to Commissioner of Police, 2 October, 1904.


\textsuperscript{197} Q.G.G. 1911: 52; 591.

\textsuperscript{198} Q.G.G. 1917: 109; 1822.

\textsuperscript{199} Q.S.A. A/45284 , an unnumbered and undated memorandum re: prostitutes soliciting on the streets.
‘evidence of the most damnifying character has been obtained from several leading chemists in the city. In the first place, it may be noted that amongst these gentlemen, as among the medical practitioners themselves, there is a most complete unanimity of opinion regarding the suspension of the Act, and they denounce it as a mistake fraught with the most serious possibilities.’

The Queensland Branch of the British Medical Association strongly regretted the rescission of the act in Brisbane, claiming that, even if the act had not been stringently enforced (presumably a complaint against the police) it was nonetheless productive of good results. It asked that the rescission be repealed, demanded regulations be made to apply to the whole state, and urged new and better legislation, dealing with both sexes, provided ‘no ticket, paper or other semblance of a licence should be issued to any prostitute.’

However the rescission of the act in Brisbane was not without its consequences. In December 1911, an act to amend the Health Act of 1900 became law. This act contained, in section 63, important clauses for the control of venereal diseases. Named venereal diseases were to be notified to the Commissioner of Public Health. Secrecy was to be maintained. Facilities for ‘gratuitous treatment’ of venereal diseases could be established. Prostitutes within the metropolitan area had to submit themselves to a

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200 Observer, 12 December, 1911.

201 Q. P. D., 8 December, 1911, p 2781.
medical examination by a medical officer at specified places and times. If a person infected with venereal disease was considered, on the signed certificate of two medical officers, to be likely to transmit the infection to others, the police magistrate had powers to detain that person in hospital for investigation, and if found to be suffering from a venereal disease, he could be detained until such time as the Governor in Council, on the advice of the Commissioner of Public Health, decided. (The Health Act Amendment Act of 1917 changed this section, so only one medical certificate was required to send a person off to involuntary hospitalization). If a person already in gaol suffered from a venereal disease in an infectious stage, the visiting justice could order the person to be kept in gaol, even beyond his period of imprisonment, until cured of his infection. Any person who knowingly infected another person with any venereal disease would be liable to a fine of fifty pounds, or six months imprisonment. Prostitutes who behaved in a riotous or indecent manner, or who solicited or importuned for immoral purposes, were deemed to be vagrant, and subject to imprisonment for up to six months. The sentence could however be carried out in a reformatory, or could be suspended. In the last case, if she failed to observe the conditions of her suspension, she could be arrested by any police officer. Men who lived off the earnings of prostitutes were likewise deemed to be vagrants. In effect, the new Health Act removed the venereal diseases from the administration of the police to the Health Department, but continued the focus on the prostitute. In debate on the Health Act in 1911, a member asked the Home Secretary

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202 See, for example, Q.S.A. A/19561, in-letter 2959 Department of Prisons, 1 October,1923 from George Streidl, a prisoner held for six weeks beyond his release date because he was suffering from gonorrhoea. He was eventually released on condition he sign an undertaking to continue treatment with his doctor until the doctor signed a certificate of cure.

203 Prostitutes were assumed to be female.
whether it was the duty of the police to arrest an unregistered prostitute for soliciting in a public place, and if so, under what law. The Home Secretary replied that any common prostitute who behaved in a riotous or indecent manner could be apprehended under section 2 of the *Vagrancy Act*. The following January, the Commissioner of Public Health, Dr J. S. Elkington wrote to the Commissioner of Police to ask for the advice and cooperation of the police in having the sections dealing with prostitution and ‘knowingly infecting another person’ enforced by the police. He commended the police for the assistance they gave in suppressing spitting in Brisbane streets, and lauded the role of the police in the interests of public health.\footnote{204 Q.S.A. A/45284, in-letter 00805 to Commissioner of Police, 10 January, 1912.} The police investigated the case of an illegitimate child in Cairns who became blind in both eyes as a consequence of gonococcal ophthalmia, with a view to prosecuting the putative father for knowingly infecting another person. The Police Magistrate pointed out a prosecution was unlikely to succeed, as Cairns was not a proclaimed town, and anyway, even if it was, it would be difficult to prove the putative father was aware of his condition.\footnote{205 Q.S.A. A/45284, in-letter 25568 to Commissioner of Police, 8 September, 1914.} Technically, of course, in such a case, it is the mother who most likely transmitted the infection to the infant, while she, in turn, was possibly infected by the father.

In March 1913, regulations made under the *Health Act* of 1911 declared primary and secondary syphilis and gonorrhoea to be notifiable in Metropolitan Brisbane.\footnote{206 Q.G.G. 1913: 100; 925.} In October 1913, metropolitan prostitutes who failed to submit themselves to examination
became liable to a fine of twenty pounds for each offence.\textsuperscript{207} There were some positive aspects. A pharmacy was established at the Brisbane Hospital, and within a few months 240 patients attended for treatment. An in-patient facility was established at the hospital. The drug Salvarsan\textsuperscript{208} was distributed free to doctors who required it for their patients, and Wasserman reactions were carried out on request by the Department of Public Health.\textsuperscript{209}

4.13 Conclusions

Venereal Disease, and especially syphilis, came to prominence as a social problem in the second half of the nineteenth century, mainly as a result of its perceived association with female prostitution (the social evil). In English law, prostitution itself, that is, the sale of sex for money, was never a crime. Prostitutes were controlled by Vagrancy Acts, legislation that was widely copied in the Australian colonies. The perception in Britain in the wake of the Crimean War and the Indian Mutiny that the British Army was enfeebled by rampant venereal disease led to the \textit{Contagious Diseases Acts} of 1864, 1866 and 1869. When the British Army asked for similar legislation in Australia, only Queensland immediately complied. In contrast to the British legislation, the Queensland act was aimed at prostitutes in proclaimed town, not garrison towns. The police took a great interest in the workings of the Act, wished for more towns to be proclaimed, and forced

\textsuperscript{207} Q.G.G. 1913: 100; 1082.

\textsuperscript{208} Salvarsan, an organic arsenical compound introduced by the German physician Paul Ehrlich in 1910 as a specific for the treatment of syphilis. It was replaced in 1914 by neo-salvarsan, supposedly with greater efficacy and fewer side effects.

many women into Lock Hospitals for compulsory treatment for sexually transmissible disease. They recognized that prostitution was unstoppable, and wanted the women to be clean for hire. The Vagrancy Act controlled how and where prostitute women lived and worked, while the Contagious Diseases Act ensured they were ‘safe’, the police not appreciating, no doubt, that the treatments available at the Lock Hospitals were not necessarily effective. The police took an interest in the management of the Lock Hospitals, even to the extent of believing that these should be under police control. Women who broke the rules of the Lock Hospitals were prosecuted by the police and often imprisoned.

The Queensland Contagious Diseases Act was not good public health law. It was soon understood that a woman who developed a venereal infection was not necessarily a prostitute and other criteria would be needed. Dr Dods observed in 1911 that there were three or four cases of venereal disease contracted from ‘decent’ girls for every one contracted from a prostitute, an epidemiologic observation as true today as it was a hundred years ago. The act ignored the sexual partners of infected women, it applied only to proclaimed towns and it completely ignored the difficult question of venereal disease among Aborigines, a problem with which many police had to contend. However, this latter experience would prove useful when the question of policing leprosy arose, initially among whites, but later among other and marginalized populations.

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210 Q. P. D., 1911-12:110, p 2893.
The worst result of the act was the involvement of the police in what should have been a purely public health problem. Even the changing of the site of the new Lock Hospital, from the grounds of the General Hospital to the gaol reserve in Boggo Road reflected the powerful disciplinary function brought to bear on women seen as prostitutes.
5.0 Policing ‘Lepers’

5.1 Introduction

When James Quigley, twenty-one year old son of a Rockhampton launderer, was diagnosed with leprosy in December 1891, much was made of the fact that he lived close to a gaol where, eight years earlier, a Chinese leper had been incarcerated. That there was no evidence to link the unfortunate Quigley to the prisoner was ignored. The Chinese were surely to blame. Quigley was summoned by the Central Board of Health to come to Brisbane for further investigation, but he escaped from supervision. The police were ordered to find, arrest and bring him to Brisbane. This was the first step in the involvement of the police in leprosy, a phenomenon quite beyond their previous experience.

5.2 Leprosy, the disease

Leprosy is a chronic infectious disease caused by the leprosy bacillus, *Mycobacterium leprae*. Though discovered in 1873, it was categorically affirmed that *Myco. leprae* was the true and only cause of leprosy at the First International Leprosy Congress, held in

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1 The use of the word ‘leper’, which is contrary to modern medical practice, is only justified on historical grounds.
Berlin in 1897. For practical purposes, it is a disease of humans only. Transmission of the leprosy bacillus is thought to be via the nasal and respiratory secretions of those suffering from low immunity leprosy. The disease is primarily one of the skin and some peripheral nerves, especially those closest to the surface of the body. Involvement of these peripheral nerves may lead to loss of sensation in hands, feet and eyes, and to paralysis of certain muscles, again especially in the hands, feet and face. Loss of sensation and paralysis lead to trauma to the peripheries, and it is the effect of repeated trauma that leads to deformity, chronic ulceration of hands and feet and, if the eyes are involved, blindness. The skin lesions in early leprosy are subtle, difficult to diagnose, and often ignored for long periods of time. Self-healing lesions are probably more common than is generally realized.

The immune response to invasion by *Myco. leprae* varies from a complete immunological response that leads to abortive infection, through various grades to no immune response whatsoever. High levels of, but not a complete, immune response are associated with limited disease, nowadays called tuberculoid leprosy. The absence of any immune response is associated with a more generalized disease known as lepromatous leprosy. In between responses give rise to borderline leprosy. A combination of genetic and environmental factors determines the ability of the host to mount an immune response against *Myco. leprae*.

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2 See footnote 37.
The average medical man of the later part of the nineteenth century recognized leprosy had different clinical presentations, though at the time no one understood the reasons for these differences. Most texts described two forms of leprosy, anaesthetic, sometimes called macular, maculo-anaesthetic or nerve leprosy, (the equivalent to today’s tuberculoid leprosy) and tubercular or tuberculated leprosy (today’s lepromatous leprosy). The former was a more localized disease, the latter a more generalized and virulent form. Some doctors recognized a form intermediate between the two, which they called ‘mixed.’ Diagnosis was established by careful examination of the body, and late in the century, by the use of bacteriology to identify the presence or absence of the leprosy bacillus, its presence always indicating a diagnosis of leprosy, its absence, however, not excluding it. Dr Eugen Hirschfeld, a German physician employed by the Brisbane Hospital who had studied under Robert Koch, made the first bacteriological examinations for leprosy in 1892. He also suggested the necessity for ‘stringent isolation’ to prevent the further spread of the disease, and believed ‘a medical examination should be made of all aliens within the colony to find out whether they are affected with communicable disease (syphilis, leprosy), and not to wait until they obtrude themselves to our knowledge, either by mere chance, or after they have communicated the disease to others.’ That there was no personnel available who could have undertaken such a mammoth task was ignored by Hirschfeld.

3 Q.S.A. COL/A707, in-letter 10215 to Colonial Secretary from Dr Hirschfeld, 22 August, 1892.

4 Q.S.A. COL 271, in-letter 06499 to Colonial Secretary, 11 June, 1892.
5.3 The Revival of leprosy in the nineteenth century

Until recently much of the extensive historiography of leprosy concerned itself with the disease of classical and mediaeval times, a brief review of which is given in appendix 3. Few modern general texts of the history of medicine refer to the revival of interest in the disease in the nineteenth century, except to mention the role of the Norwegian physician, G. H. A. Hansen, as the discoverer of the leprosy bacillus in 1873.

Why leprosy largely disappeared from Western Europe by the end of the 17th century remains uncertain. The naturalist clergyman Gilbert White credited improvements in the diets of the population, especially a decrease in the amount of salted meat and fish, increased consumption of fresh vegetables and, on a different note, the use of linen, rather than woollen, underwear.\(^5\) The hypothesis that tuberculosis somehow ‘displaced’ leprosy has some superficial attractions, but has been difficult to demonstrate in human situations.\(^6\) Some nineteenth century physicians believed strict segregation of the afflicted caused the decline, though there is little evidence that separation in ‘leper-houses’ was strictly enforced. George Newman, a physician who wrote about mediaeval

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leprosy at the end of the nineteenth century, did not subscribe to this view.\(^7\) The decline in the prevalence of leprosy was also associated with an increase in the prevalence of syphilis, and clearly at times confusion existed between the two diseases.\(^8\) Despite the decline, interest in leprosy never entirely disappeared, increased in the nineteenth century and accelerated in the final decades of the century (table 5.1). There were a number of reasons for the increasing interest in the problem of leprosy. Firstly, this was a period of rapid colonial expansion, which came with the perception that leprosy was a common problem in many newly acquired colonial possessions,\(^9\) and especially in India.\(^10\) Other explanations included the experience of widely reported local outbreaks of the disease in Canada\(^11\) and Hawaii.\(^12\) The Chinese were widely blamed for the apparent world wide spread of the disease,\(^13\) in Hawaii, New Caledonia, Victoria and other places. In 1885, British Archdeacon Henry Wright wrote that a significant risk of the reintroduction of


\(^8\) Both diseases lead to skin eruptions, and nerve damage may also occur in some forms of syphilis.


\(^12\) see, for example, Report of the President of the of Health to the Legislative Assembly of 1866, on Leprosy, Honolulu, H.I. 1886.

leprosy into Britain existed,\textsuperscript{14} a claim he repeated in 1889, asking, ‘Is England in Danger?’ and replying in the affirmative. In that year, the Belgian priest Father Damien, who had devoted his life to the care of leprosy sufferers in Hawaii, and

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had contracted the disease from his charges, died,\textsuperscript{15} an event generating a quite extraordinary panegyric in the \textit{Brisbane Courier}.\textsuperscript{16} In Britain, a National Leprosy Fund was established in memory of Father Damien under the patronage of the Prince of Wales. One purpose of the Fund was to set up a Commission to investigate the state of leprosy in India. The period saw ongoing disputations about the causes of leprosy, especially the theories of contagion versus those of heredity.\textsuperscript{17} If the disease was contagious, segregation would be an appropriate control measure, if hereditary, it was not. Lastly,


\textsuperscript{16} \textit{Brisbane Courier}, 14 May, 1889.

science was taking an interest in the problem of leprosy, initially in Norway, where, in the eighteenth and early nineteenth century a resurgence of leprosy occurred,\textsuperscript{18} with the work of Daniel Danielssen, Carl Boeck and Danielssen’s son in law, Gerhardt H. A. Hansen.

The word leprosy itself came in the Middle Ages to have three meanings: as a specific disease\textsuperscript{19}, as a loathsome disease, generally of the skin,\textsuperscript{20} and as a stigma.\textsuperscript{21} In 1867 the Brisbane Courier noted that a Chinaman had been admitted to the Toowoomba Hospital with leprosy, but made no further comment.\textsuperscript{22} It is impossible to know now whether this represented ‘true’ leprosy, or another loathsome disease, perhaps syphilis, but this appears to be the earliest printed record of the word in Queensland.

\subsection*{5.3.1 Contagious or hereditary?}

Leprosy had long been considered to be a contagious disease, an opinion expressed in the

\begin{footnotesize}
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\item\textsuperscript{18} Peter Richards. \textit{The Medieval Leper and his Northern Heirs}. Barnes and Noble, New York, 1995, p 84 passim.
\item\textsuperscript{19} Today called Hansen’s Disease in Queensland.
\item\textsuperscript{20} A correspondent to the Brisbane Courier, 22 October, 1867, writing on the subject of the \textit{Contagious Diseases Act}, says “it is no doubt unpleasant for young gents in their teens to suffer from this lewd leprosy’ meaning syphilis. Measles was sometimes said to be a ‘loathsome’ disease. \textit{Brisbane Courier}, 28 May, 1861, describes an outbreak of measles in Tana, saying many thousands had died of ‘this loathsome disease.’
\item\textsuperscript{21} The Brisbane Courier, 22 December, 1866 quotes the Wilna (Lithuania) Journal, ‘that the country must be cleansed of this leprosy, and that the jews must be either converted or exterminated.” The Concise Oxford Dictionary of 1976 gives two meanings to the word leprosy: a chronic infectious bacterial disease affecting the skin and nerves; and, figuratively, moral corruption.
\item\textsuperscript{22} Brisbane Courier , 29 October, 1867.
\end{itemize}
\end{footnotesize}
segregation of persons suspected of having the disease.\textsuperscript{23} By the beginning of the nineteenth century, this opinion gave way to the idea that the disease might be hereditary.\textsuperscript{24} Part of the disagreements between the contagionists and their opponents lay in semantic confusion. Some used heredity to mean only a predisposition, while others implied a direct effect. Contagion principally meant transmission by touch, but could be used to mean more indirect transmission. The transmitted matter was also named contagion.\textsuperscript{25} A clinical fact confusing the contagionists was the apparent immunity of those who cared for leprosy patients from the disease. When the physician W. J. Collins visited Bergen, he asked the attendants whether any of them had taken the disease, or knew of any such person, and all answered in the negative.\textsuperscript{26} In 1847, Daniel Danielssen and Carl Boeck published a monograph on leprosy which established that leprosy was a hereditary, household disease.\textsuperscript{27} In 1857 Scottish physician Alexander Fiddes promoted the hereditary transmission of the disease, adding,

\begin{quote}
\textquoteサーThe opinion that leprosy may be communicated by contact has been entertained by many from the time of the Hebrew Theocracy to the present day...but whatever may have been the case in former times, it is certain now that leprosy has no contagious
\end{quote}

\begin{thebibliography}{99}
\bibitem{23} Leviticus, chapter 13. Modern Biblical scholars agree that the word translated as leprosy in the King James Bible did not mean ‘Hansen’s Disease’.


\bibitem{26} W. J. Collins. Notes on the Leprosy Revival \textit{Lancet} 1890;1; 1064-1065.

\bibitem{27} Daniel C. Danielssen & Carl Boeck. \textit{On Leprosy}. Christiana, 1847 French translation, 1848 Paris. This was the first medical text devoted entirely to a single subject.
\end{thebibliography}
properties, and it ought to be excluded from the category of diseases that are propagated in this way.’

In 1862, in response to a request from James Walker, Governor of the Windward Islands, the British Secretary of State for the Colonies, the fifth Duke of Newcastle, requested the Royal College of Physicians of London to establish a commission to investigate the nature of leprosy. The investigation consisted of a questionnaire, sent to British dependencies (and a few other territories) having a leprosy problem. One of the questions put was, ‘does the disease appear often to be hereditary?’ Most respondents thought it was, though a few hedged their bets. ‘Opinions are divided’, and ‘often hereditary, but not always so,’ whereas on the question of contagion, most respondents said ‘no’, some ‘yes’, and some ‘occasionally’. Despite the obfuscation, the College came down solidly against contagion. The report, though methodologically deeply flawed, was influential.

A number of Norwegians immigrated to North America during the nineteenth century, including some who suffered from leprosy. Boeck visited the United States in 1869-1870, and found eight of nine cases of the disease in Norwegians developing after immigration. He felt this confirmed his view on the hereditary nature of leprosy. Later, Hansen himself went to America, and found leprosy was dying out among the

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descendants of the Norwegian patients. It could not, in his opinion, therefore be a hereditary condition.\textsuperscript{31} (He also noted that if Father Damien suffered from leprosy, then the disease, if hereditary, must have lain dormant within his predecessors for hundreds of generations.)

In England, a number of leprosy patients were diagnosed in the second half of the nineteenth century, the majority being Englishmen who had lived in tropical countries, especially the West Indies or India. Many of them had cohabited with leprous women. Yet the editor of the \textit{Lancet} could say ‘there was hardly a hospital in London that has not had within its walls cases of leprosy within the past decade…nor as far as we know, has there ever been an instance of the communication of the disease from one of those subjects to others in this country.’\textsuperscript{32} It was all very confusing.

In Brisbane Dr William Lyons, who had worked in Madras, also noted the apparent immunity from leprosy those who cared for the patients appeared to have.\textsuperscript{33} At the same time, the case of the Hawaiian, Keanu, received much attention. The death sentence imposed on Keanu—apparently free of any signs of leprosy at the time— for murder would be commuted to life imprisonment if he consented to undergoing inoculation with


\textsuperscript{32} Anonymous, Is Leprosy Contagious? \textit{The Lancet}, vol 1, 1889, p 1252.

\textsuperscript{33} \textit{Brisbane Courier}, 26 April, 1892.
lepropus material. The inoculation was performed in September 1884.\textsuperscript{34} Three years later, a certificate signed by the president of the Hawaii board of health confirmed Keanu was now a leper.\textsuperscript{35}

The discovery, in 1873, of an alleged bacterial cause of leprosy by Hansen\textsuperscript{36} was not immediately recognized or accepted (and certainly not with the enthusiasm accompanying Robert Koch’s announcement of the discovery of the tubercle bacillus in 1882). Arguments about heredity, contagion and bacteria continued until the first leprosy congress held in Berlin\textsuperscript{37} in 1897, at which it was categorically stated that Hansen’s bacillus was the only true cause of leprosy, and compulsory segregation was desirable, statements reinforced at the Second Congress, held in Bergen in 1909.\textsuperscript{38}

\textsuperscript{34} The inoculation was undertaken by Dr Edward Arning, an Anglo-German bacteriologist who worked in Hawaii on the problem of leprosy from 1883 to 1886. See Oswald A.Bushnell. Dr Edward Arning The First Microbiologist in Hawaii, The Hawaiian Journal of History, vol 1, 1967, pp 3-30. Arning also helped establish the diagnosis of leprosy in Father Damien in January 1885.

\textsuperscript{35} Anonymous. The Contagious Nature of Leprosy, British Medical Journal, vol 2, 1888, pp 1171-1172. The inoculation proved nothing. Leprosy is a disease with a long incubation period; it is entirely conceivable that Keanu was already infected when he underwent the inoculation. Archdeacon Wright was so impressed with the experiment, he wrote to The Times of London about it, 19 November, 1888.


\textsuperscript{37} The original intention was to host the conference in Bergen, in honour of G.H.A.Hansen; when he backed down, London and Moscow were proposed, but as an International Congress of Dermatology had already been held in London in 1896, and Moscow had few claims, Berlin was chosen, with the eminent pathologist, Rudolf Virchow its president. See Edward Ehlers. The Proposed Leprosy Congress, Journal of the American Medical Association, vol 27, 1896, p 967 and Pandya. The First International Leprosy Conference, Berlin, 1897: the politics of segregation. História, Ciências, saúde-Manguinhos vol 10, 2003, supplement 1.

\textsuperscript{38} Anonymous. The International Congress on Leprosy, British Medical Journal vol 2, 1909, p 1163.
After a two year investigation in India, the commissioners appointed by the Prince of Wales’ National Leprosy Fund issued their report in 1892. The report stated that leprosy was an ‘infective’ disease, caused by a microbe, it was not hereditary, but insufficient evidence existed to state whether it was maintained or diffused by contagion. The commission’s comments on contagion caused a storm of criticism. Some members of the Executive Committee of the National Leprosy Fund rejected these statements, demonstrating thereby a widespread commitment to segregation.

5.4 Leprosy in Queensland

By the beginning of 1880, there had been, according to the New South Wales public health physician John Ashburton Thompson, who had a particular interest in the disease, eight cases of leprosy in Queensland. Three were in Chinese men and five in ‘whites’, though a number of cases probably also existed among the Pacific Islanders. Some of the cases included in Thompson’s statistics were diagnosed retrospectively by Dr Joseph Bancroft, a prominent medical figure of the time.

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39 Leprosy in India. Report of the Leprosy Commission in India 1890-1891. Calcutta 1892, chapters 4 and 5. The commissioners appear to have used the word ‘contagion’ in its exact sense, that is, from skin to skin contact.


41 For a detailed analysis of the numbers of cases of leprosy, see G. Hugo Rée, Pattern of Leprosy in Queensland, Australia, Leprosy Review 1991:62:420-430


43 Bancroft came from Manchester. He built a house in Brisbane, which he named Kelvin Grove, after the Glasgow Botanic Garden. Bancroft’s initial appointment was house surgeon to the Brisbane Hospital. Looking through the old hospital case books, he came across the case of Oun Tsar, a Chinese man
The first case to reach public notice was a Chinese man, Ah Sam, who, in 1877, was brought down from Cooktown to Rockhampton, under sentence of three months imprisonment on a charge of vagrancy. The constable whose duty it was to search the prisoner on reception at the gaol refused to do so, fearing the contagion. For this, he was suspended for insubordination. Ah Sam’s condition had been previously diagnosed in Cooktown, where the European inhabitants panicked lest the contagion should spread. The Brisbane Courier hinted he had been sentenced to three months for ‘a trivial offence’ in order to remove him from Cooktown. The item stimulated an anonymous correspondent to affirm that leprosy was not a contagious disease, but adding that doubtless the bulk of Queenslanders thought differently, ‘just as many persist in believing typhoid and several other forms of fever to be infectious…’ At the end of his sentence, Ah Sam apparently stayed in Rockhampton, for over the next three years, he was sentenced to six months imprisonment in Rockhampton on four occasions on charges of vagrancy. By the end of the eighties, a further seventeen cases had been diagnosed, fifteen from the Chinese population, one a Cingalese, and one a South Sea Islander, Thompson considered this to be an underestimate, as Bancroft admitted he had seen a

admitted to the institution on a number of occasions in and after 1855 and considered him to be an example of anaesthetic leprosy. See Q.S.A. HOS1/25.

44 The case reported by the Brisbane Courier on 29 October, 1867 appears to have caused no alarm or comment.

45 Brisbane Courier, 27 November, 1877.

46 Brisbane Courier, Anonymous letter, 28 November, 1877.


number of Islanders with a disease he originally called ‘Islanders’ Toe Disease’, which he later realized was leprosy. At the Australasian Sanitary Conference in Sydney in 1884, Bancroft pointed out to the audience the contagious nature of leprosy, known to attack white men living among leprous races. Clause 50 of the resolutions of the conference called, unsuccessfully, for a special examination of all Indian and Chinese immigrants upon their arrival in Australia to ascertain the presence or absence of leprosy among them.

In 1885, Samuel Griffith, then the Chief Secretary, agreed that, should the opportunity present itself, Chinese patients being held at the quarantine station in Cooktown should be shipped back to China, with a gift of a few pounds since they were destitute. Later, some patients were also returned to China, at the expense of local Chinese charities or at government expense. Dr Arthur Salter, the Government Medical Officer at Thursday Island, thought the expense of returning a patient to China would be considerably less


50 Though this message was not universally accepted. In 1888 an officer of the Colonial Secretary’s office informed the Police Magistrate at Georgetown ‘no reason for public alarm as disease is not infectious.’ Q.S.A. COL/A545, 10 April, 1888.

51 Such an examination would have been a waste of time and resources. The earliest signs of leprosy are subtle and difficult to detect. It is unlikely that many ‘aliens’ came to Australia suffering from advanced disease, and most Chinese, when diagnosed, admitted to being in the country for many years.

52 Q.S.A. COL/A444, in-letter 8667 to Colonial Secretary, 17 November, 1885.

53 Q.S.A. COL 264 gives details of a number of Chinese patients who were repatriated in 1897 by the China Navigation Co. steamship Whampoa. The Brisbane Courier reported (25 August, 1896) that Home Secretary Tozer had learned that the Chinese authorities had no objection to Chinese lepers being repatriated.
than segregation at Friday Island. An occasional attempt was made to return Islanders to their home country.

Despite the willingness to return Chinese ‘lepers’ to China, in 1889 six such individuals were incarcerated on Dayman Island, a deserted island in the Torres Straits, where most soon died, apparently of bronchitis and other respiratory disorders. Dayman Island had been specifically selected by John Douglas, the Government Resident on Thursday Island, and a previous Colonial Secretary of Queensland, as it was deserted, had a reliable water supply, was within an hour’s steaming from Thursday Island, and the white population objected to the use of inhabited islands, or places closer to Thursday Island. Such a harsh form of quarantine reflected the stigma attached to the Chinese patients: they suffered from physical deformities, they belonged to an undynamic and deeply conservative race, and they were unwelcome in Australia. In 1891, the Central Board of Health, in response to a request from the Colonial Secretary, issued regulations for the

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54 Q.S.A. COL 264, from Dr Salter to John Douglas, Government Resident at Thursday Island, 27 November, 1891. Salter had some doubts whether this particular man did indeed suffer from leprosy.

55 Q.S.A. COL 269, a bundle of letters dealing with Jimmy Tagaro, a Pacific Islander, suspected to have leprosy in September 1896, who went to the Immigration Agent who tried to get him returned home, but Jimmy apparently did not want this and escaped to Bundaberg, where he was arrested by the police on 14 October, 1896. COL 268, a smear positive Islander, Charlie Tanna, was returned to his island in March 1898. In 1900 a Japanese patient was returned to Japan (COL 265, in-letter 18944 to Commissioner of Police, 29 November, 1900. The Brisbane Courier reported on 23 October, 1897, that Dr P. Smith, in his report on the leper lazarets at Dunwich and Peel Island ‘on the 19th July, two Chinese and one Kanaka left and on the 16th September one Kanaka, to be sent to their respective native countries.’

56 Q.S.A. COL 264. in-letter 03511 to Chief Secretary, 16 April, 1889. This file contains numerous correspondence about Dayman Island.

57 See next chapter for a discussion of quarantine.

prevention of the spread of leprosy.\textsuperscript{59} The regulations made leprosy notifiable to the Central Board of Health, and ordered the patient to be kept in a lazaret.\textsuperscript{60} Regulation 2 authorised the use of ‘such force as may be necessary’ to remove or bring to a lazaret persons so ordered. The regulations were to be in force for twelve months from August 1891, but in March 1892, the Colonial Secretary, Horace Tozer, introduced a Leprosy Bill into the Legislative Assembly, claiming uncertainty about the legality of the detention of patients on Dayman Island.\textsuperscript{61} The bill was largely copied from the New South Wales \textit{Leprosy Act} of 1890.\textsuperscript{62} In debate on the bill in the Legislative Assembly, there is no mention of the role of the police, though in the Legislative Council, the Hon. F. T. Brentnall said, ‘have not these men suspected of leprosy during the last few months had to be hunted as if they were criminals? …Have not the detectives had to be set to work to discover them, even when they have only been suspected lepers?’\textsuperscript{63}

\textsuperscript{59} Q.S.A. COL 264, Regulations for the treatment of persons affected with leprosy and for the prevention of the spread of that disease, 1891.

\textsuperscript{60} Lazaret (lazarette or lazaretto) : a hospital for the poor, especially lepers. Also, a ship or building used for quarantine. The term is probably derived from the biblical beggar Lazarus (St. Luke, chapter 16, verse 20). Plague hospitals were also sometimes called lazarets.

\textsuperscript{61} There were other issues. In March 1892, the Board had expressed doubts about the way leprosy patients were being looked after. Tozer insisted that, if two doctors had certified a case of leprosy, the board had either to issue a warrant for the arrest of the patient, or express their dissatisfaction with the doctors’ certificates. \textit{Brisbane Courier}, 12 March, 1892.

\textsuperscript{62} When he introduced the New South Wales bill into the Legislative Assembly of that colony, the Colonial Treasurer said: ‘Where the surroundings and mode of life of the household in which the case is found are good, we do not think there is really urgent reason for the removal of the infected person, for all experience goes to show that under such circumstances the disease is not easily communicated.’ Anonymous report in the \textit{Australasian Medical Gazette}, vol 10, 1890, pp 25-26. New South Wales would treat its leprosy patients with greater tolerance than Queensland.

\textsuperscript{63} Proceedings of the Legislative Council, 14 April, 189.
The new act came into effect from 20 July, 1892. Section 2 of the act dealt with the proclamation of places to be lazarets, section three made leprosy notifiable, by a householder and by a medical practitioner, in the first instance to the nearest Police Magistrate, who would report to the Minister, with a copy to the Central Board of Health. After confirmation of the disease, the patient would be transferred to a nominated lazaret, using such force as may be necessary, where he would remain until either cured, or released by order of the Colonial Secretary. If a patient escaped from the lazaret, he would, when recaptured, be returned to the lazaret also ‘with such necessary force as the case may require.’ Section ten retrospectively validated any previous incarceration of ‘lepers’ and section eleven allowed people to be detained in specially appointed places, where they would receive such supervision and treatment as the Governor may direct. The *Leprosy Act* effectively took the control of leprosy patients out of the hands of the Central Board of Health, and placed it into the Minister’s hands. New leprosy regulations published in 1897 spelled out in detail the handling of patients’ effects. Section 17 specified that, after death, and within twenty-four hours, the body was to be buried in quicklime.64

In 1891 Salter, who was responsible for the Dayman Island patients, complained of the conditions on the island.65 The following year, and despite vocal opposition from the people of Thursday Island a new lazaret was established on Friday Island, in the Torres Straits —where there already existed a quarantine station— for coloured patients. From

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64 Q.G.G. 1897:68;1318.
65 Q.S.A. COL 264, in-letter 5874 to Colonial Secretary, 27 May, 1891.
1892, after leprosy was found in an increasing number of white men, the government established a separate lazaret on Stradbroke Island, close to, and under the supervision of the superintendent of the Dunwich Benevolent Asylum. In 1907, both these lazarets closed, and all patients were transferred to a purpose built establishment on Peel Island (figure 5.1). In 1908, the government of Queensland wrote to Dr. Hansen, asking his opinion on segregation. In his reply, Hansen

'recommended the isolation of as many patients as possible; in Norway, government pays all expenses: since 1885 an optional coercion has been

**Figure 5.1** Cottages for white patient on Peel Island (John Oxley Library)
employed in this country, the local board of health giving the leprous certain
instruction in regard to isolation at home if he wishes to stay there: if he cannot
or will not comply, the Board may compel him to enter the institution; he should
have his own bed, his own room, his own eating outfit, which must be cleansed
separately, his clothes washed separately and not worn by others. These will
prevent the transmission to others. I have found it useful to scare the other
inmates having made the experience that it is easier to make an impression on
the healthy than on the sick, who only reluctantly will give up their so-called
human rights among which they commonly also reckon an eventual risk of
infecting their fellow men. It has the best effect to impel the healthy to be on
their guard…’

The Queensland government could say with confidence it was doing what Dr Hansen
advocated. The medical profession, if it thought about leprosy at all, generally supported
the idea of segregation, though Dr Lyons considered the idea of a lazarette ‘a survival
from medievalism, painfully suggestive of the Inquisition, the rack and other barbarisms
of the middle ages’, a position later supported by Thomas Bancroft, son of Joseph
Bancroft.’

Many individuals underwent medical examination for ‘suspected’ leprosy. The definitive
diagnosis was established by the results of clinical examination and the taking of skin

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66 Q.S.A. COL/324, in-letter 13484 to Chief Secretary, received 11 November, 1908.
67 Brisbane Courier, 26 April, 1892.
68 Brisbane Courier, 1 May, 1894.
smears for microscopic examination for *Myco. leprae*. Though Hirschfeld made the first such examinations in 1892, C. J. Pound (figure 5.3) the bacteriologist at the Stock Institute, (later the Laboratory of Bacteriology and Pathology), took over the work, and soon his reports became the only ones accepted by the Colonial Secretary.69

As many patients came from remote areas of Queensland, delays, sometimes of several weeks, inevitably occurred before a definitive diagnosis could be established. The situation was made worse by the taking of inadequate specimens by inexperienced doctors, or as a result of the specimens being spoiled, by heat, insects or improper parceling, before arrival in Brisbane, necessitating the taking of further specimens. In the meantime, locals objected, often vociferously, to the detention of lepers—both coloured and white—close to centres of population.70 Smears negative for *Myco. leprae* caused concern if the doctors were convinced the case was one of leprosy. White patients in these circumstances might be given the benefit of the doubt,71 but coloured patients were, in general, sent to the lazaret.72

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69 This change in practice appears to originate with the case of a young white man, P.M., bacteriologically diagnosed by Hirschfeld in November 1894. There were doubts about the diagnosis. The patient was sent to Stradbroke Island, where Pound saw him, took upwards of thirty specimens and could find no trace of bacilli. The case caused considerable animosity between the medical fraternity and the Colonial Secretary. Q.S.A. COL 274, a series of letters, beginning with in-letter 12597 to Colonial Secretary from Hirschfeld, 1 November, 1894.

70 Q.S.A. COL 264, in-letters 3511 and 3529 to Colonial Secretary, 16 and 17 April, 1889 complaining of possible use of Friday Island as a lazaret: COL 271, in-letter 12070, 10 October, 1892; and telegram from Police Magistrate F. Mowbray to Colonial Secretary, 10 October, 1892, saying the public were alarmed at the presence of a leper in their midst; COL 273, in-letter 17633 from the ratepayers of Georgetown, forwarded to Commissioner of Police, 24 September, 1900, complaining of the presence of an Aboriginal leper in their midst. COL 269, from Town Clerk of Cairns, complaining of presence of a leper in their midst, 23 March, 1898: *Brisbane Courier*, 28 January, 1898; *Cairns Daily Argus*, 3 September, 1904; and others.

71 See, for example, the case of the Englishman J.L.W. a miner from Herberton. In 1892, Hirschfeld took smears, but these were negative for leprosy bacilli; he therefore concluded that the patient was not suffering from leprosy (*Brisbane Courier*, 18 November, 1892). The patient was therefore set free. Three
5.5 Police involvement

Quigley was the first white person to be detained under the regulations of 1891. The Colonial Secretary ordered him to come south for further investigation but Quigley escaped from supervision. The Colonial Secretary then ordered the police to search for years later he was confidently diagnosed by Drs Bancroft, Thomson and Taylor as a case of anaesthetic leprosy. He died at Stradbroke Island in 1901.

72 See, for example, Q.S.A. COL 273, in-letter 07924 to Home Secretary’s office, 25 June, 1897:- an Aboriginal man seen by Dr Kortum of Cairns in July 1897, who thought the man had leprosy, but smears for *Myco. leprae* were negative, despite which he was sent to Friday Island, where he died. There are other examples. COL 265, in-letter 00129 to Commissioner of Police, re an Islander named Tobie who was transferred to Friday Island despite a negative smear, 22 December, 1899.
him. He was subsequently detained in Brisbane and moved to accommodation in the grounds of the Brisbane Hospital.\textsuperscript{73} The medical superintendent of the hospital ordered the two constables who guarded him to leave, ‘in consideration of the lad’s feelings,’\textsuperscript{74} a condescension accorded to relatively few patients. There then followed a flurry of police activity. In February 1892, the Townsville police were ordered to escort an Aboriginal man, suspected to be a leper, to Thursday Island, and ‘to take charge of him there while awaiting orders.’\textsuperscript{75} In March, the police were ordered to arrest an Islander with suspected leprosy, ‘but as it appears that Silla escaped from the Reception House at Rockhampton…every effort (is) to be made by police to assist in enforcing the order of the board.’\textsuperscript{76} Shortly after, the escape of the suspect James Hemsworth, who also came from Rockhampton, led the Police Commissioner to put a notice in the Police Gazette, saying his arrest ‘was very desirable’.\textsuperscript{77} Three days later, a memorandum to all police stations from the Police Commissioner’s Office enclosed a copy of a form of report to be completed on the discovery of a supposed case of leprosy. Cases were to be reported to the Commissioner of Police in the first instance by telegram, but be followed by the completed report.\textsuperscript{78} The report asked for the name, country of birth and age of the

\textsuperscript{73} Q.S.A. COL 271, an extensive correspondence dealing with James Quigley. Attempts were made to link Quigley’s infection with that of the Chinese man imprisoned in Rockhampton in 1877. See also the Brisbane Courier, 13 and 15 February, 1892, and 12 March, 1892 dealing with other cases of leprosy.

\textsuperscript{74} Q.S.A. COL 271, in-letter 02595 to Colonial Secretary, 4 March, 1892.

\textsuperscript{75} Q.S.A. COL/G70, out-letter 92.555 to Commissioner of Police, 21 February, 1892.

\textsuperscript{76} Q.S.A. COL/G71, out-letter (number illegible) to Commissioner of Police, 13 March, 1892. The following day, similar orders were issued for the Commissioner with respect to a Chinese man, Ah Hing, at Herberton.

\textsuperscript{77} Q.P.G., 1892:29;286.

\textsuperscript{78} Q.S.A. POL11/A1, Circular Memorandum from Police Commissioner’s Office, 21/6/1892.
suspect, where and by whom discovered, where he now was, whether he had been examined by a medical man, and if so, with what results, and lastly asked the police making the report to add any further details if necessary. From then on, police were expected to arrest suspect cases, bring them to a government medical officer, and keep control of them until their final disposal had been arranged by the Board or the Minister.  

The police were often the first point of contact with a suspect. Employers, suspicious of abnormal signs, particularly in Aboriginal, Pacific Islander or Chinese patients, often contacted the police rather than a medical man. Police also acted on rumours, by arranging for individuals to be taken to a medical man for further investigation. An unnamed Chinese man, alleged anonymously to be a leper, escaped from his camp in North Queensland when the police approached to arrest him. Shortly after, Constable Connoly, in plain clothes and assisted by a native tracker, went to hunt for him. When captured, the constable noted he was in a loathsome condition, and had to be handled on and off his horse, causing some anxiety. This man, once he was settled at an isolation station at Cooktown, expressed his appreciation for the tenderness shown him by the police on his journey. Inspector Hervey Fitzgerald informed the Commissioner of Police that the case of the ‘Maytown leper…was particularly offensive, (and) the stench sickening.’ This unfortunate Chinese man was initially detained in disused police

79 See, for example, Brisbane Courier, 12 March, 1892.
81 Q.S.A. COL/A700, in-letter 06874 to Commissioner of Police, 23 May, 1892.
quarters. He was an opium addict. Six weeks after his arrest, Fitzgerald asked his commissioner if he could supply him with opium. The commissioner forwarded the letter to the Colonial Secretary, Horace Tozer, who said he could—perhaps the first time the police actually gave opium to an addict! Fitzgerald also bought a bottle of whiskey, allegedly to use as disinfectant!

The police, especially when patrolling areas populated by Aborigines, kept a look out for cases of leprosy and became, on occasions, proficient diagnosticians. In June 1900, Constable John Flynn found an Aboriginal man with suspicious signs of leprosy at a local ‘Black’s camp’ near Eulo. Here he made the man undress and examined his body. He found no discolouration or eruptions on the body, but the fingers of both hands and the toes of both feet were in a bad state. The constable judged him to be suffering from leprosy and took him back to Eulo. In September 1903, Acting Sergeant Walter King, from Banana, near Rockhampton, examined an Aboriginal and, judging from his appearance and from the state of his hands and feet, he thought he looked a suspicious case of leprosy. His superior, Inspector Fitzgerald wired the Commissioner to say he did not think it was a genuine case from the description, but King was ordered to find an old saddle and bring the man to Rockhampton by horse for examination by Dr Vivian Voss, the Government Medical Officer in Rockhampton. Voss thought the case a genuine one,

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82 Q.S.A. COL/A700, in-letter 04271 to Commissioner of Police, 11 April, 1892.
83 Q.S.A. COL/A700, in-letter 04271 to Commissioner of Police, 11 April, 1892.
84 Q.S.A. COL 268, in-letter to Commissioner of Police dated 12 June, 1900.
and took skin smears. The police occasionally decided themselves that an alleged leper did not in fact have the disease.\textsuperscript{85}

But many hospitals refused to admit patients with loathsome diseases, and leprosy was consistently mentioned as loathsome. Once the police had arrested the suspect, they had to accommodate their prisoner until bacteriology had been done, the results given to the Minister, and the Minister had decided where, and when, the patient was to be segregated. Three weeks after arriving in Rockhampton, Inspector Fitzgerald wired the Commissioner to find out the results of bacteriology, as it proved costly to isolate the suspect from Banana. He had the satisfaction of being able to tell his superior that the patient, who arrived in Rockhampton in a starved and emaciated condition, had, under police care, put on a couple of stone in weight, the result of an abundance of food. The police also gave him a generous supply of tobacco.\textsuperscript{86} The diagnostic processes often took considerable time, much to the disgust of local citizens who objected to the presence of suspected cases of leprosy in their midst. Furthermore, shipping a patient from a rural area to either Friday Island, Stradbroke Island, or, after 1907, Peel Island, was often a problem. Commercial shipping lines were unwilling to accept leprosy patients, or demanded exorbitant fares for the trip. Government steamers were often engaged in other duties. Cobb and Co refused to take leprosy patients in their coaches, and station

\textsuperscript{85} Q.S.A. POL/J19, in-letter 12474 to Commissioner of Police, 17 October, 1896. Constable Whelan reported that, in his opinion, the alleged leper at Ayton was not suffering from leprosy, as other Chinese men in the camp had had similar symptoms, and recovered spontaneously.

\textsuperscript{86} Q.S.A. COL 274, in-letter 18258 to Police Commissioner, 10 October, 1903.
masters were always suspicious. Consequently, the police frequently had to keep a suspect, or a patient, for weeks or months. Though prisoners, the police sometimes provided such patients with tobacco, matches and, Constable Reside claimed for an Aboriginal woman at Georgetown, ‘other luxuries (unspecified) that are not allowed other prisoners.’

Holding patients pending their removal to a lazaret and escorting them to the lazaret often placed the police in unexpected logistical situations not governed by regulations. Patients were commonly held in a tent in police paddocks. The police in Normanton erected an iron hut in a paddock, six by eight feet, for one patient. Others were held in the police court stables, another in a tent in the grounds of the Rockhampton Lock hospital, some in hospital grounds and at least one patient in a tent in the grounds of the Rockhampton Reception House. In 1892, the Police Magistrate in Mackay informed the Colonial Secretary of the public alarm in town caused by holding a leprous Pacific Islander from Homebush, near Mackay, in a tent in the police lock-up yard; he therefore authorised the purchase of a tent, and the patient was removed to the police paddock. Inspector John Isley complained to the Commissioner of Police that the paddock, situated five miles from town, was without shelter, and it would need two constables to watch the patient.

87 Q.S.A. COL 269. In-letter to Commissioner of Police, 14 June, 1900, describes the case of ‘Tommy’ whose name was published in local papers, so the station master refused to allow him to travel except with a medical certificate to say he was not suffering from a contagious disease.

88 Q.S.A. COL 265, in-letter 17884 to Commissioner of Police, 17 August, 1900.

89 Q.S.A. COL 322, in-letter 14829 to Commissioner of Police, 20 October, 1905. In 1903, Sergeant Fraser erected a humpy for an Islander with leprosy after his employer threw him off his property. COL 270, from Sgt Fraser to Inspector Graham, Townsville, 10 July, 1903.

90 Q.S.A. COL 271, in-letter 03282 to Commissioner of Police, 18 March, 1892. If a leprosy patient was held at a quarantine station, passengers off ships needing quarantine could not be held at the same place.
Isley thought it inhuman to place anyone in such a situation. The Colonial Secretary noted ‘there was further unnecessary panic concerning this disease.’ Sometimes doctors tried to send leprosy patients to quarantine stations, but the Colonial Secretary was having none of that. Family or others sometimes abused police guarding patients, presumably unaware they were acting under orders. Police sometimes guarded the patients themselves, sometimes they contracted for a civilian to undertake the task, and sometimes they trusted the person sufficiently to merely call in at intervals to see all was well.

Acting Sergeant Daniel Whelan undertook a long patrol through Cape York, between 7 August and 11 October, 1908, in the course of which he detected a number of Aboriginal patients he suspected to have leprosy. He organized for the Thursday Island police boat to meet him, and transferred a number of patients.

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91 Q.S.A. COL 271, in-letter 12101 to Commissioner of Police, 10 October, 1892.

92 Q.S.A. COL 273, from Inspector Meldrum to Commissioner of Police, 12 December, 1900.

93 Q.S.A. COL 274, in-letter 23335 to Commissioner of Police, describing how the brothers of Jacob Fox, held in a tent at Cordolba under police guard, had abused the police, and threatened to shoot their brother, rather than allow him to live in such a state.

94 Q.S.A. COL 275, in-letter 15971 to Commissioner of Police, complaining of the amount of time it takes to guard lepers, 21 November, 1905.

95 Q.S.A. COL 269, Sub-Inspector William Cooper told the Commissioner of Police he was arranging for two men to look after “a leper” noting there were no spare police to look after the patient, 23 March, 1898. The cost would be seven shillings and sixpence for each man, plus two shillings per day to ration the patient.

96 Q.S.A. COL 273, in-letter 13168 to Commissioner of Police, 15 August, 1902. Sub-Inspector Quilter ordered a constable to visit a suspect leper “every other day.”
'I may mention that I rationed several lepers while waiting for the police boat and conveying the lepers to suitable places for the police boat to take them away... Owing to the constant handling of the lepers lifting them in and out of the saddle, I had to burn all the trackers uniform also my own khaki uniform and one borrowed riding saddle. Most of the lepers were helpless and had to be lifted on and off the horse.'

In forwarding Whelan’s report to the Commissioner of Police, Inspector Hugh Malone of Cairns recognized that ‘without taking into consideration the danger of contagion which this work entailed…the thorough manner in which he has carried out this disagreeable duty calls for some reward’. For Whelan’s good work, Commissioner W. Geoffrey Cahill recommended a reward of £5. Sub Inspector William Brett of the Thursday Island police heard of this, and wrote to Inspector Malone in Cairns describing an occasion when he and a constable had removed four lepers from Aurukun, and asking for a reward for himself and the constable. Inspector Malone forwarded a copy of the letter to the Commissioner of Police, stating that Brett was, ‘the first officer that I have ever heard of asking for monetary reward for performing his ordinary duty. I think it is very unbecoming of an officer to compare the duty performed by the constables under him with that performed by himself.’ Brett did not receive a reward.

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97 Q.S.A. POL/J22, in-letter 18599 to Commissioner of Police, dated 14 October, 1908. Whelan was at the time based at the Native Police camp at Coen. His death at Coen in 1911 represented the final closure of frontier policing in Queensland, and by the beginning of the Great War, the Native Police had finally disappeared. (Jonathan Richards “A Question of necessity”, 2005, p 154).

Occasionally, the police erred in their diagnoses. A Pacific Islander, brought in by the police for Dr Baxter Tyrie in Cairns to examine, turned out, in the latter’s opinion, to have bilateral Dupuytren’s contractures, not leprosy.\footnote{Q.S.A. COL 275, in-letter 06628 to Home Secretary, 28 July, 1914 Dupuytren’s Contracture is a non-infectious clawing of the fingers of the hand towards the palm. The cause is unknown.} Dr Ahearn from Townsville said a Chinese man from the lower Burdekin suffered from psoriasis,\footnote{Q.S.A. COL 264, in-letter 14885 to Colonial Secretary, 11 November, 1895, Psoriasis is a chronic, non-infectious auto-immune disease of the skin and joints.} and, no doubt, there were other cases.

Patients held in custody, whether in police paddocks or elsewhere, had to be fed. If possible the police contracted with a civilian, sometimes an Aboriginal,\footnote{Q.S.A. COL 264, in-letter 13170 to Commissioner of Police, 26 November, 1895, describes the case of Boura Paddy who was “looked after by another Aboriginee.”} often a Chinese man, rarely a white person, or friends and relatives to ration the patients, otherwise they arranged it themselves. Constable Patrick Joyce employed a storekeeper named Ah Kee to ration a female Aboriginal patient at 2/6\(^d\) per day. Ah Kee only fed her for six days and then ‘knocked off on account of her being a leper he did not care to have any truck with her.’ Constable Joyce then had to take over the duties, since all other civilians refused to go near her.\footnote{Q.S.A. COL 265, in-letter 17884 to Commissioner of Police, 27 August, 1900 COL 265, in-letter 16221 to Commissioner of Police, 24 December, 1898, and others.} Inspector James Lamond, to whom Joyce sent the food vouchers, thought 2/6\(^d\) unreasonable, and ordered the woman be rationed at as reasonable a rate as possible.\footnote{Q.S.A. COL 265, in-letter 17884 to Commissioner of Police, 27 August, 1900.} On 12 December, 1900, Inspector Alexander Meldrum of Townsville notified the Commissioner of a new case of leprosy in a married, white
woman. The Government Medical Officer wanted her moved to the Quarantine Station at Magnetic Island, but the Colonial Secretary quashed the idea, and ordered she be isolated until she could be shipped to Brisbane. Meldrum arranged her isolation in a tent at the rifle range. Her husband occupied a separate tent some distance away. He thought the couple to be in ‘rather poor circumstances’ and recommended they be allowed rations, a suggestion that was approved.\textsuperscript{104} An elderly white man from Port Douglas consulted Dr William Bacot in Townsville for a cancer of his mouth, but in addition to the cancer Bacot found he also suffered from leprosy. Though Bacot ordered the man to report to the Townsville police, he refused and took ship back to Port Douglas, where a local doctor also considered he had leprosy. The local police put him in a cell, much to the irritation of the Commissioner of Police, who ordered him removed to a tent in the police yard. Constable Albert Thiesfeld reported the man was in a very bad state, and he had to make special custards of egg and milk which were all the unfortunate man could swallow without pain. This necessarily cost significantly more than standard rations, so the vouchers had to be forwarded to the Commissioner for payment, which were approved. The constable also bought bandages and dressings. This unfortunate patient was ordered to Dunwich. After his departure an extra charge of 2/- was forwarded to the Commissioner for four pounds of sulphur for fumigating the police buildings. A special hut was built on the schooner \textit{Tom Fisher}. The weather was bad, and the patient, in a very poor state, disembarked at Maryborough where the Government Medical Officer

\textsuperscript{104} Q.S.A. COL 273, a series of letters, but see in-letter 09844 to Commissioner of Police, 15 July, 1904.
and two constables met him. The hut was removed and burned.\textsuperscript{105} The patient took the train, under police escort, to Brisbane, and thence to Stradbroke Island, where shortly after, he died.\textsuperscript{106}

Occasionally, patients died while still in police custody. Sergeant John McGrath was involved in the detention of an Aboriginal patient, isolated a mile out of Cunnamulla, who died only two months after the suspicion of leprosy was raised. McGrath ordered the man buried, at a cost of £1, and also had the man’s camp, blankets and clothing burned.\textsuperscript{107} Sam Wee Gee Gee, a Chinese patient, died on board the brigantine taking him to Friday Island. Acting Sergeant McGuire investigated and arranged an inquest on board the ship, which concluded the man died of dysentery.\textsuperscript{108}

Escaping from police custody was surprisingly common, and police spent much time looking for the escapees, sometimes successfully, occasionally not. David Silla, an Islander, escaped from custody in 1892. When recaptured, the Police Magistrate, W.G. Hartley, in Rockhampton asked the Colonial Secretary where he should be confined, adding that in the meantime he had committed him as a vagrant.\textsuperscript{109} One escapee, a Pacific Islander, was a suspect case only. The Police Magistrate in Cairns told Sub

\textsuperscript{105}Q.S.A. COL 274, in-letter 03404 to Home Secretary 13 March, 1906, describes the extraordinary steps Dr Linford Row, the Superintendent of the Dunwich Benevolent Asylum, took to ensure the complete destruction of this hut.

\textsuperscript{106}Q.S.A. COL 274, a series of police letters referring to this patient.

\textsuperscript{107}Q.S.A. COL 264, in-letter 13170 to Commissioner of Police, dated 26 November, 1895.

\textsuperscript{108}Q.S.A. COL 270, in-letter 12099 to Commissioner of Police, 22 July, 1904.

\textsuperscript{109}Q.S.A. COL 271, in-letter 03196 to Colonial Secretary’s Office, 18 March, 1892.
Inspector John Ferguson that the police had no power to restrain him, apparently as the disease had not been confirmed. Despite this ruling, on being recaptured, he was ‘put under restraint.’ The Commissioner of Police confirmed the rightness of this course, saying he was now a confirmed ‘leper’ and could be forcibly detained. At least one man escaped because, as the police admitted, the caretaker who had been appointed to look after him was completely prostrated through consumption, so ill in fact the police took him to hospital before setting off to find (and recapture) the escapee. Occasionally the police made the mistake of assuming, because of severe disabilities, a patient would be unable to escape. As one policeman said, ‘(the patient) was placed in a camp about two hundred yards from the barracks- no restraint was put on him, as the Sergeant thought the state of his feet would stop him getting away’, which it did not. Chinese people harboured escapees, sometimes refusing to tell the police of their whereabouts, but assuring the police the patients were ‘all right’. Aboriginal patients, but not white patients, were sometimes chained to prevent escape. An Aboriginal woman, manacled to a tree by a chain and an old handcuff around her ankle within an iron stockade eight feet high in Georgetown managed to escape, probably with the help of outsiders, but she left the handcuff behind. She was recaptured, but

110 Q.S.A. COL 269, in-letter 03689 to Commissioner of Police, 2 February, 1898.
111 Q.S.A. COL 269, in-letter 12348 to Commissioner of Police, 23 September, 1898.
112 Q.S.A. COL 269, in-letter 09787 to Commissioner of Police, 14 June, 1900.
113 Q.S.A. COL 273, in-letter 11845 to Commissioner of Police, 19 September, 1898.
114 The Queenslander, 12 July, 1902 has a photograph of a chained Aboriginal ‘leper’.
115 Q.S.A. COL 265, in-letter 14777 to Commissioner of Police, 24 September, 1900.
subsequent investigations showed she did not suffer from leprosy. An Aboriginal man from Cairns, diagnosed by Dr Tyrie, escaped from custody, due, Tyrie thought, to gross carelessness on the part of the police. However, he was recaptured, and, on Tyrie’s orders, chained by the neck. Inspector James McGrath was furious, and wrote to the Commissioner complaining this was against police instructions, but Tyrie claimed that he had special powers under the Leprosy Act. McGrath ordered a constable to remove the chain, but Tyrie countermanded the order. McGrath suggested it would be better if the Health Department employed a man to look after lepers, thus relieving the police of this duty. Commissioner Cahill agreed, telling the Home Secretary he entirely disapproved of a prisoner being chained in this manner; the health authorities said they had no alternatives, adding that to employ a man was not feasible.116 As late as 1929 the police reported that if an Aboriginal patient was to be removed from the Cooktown lockup, it would be necessary to engage a watchman, as he would have to be placed in leg irons and chained up to prevent him escaping.117 Some patients managed to escape and were never recaptured and some died in the bush.118

Patients also attempted to escape from Peel Island. In December 1916, the Commissioner of Police wrote to the Home Secretary about two escapees from the island.


117 Q.S.A. COL 268, in-letter 4580 to Inspector of Police Cairns, 4 December, 1929 despite a letter from the Comptroller of Prisons, dated 13 August, 1923 saying prisoners travelling by train should not be in leg-irons unless there was the likelihood of extreme danger to the escort. A/19561.

118 Q.S.A. COL 273, case 93, in-letter 12977 to Commissioner of Police, 16 July, 1900.
After investigation, he believed the two men had drowned.\(^\text{119}\) The Commissioner of Public Health quoted a case of a man who absconded from Peel Island, was never traced by the police, but voluntarily returned two years later after his condition had deteriorated.\(^\text{120}\) For the record, two patients also escaped from Fantome Island, but were recaptured at Proserpine.\(^\text{121}\)

The issue of compensation for material that was destroyed was a touchy one that frequently involved the police. After the departure of a married white woman for Dunwich, Inspector Meldrum, at the G.M.O’s request, suggested that the tent she had occupied should be burned. The tent belonged to the husband, who refused to allow this unless he received £3-10-0 compensation. The matter dragged on for several months, and was only resolved after calling in a sail-maker, who valued the tent at £6-10-0! Compensation of £3-10-0 was then paid and the tent was burned.\(^\text{122}\) A Pacific Islander who escaped from detention slept for two nights in a hut belonging to a local landowner. Constable Michael Cavanagh reported the owner of the hut wanted compensation of £2 for destruction of the hut and a tarpaulin the man had slept under. The same individual also claimed the man rested on a punt and some timber and also demanded £2 for destruction of the timber and for the punt to be cleaned and disinfected. The letter passed up the chain of command, from constable to sergeant to inspector, and finally to the Commissioner of Police, who forwarded the whole file to the Home Department, saying

\(^{119}\) Q.S.A. COL 322, in-letter 11782 to Home Secretary, dated 28 December, 1916.

\(^{120}\) Q.S.A. COL 323, reference MLA/293 dated 18 September, 1923.

\(^{121}\) Q.S.A. POL/J30, in-letter 4197 to Inspector of Police, Townsville, 30 September, 1940.

\(^{122}\) Q.S.A. COL 273, case 96, starting with in-letter 19078 to Commissioner of Police, 8 December, 1900.
he was not in a position to make any recommendations. Not infrequently, the police had to assess the value of material being destroyed, while also giving an opinion on the need for this. In 1912, Constable Otto Kreutzmann assisted the Government Medical Officer, Dr Tyrie in Cairns, to burn three huts belonging to a Pacific Islander who Tyrie said had leprosy. As the patient had two companions, Kreutzmann and Tyrie considered £5 compensation for each of the companions would be fair. Tyrie, however, received a reprimand, being told it was the local authority’s duty to deal with houses unfit for human habitation. Clearly, neither the police, nor the Government Medical Officer were aware of the limits of their powers or responsibilities. Dr Bacot of Townsville diagnosed a twelve year old white schoolboy as having leprosy in April 1901. Unusually, Acting Sergeant Fraser told his inspector the boy would remain at home, and be looked after by his older sister. He thought it unlikely the boy would abscond, and consequently withdrew the constable who had been on guard duty, but said he would arrange to visit the house periodically. He thought the sister should be given some compensation, as the family was in poor circumstances and added the comment ‘and this case is not likely to improve their position.’ Inspector Meldrum ordered Fraser to make enquiries into the family’s circumstances, and supply rations if required. He also ordered Fraser to report on the size and value of the house in which the child lived, since the Government Medical Officer had ordered its destruction. Fraser replied that it would be a good idea to have the house destroyed by fire, it being in a very dilapidated condition, rotten with termites, and of little value except for the iron roof. He thought £35 would be a fair

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123 Q.S.A. COL 269, in-letter 13535 to Commissioner of Police, 20 October, 1898.

124 Q.S.A. COL 276, in-letter 28131 to Commissioner of Police, 5 January, 1912.
compensation. The Home Secretary of the time, Justin F. G. Foxton, approved an allowance of £1-0-0 per week for the young woman who was looking after her brother, until such time as his disposal was arranged, but on condition the owner of the house accepted £25 as compensation for the house, in which case it should be burned. If the iron on the roof was good, the Home Secretary suggested it should be removed when it could be scorched by fire or otherwise disinfected and re-used.125

Section 8 of the 1897 regulations ordered that all excreta should be burned. If this was not possible, it was to be disinfected with corrosive sublimate and removed daily. Police were expected to ensure that this happened to those patients in their custody. Sub-Inspector Bowen in Cairns notified his superiors of a Cingalese patient being held in isolation. ‘The excreta and water used for washing was removed by the leper every night into the scrub about a mile from a residence and disinfected’,126 while in the case of a Normanton patient, the excreta was burned.127

In 1898, a rumour spread that a young white male patient might have attended school in Brisbane. The police were asked to investigate the allegation. Constable Charles Bell investigated, but found no evidence the boy had attended school in Brisbane,128 no doubt, allaying some fears. Parents found the possibility that a ‘leper’ might have

125 Q.S.A COL 273, Case 98, in-letter 11975 to Home Secretary, July 1901.

126 Q.S.A. COL 270, in-letter 16921 to Commissioner of Police, 6 November, 1905 .COL 276, in-letter 12002 to Commissioner of Police; Inspector Lamond informed his superior that all excreta from the case of A.C. in Normanton were being burned.

127 Q.S.A. COL 276, in-letter 12002 to Commissioner of Police 28 August, 1905.

128 Q.S.A. COL 273, in-letter 14254 to Commissioner of Police 18 November, 1898.
attended school very disturbing. A school in the Gulf country was closed in 1900 as parents kept their children away ‘owing to leper being too near school one hundred yards away.’ The principal of a school at Emu Park asked the Education department to remove three Kanaka boys from the school as one of them was the son of a recently deceased leper.

The police also looked for missing persons. J.C., a married white man, was sent to Stradbroke Island in 1898, but was discharged in 1905. He evidently did not return home, for in 1912, his wife informed the Home Secretary she wished to remarry. The police made enquiries in New Zealand, where her husband had said he might be going, but without any success. Earlier, J. C.’s wife complained to the Home Secretary that she had lost her job as a result of defamatory statements being made about her. The police reported the allegations unfounded, acknowledged that Mrs. C. had difficulty finding work, but stopped short of saying this was because of her husband’s illness.

In September, 1900 a health officer who took specimens for investigation of leprosy from a shearer in Dalby Hospital had an accident and his place was temporarily taken by Dr Hugh T. Bell. Bell failed to examine the shearer, to the disgust of the local sergeant, who

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129 Q.S.A. COL 265, in-letter 14777 to Commissioner of Police, 24 September, 1900.

130 Q.S.A. COL 264, to Under Secretary of the Education Department, 22 March, 1895.

131 Q.S.A. COL 276, in-letter 14900 to Colonial Secretary, 12 December, 1912. On his discharge, J.C. evidently did not go to New Zealand; in about 1910, he suffered a relapse of his leprosy while in New South Wales and was admitted to the NSW lazaret. In 1920, the Queensland Public Health authorities stated they did not wish to have him back in Queensland.

132 Q.S.A. COL/276, in-letter 12167 to Home Secretary, 26 July, 1901.
complained to the Senior Inspector of Police in Brisbane that ‘Dr Bell has not looked at patient and he is getting very discontented at not being examined. I think he will cause trouble if not examined soon.’ However, once the suspicion of leprosy was raised the Hospital Committee became worried, and asked the Home Secretary to ‘take action at once.’ The police, ordered to isolate the man pending further examination as to the nature of the disease, isolated the patient in a tent in the hospital yard, and placed a constable in charge. The sergeant indulged in a little contact tracing by noting the patient was known out west as ‘a great combo’—a white who co-habits with a black woman—and had worked at a station where a black woman had recently been removed, suffering from leprosy.

Many rural doctors were ignorant of leprosy. Dr William Kirkaldy of Charleville, when asked to examine a half caste woman for leprosy, wrote to Inspector Lamond saying he had absolutely no experience of the disease, and asking if Lamond could send her to Brisbane. Doctors sometimes attempted to profit from their isolation. Inspector Fitzgerald reported the doctor in Maytown would not examine a Chinese patient unless he was paid a fee of £20, and asked if the cost would be sanctioned. The patient was sent to Cooktown instead.

133 Q.S.A. COL 273, in-letter 16757 to Senior Inspector of Police, 10 October, 1900.


135 Q.S.A. COL 273, in-letter 12102 from Dr Kirkaldy to Inspector J. Lamond. 1 October, 1898, copied to Commissioner of Police.

136 Q.S.A. COL 271, in-letter 03294 to Commissioner of Police, dated 21 March, 1892.
The police, who made the arrangements for the transfers, escorted all cases of leprosy to their final destination. Railway station masters sometimes caused problems, wanting compliance with the bye laws relating to contagious or infectious diseases, otherwise refusing permission for the patients to travel. Many patients were diagnosed in places far from railway lines. Some travelled by horse, some in drays, some by ship and some on foot. Constable Kreutzmann informed his superiors he had located a ‘leper’. Despite the fact that he had very sore feet, the policeman made him walk several miles to the leper station.\textsuperscript{137} A. C., a white boy, was only fifteen years old when he was diagnosed with leprosy, originally in Sydney, then in Normanton where he lived. In August 1905, he was isolated in a police paddock, four miles from town, with a police guard. In December, Inspector Lamond tried to employ a Chinese man, who had a garden close to where the boy was isolated, to look after him for two pounds a week, citing the need for all police to help deal with an outbreak of cattle rustling. Home Secretary Peter Airey thought that, since the police had looked after him since August, they should continue to do so until the end of January. In February, the doctor who had diagnosed the case praised the police for the way they had managed the case.\textsuperscript{138} It would be another three months before the boy was transferred to Brisbane. He travelled, with a police escort, on horseback from Normanton to Cloncurry.\textsuperscript{139} Police in the outback towns through which they passed monitored the journey, wiring their superiors of the progress of the two men. From Cloncurry, the pair took the train to Townsville and then ship to Brisbane. The

\textsuperscript{137} Q.S.A. COL 276, in-letter 28131 to Commissioner of Police, 5 January, 1912.

\textsuperscript{138} Q.S.A. COL/276, in-letter 00-2521 to Commissioner of Police, 8 February, 1906.

\textsuperscript{139} Q.S.A. COL 276, in-letter 005484 to Commissioner of Police, 10 April, 1906.
journey started on April 5, 1906, they reached Stradbroke Island on 8 May. Inspector Herbert Durham wrote to the Commissioner of Police to complain about the amount of time being wasted by police guarding leprosy patients, and made the point that it was unfair, in the event of an escape, to expect constables, especially married men with families, to re-arrest or struggle with such patients if any resistance was offered. Inspector Meldrum urged that secrecy be observed when dealing with suspected leprosy, otherwise the name and condition of the patient might get publicized in the press, which led to shipping companies refusing to take the patients; but this suggestion was ignored. Generally, in contrast to the escorting of insane patients, police in uniform escorted leprosy patients. However, when a white man with suspicious signs of leprosy was found in Isisford, the constable ordered to bring him to Brisbane, a journey taking eight days, was told to conduct the affair with the utmost discretion. Plain clothes would be allowed, so long as the constable carried his uniform with him in a portmanteau, ‘for use if necessary.’ There is no indication why this degree of discretion was required on this occasion, nor what emergency might cause the constable to change into his uniform. At the lazaret, the escorting policeman was given a certificate: ‘received from Constable… one …patient, suspected leper.’

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140 Q.S.A. COL 275, in-letter 15971 to Commissioner of Police, 11 November, 1905.
141 Q.S.A. COL 265, in-letter 18944 to Commissioner of Police, 11 November, 1900.
142 Q.S.A. COL 273, in-letter 08374 to Commissioner of Police, 4 May, 1899.
143 Q.S.A. COL269, a series of letters detailing the role of the police in the case of an Aboriginal male named Tommy, between 4 June, 1900 and 27 January, 1901.
Sergeant Fraser heard that a Pacific Islander had been turned out of his humpy because he was a leper, so he arranged for a new humpy built in the scrub, supplied the patient with rations, and ‘presumed that his actions would be approved off’[sic].\textsuperscript{144} His presumption proved correct. The Colonial Secretary’s office ordered the police not to bring leprosy patients to Brisbane on Saturdays, Sundays or public holidays, as ambulance bearers, disinfectors, Dunwich boatmen and lazaret officials might not be available.\textsuperscript{145}

Looking after leprosy patients was not a welcome task. Constable Frederick Grimbower looked after a Pacific Islander for 122 days. He said the work was distasteful and dangerous.\textsuperscript{146} He claimed an extra allowance of £21-7-0, but a grant of £5 was later approved. Inspector Hervey Fitzgerald wrote that his sergeant, who was looking after an Aboriginal patient, said his condition was loathsome in the extreme, and expressed dread of infection with the summer heat.\textsuperscript{147}

Though leprosy patients were generally transferred to an established lazaret, Section 11 of the \textit{Leprosy Act} stated that if an individual had the means to provide for his proper maintenance and medical care, the Governor in Council could direct him, not to a lazaret, but to a specially appointed place. This happened only once in the period covered by this study (1859-1919). Dr Ernest Humphrey of Townsville diagnosed a white man in 1904. The patient, then sixty-four years old, lived fifty miles from Townsville, and wished to be

\begin{footnotesize}
\begin{enumerate}
\item[144] Q.S.A. COL 270, in-letter 16083 to Commissioner of Police, 10 June, 1903.
\item[145] Q.S.A. COL 323, out-letter 26/10048 to Inspector of Police 9 April, 1929.
\item[146] Q.S.A. COL 270, in-letter 00522 to Commissioner of Police, 4 January, 1905.
\item[147] Q.S.A. COL 271, in-letter 11502 to Commissioner of Police, 10 October, 1892.
\end{enumerate}
\end{footnotesize}
isolated in his own paddock, but was not keen to see any doctors. After a considerable
time, numerous letters and changes of plans, the Under Home Secretary wrote to
Humphrey to inform him the Governor in Council had appointed a detached room of the
son’s agricultural homestead to be a place for the purposes of section 11 of the Leprosy
Act of 1892. The decision was not pleasing to members of the Ollera Progress
Association, who wrote to the Home Secretary to complain. Humphrey was expected
to visit every three months, required police assistance to arrange the visits, and finally
complained that the family ‘look upon me as a scoundrel of the first water.’ He asked if
the Home Secretary could instruct the police to threaten to remove the patient to
Stradbroke, believing this might smooth matters. He also complained that he had to
hire his own horses, as the police no longer helped him as formerly they had, but the
Home Secretary was no longer interested in the matter. This man died in April 1906 at
his home.

Section 10 of the 1897 regulations said patients were not permitted to be kept in a place
not proclaimed a lazaret. In 1905, the newly appointed Commissioner of Police W. S.
Cahill wrote to the Home Secretary stating he thought the lepers were not being dealt
with in strict conformity with the law (and especially section 10). Section 13 provided
heavy penalties for violating the regulations and he felt the police were, unwittingly,
parties to breaches of the regulation,

148 Q.S.A. COL 265, in-letter 15713 to Home Secretary, 5 December, 1904.
149 Q.S.A. COL 265, in-letter 12670 to Home Secretary, 12 December, 1904.
150 Q.S.A. COL 265, in-letter 01623 to Home Secretary, 6 February, 1905.
Regarding the general question of Police acting under the Leprosy Act...I beg to point out that, while...arrangements have been made on the recommendation of the Public Service Board for direct communication between officials in purely formal matters, the isolation, custody and care of persons afflicted with leprosy cannot possibly come under this category - these are not purely formal matters: they are very serious matters indeed, and, in my opinion, require very much more serious consideration than has been given to them.\textsuperscript{151}

Home Secretary Peter Airey replied that the police must do the best they could under the circumstances.\textsuperscript{152} Police, Airey said, merely needed to isolate these lepers as far as possible. For any shortcomings in the observance of the act and regulations, the Home Department would take the responsibility. It would be quite impossible, under the circumstances, to carry out the regulations in their entirety, which presumably meant that not every tent, hut or stable where leprosy patients were held by the police until they arrived at their final destination would be proclaimed a lazaret. Cahill was satisfied.

The police care of leprosy patients involved significant costs. In 1905, the cost of looking after a patient for two weeks totalled: £10/5/4\textsuperscript{d} for two constables’ salaries, working twelve hour shifts, rent allowance for one constable 15/-, and rations to patient, £1/15/10\textsuperscript{d}.\textsuperscript{153} Lamond’s costs at Normanton for looking after a white man for ten weeks

\textsuperscript{151} Q.S.A. POL/J22, in-letter 17423 from H.M.Cahill to Home Secretary, 12 December, 1905.

\textsuperscript{152} Q.S.A. POL/J22, minute attached to Cahill’s letter of 12 December, 1905.

\textsuperscript{153} Q.S.A. POL/J22, in-letter 16340 to Commissioner of Police, 28 November, 1905.
came to: £41/3/3d for one constable’s wages and allowances, 12/7d for contingencies (not specified), 10/6d for doctors fees and £2/10/- for patient’s rations per month.\textsuperscript{154} Cahill reported on eleven patients under police control at the end of November 1905. Costs incurred in looking after six of these, for varying periods of time, amounted to £117/14/2d. The other five incurred no costs, since they had either not yet been declared lepers, or the police only visited occasionally, or the relatives supplied rations.\textsuperscript{155}

Every department of government tried its best to deflect costs, but often the police bore the costs unless another agency could be made to pay. Government bureaucracy was racialized, with different departments managing different races. If the case was a Pacific Islander, the police charged expenses to the Inspector of Pacific Islanders, the Home Secretary’s Department took responsibility for expenses incurred in looking after whites, while the Chief Protector of Aborigines and the Police Department shared costs for caring for Aboriginal patients. A Pacific Islander from Mackay was ordered to the Friday Island lazaret with conveyance on the schooner \textit{Tom Fisher}. Sub-Inspector Martin told his superior he had some difficulty getting the patient to the ship owing to the unwillingness of the local boatmen to permit their boats to be used for the purpose. He eventually made arrangements to convey him in a steam launch, at a cost of 30/-, ‘which I consider very reasonable. This and other expenses will be paid by the Polynesian Department.’ But F. C. Hornsbrook, the Inspector of Islanders in Mackay took objection to the charge of £11-6-1 (this included the 30/- for the steam launch) and passed the

\textsuperscript{154} Q.S.A. POL/J22, in-letter 16438 to Commissioner of Police, 30 November, 1905.

\textsuperscript{155} Q.S.A. POL/J22, in-letter 12753 to Home Secretary, 11 December, 1905.
problem to the Immigration Agent in Brisbane. The man had lived in Queensland for sixteen years, the Agent said, and he could not see why the Pacific Islanders Fund should be asked to defray the cost of conducting another department’s business. The final outcome was unclear.

Though neither the Leprosy Act, nor the regulations of 1897 mentioned money, police were sometimes ordered to inquire into the ability of patients’ families to support them—as they did for many other situations, including lunatics. The cost of maintaining a patient in a lazaret was estimated at 26/- per week. A blind, destitute sixty-nine year old man, a resident of the Dunwich Benevolent Asylum, was diagnosed with leprosy. Three constables visited his wife, daughter and son in Brisbane, and two constables interviewed another son and daughter in Mitchell about their ability to support their father. All the police reports agree the whole family was poor. The police handled money matters, for the general population as well as for leprosy patients. In the nineteenth and twentieth centuries, the police distributed pensions for indigent whites, a useful means of ensuring the money was wisely spent. The wife of a man incarcerated on Peel Island was granted an allowance of 15/- per week, paid by the Ipswich police, after her father had been interviewed by the police and showed he was unable to support her.

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156 Q.S.A. COL 274, in-letter 0236, Department of Polynesian Immigration, 25 January, 1904.
157 Q.S.A. COL 274, case 114, in-letter 11440 to Commissioner of Police, 16 June, 1903.
158 Q.S.A. COL 278, in-letter 24031 to Commissioner of Police, 21 October, 1911.
If families received a pension from government, this was sometimes reduced by 26/- per week to cover the costs of maintenance. A leprosy patient at Dunwich wrote to the Home Secretary in 1899, saying his wife, at Laura, was starving and destitute, presumably hoping that she would not be liable for any costs. On a number of occasions in the next few months, Constable David Twaddle, and other police, visited the family, and found nothing amiss. The wife’s health, despite her husband’s reports, was good. The police even suggested that since the husband had left, the family was better off, because he used all their money for drinking. The constable also spoke to the local Burns Philp storekeeper who said the woman’s credit was still good.\textsuperscript{159}

The Legislative Assembly was well aware the police were being used in these roles, and presumably found nothing wrong with the situation. In July 1900, Mr William Maxwell, the member for Burke, asked the Home Secretary if he was aware that an Aboriginal woman, supposedly suffering from leprosy, was wandering about the Etheridge district. The Home Secretary replied he was aware of the case, and said she was brought into Georgetown by the police and isolated, pending enquiries.\textsuperscript{160}

The first woman to be diagnosed with leprosy in Queensland was a twenty-two year old white Brisbane woman in 1895. How or where she became infected remains uncertain. The government wished to send her to New South Wales, having no facilities for females, but the New South Wales Board of Health refused to accept her. After a prolonged stay.

\textsuperscript{159} Q.S.A COL 264, in-letter 07433 to Home Secretary, 8 April, 1899; 04448, to Commissioner of Police, 15 March, 1899; and 17268, also to Commissioner of Police, 13 November, 1899.

\textsuperscript{160} Questions in the Queensland Legislative Assembly, 27 July, 1900.
at the Immigration Depot in Brisbane, she was sent to a purpose-built cottage on Peel Island. Subsequently more women were diagnosed with leprosy, as the New South Wales Board had predicted.\textsuperscript{161} Facilities were established on Stradbroke Island, until 1907 when separate male and female cottages\textsuperscript{162} were built on Peel Island.

The final saga in the history of the police and leprosy patients occurred in January 1940, with the transfer of all the coloured patients from Peel Island to Fantome Island, in the Palm Island group off the coast of Townsville. A special train was commissioned, which took the patients to Cardwell, arriving at 3.40 a.m. The Deputy Superintendent of the new institution, the health officer and the Cardwell police met the train carrying forty-nine patients, Matron O’Brien and three constables. On the direct orders of the Director-General of health, the transfer was kept secret.\textsuperscript{163}

5.6 Conclusions

Police interest in leprosy started with the case of James Quigley, a young man who was the first to be notified under the Leprosy Regulations of 1891. He disappeared, and the police were ordered to find him and arrest him. Shortly after, another white man was diagnosed with the disease, and also disappeared, and again the police spent much time looking, unsuccessfully, for him. Following the passage of the Leprosy Act in 1892, the Police Commissioner instructed his men to complete a report on every case of leprosy

\textsuperscript{161} Q.S.A. COL 272, in-letter 12940 to Prime Minister of Queensland, 22 October, 1895.

\textsuperscript{162} For whites. Aboriginal patients were not gender segregated.

\textsuperscript{163} Q.S.A. A/45216.
they found, or who was notified to the local police magistrate. The police soon found themselves in the role of guardian of leprosy suspects during the long periods between the arrest of the suspect and his ultimate disposal, either as a free man or to a lazaret. In this role, the police had to ration the patient, deal with intercurrent health problems and arrange sanitary matters. Patients sometimes escaped from their care, and had to be found. Once the patient was diagnosed positively and sent to the lazaret, his housing, bedding and other personal items were often burned. Police became involved in the valuation of such items. They interviewed relatives about the financial situation of patients or dependants, checked on rumours of contacts, and lastly escorted patients from place of detention to the lazaret. When on patrol they kept their eyes open for cases of leprosy among the Aborigines, and many became proficient diagnosticians. Aborigines with suspected leprosy were removed by the police, brought to a Government Medical Officer, and if the suspicion was confirmed by the doctor, isolated under bleak conditions until the results of bacteriology were available. Neither the Leprosy Regulations, nor the Leprosy Act, nor the Protection of Aborigines Act of 1897 gave these powers to the police, yet no one complained. In effect the police became diagnosticians, nurses, carers, almoners and valuers for a group of people who were feared by the wider population.

Lunacy, venereal disease and leprosy were managed by the police by arrest and incarceration. There were, however, other diseases which governments and the health bureaucracy hoped might be prevented by quarantine. Police would prove to be an important constituent of the quarantine system.
6.0 Policing quarantine

6.1 Introduction

The emigrant ship *Royal Dane* (fig. 6.1) arrived in Keppel Bay on 25 July, 1865, after a ninety-four day journey from London. The ship, carrying navvies\(^1\) contracted to work on the Queensland railways, contained a higher than usual number of children on board. Fifty-two cases of measles occurred during the journey. Of thirty-four deaths, thirteen

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\(^{1}\) Navvy, a labourer employed for excavating etc. on canals, railways etc.
were attributed to measles. The ship was quarantined in Keppel Bay until 2 August, 1865. To force quarantine on a ship and its complement for measles would today be considered an unusual and unnecessary action, since measles is—or was until the development of a measles vaccine—an endemic disease in Queensland.

Modern states are defined by their borders as well as by their political, economic and cultural institutions. A border defines a barrier—whether a geographic barrier, such as a coast line or river, or an invisible line on a map—to the free movement of people, goods and services. Governments have a duty, among other duties, to protect those living within the borders of a state from threats to their security and well-being, whether these be military or para-military threats, or more prosaic threats from the introduction of noxious macro- or microscopic organisms. The protection of the population from the importation of noxious organic substances is called quarantine, and is generally the function of a specialized bureaucratic organization. In the absence of a bureaucracy, such as existed in colonial Queensland, the police, as part of their extraneous duties, carried out important quarantine duties. In this chapter I examine the role of the police in this area, in both general terms, and with specific reference to smallpox, plague and the pandemic of influenza that was commonly called Spanish Influenza.

6.1.1 What is quarantine?

Quarantine dates from the fourteenth century, when the Venetians segregated suspect
ships, goods and personnel in order to prevent the entry of bubonic plague coming from the Orient.\textsuperscript{2} The period of segregation initially enforced was forty days. Plague administration in Italy became the model for the rest of Europe, though England lagged behind the Continent, only introducing plague regulations in the sixteenth century.\textsuperscript{3} However, quarantine was never popular in Britain, and opposition to quarantine increased in the nineteenth century,\textsuperscript{4} eventuating in the abolition of human quarantine in Britain in 1896.\textsuperscript{5}

In the twenty-first century, isolation refers to the removal of symptomatic individuals from contact with the general population, while quarantine refers to the removal of individuals, usually in significant numbers, who have had contact with an infected individual, but have no symptoms. The distinction is important. In Queensland, the regulations of the Central Board of Health for the management of measles, scarlet fever, or whooping cough insisted on isolation, which meant placing them in a separate room, at home or in a hospital.\textsuperscript{6} If the children of police contracted such diseases, senior officers


\textsuperscript{4}An important critic of quarantine in Britain was Dr Gavin Milroy, an anti-contagionist who later wrote, largely by himself, the Report of the Leprosy Committee of the Royal College of Physicians of London, published in 1867 (see chapter 5). See Rod Edmond. \textit{Leprosy and Empire}, 2006, p 52. Britain depended on trade, and quarantine was seen as an hindrance to trade.


\textsuperscript{6}Temporary hospitals were sometimes erected to deal with epidemics of childhood diseases. For example a hospital was erected in Victoria Park, Brisbane, during the scarlet fever epidemic of 1898/99.
wished to be assured that all such children were, indeed, being isolated.\textsuperscript{7} All these childhood diseases were well known in Queensland, and periodic outbreaks were common. Outbreaks of these diseases also occurred on emigrant ships, and these sometimes led to the quarantining of all passengers and crew, rather than just the isolation of the sick individuals.

Quarantine is not an all or nothing phenomenon. The definitions and length of quarantine have varied widely, depending on the era, the location and the perceived threat from specific disease (especially the incubation period\textsuperscript{8} of the disease, and its perceived infectivity to the healthy.) Quarantine has also been disproportionally used against those diseases perceived to be linked to the alien or the poor,\textsuperscript{9} or associated with ‘filth’.\textsuperscript{10} The word is not necessarily restricted to maritime quarantine, but also includes land quarantine and airport quarantine. It also applies to animal and vegetable materials as well as diseases of both humans and domestic animals caused by microbes. In the twenty-first century, the issue of quarantine is not whether it is a legitimate tool for protecting public health—no one would doubt it—but under what circumstances it should be used, and with what safeguards against its abuse. These were not considered in the nineteenth century, and though many people complained of the conditions under which they were quarantined, their complaints were, by and large, ignored.

\textsuperscript{7} Q.S.A. A/45275, for a series of letters in March 1899 about scarlet fever.

\textsuperscript{8} The interval in days between exposure and development of symptoms.


\textsuperscript{10} Plague was for a long time considered to be a ‘filth’ disease.
6.2 Quarantine in Australia

The early Australian authorities recognized the very isolation of Australia provided a great measure of protection against the importation of exotic diseases. In the early days of sailing vessels, the long intervals between landfall constituted a significant period of quarantine, but the increasing development and speed of steam ships, with their insatiable need for coal, bunkered in various Middle-Eastern and Eastern ports, brought the perceived oriental danger much closer to home. No quarantine restrictions were enforced in New South Wales for the first sixteen years of the penal settlement. In 1802 Governor King instituted a system of medical inspection of convict ships, and in 1804, when news reached Sydney of yellow fever in New York, an early system of quarantine was instituted, with ships coming from New York having to anchor off Bradley’s Point.\(^{11}\) In July 1814, the convict ship *Surrey*, arriving in Sydney with typhus on board, was placed under the ‘most rigid quarantine restrictions’ on the North Shore. The convicts and their guards were housed in tents, and placed under the care of D’Arcy Wentworth and William Redfern.\(^{12}\) In July 1828, the convict ship *Bussorah Merchant* arrived in Sydney Harbour. The master dined on shore before it was known that smallpox had occurred during the voyage. Free passengers\(^{13}\) were isolated on shore at Neutral Bay (close to Bradley’s Point), under a military guard, while the convicts and their guards were housed in tents, and placed under the care of D’Arcy Wentworth and William Redfern.

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\(^{13}\) A small number of ‘free’ immigrants arrived in New South Wales between 1788 and 1831, often family or friends of convicts or the military. Numbers of immigrants increased in the 1820s.
isolated at North Heads. The first Australian *Quarantine Act* was the New South Wales Act of 1832, whose original aim was to prevent the introduction of ‘malignant cholera’\(^{14}\) or other infectious diseases. In October 1832, the Quarantine Regulations ordered ships’ masters to provide written answers to questions about which ports they had called at, whether they had any communication with infected vessels, and whether there had been sickness on board. If a surgeon was on board, he also had to answer the same questions. Severe penalties were prescribed for those not reporting truthfully.

In 1831, a two-part system of emigration from Britain was worked out between Governor Sir Richard Bourke and Frederick Robinson, Viscount Goderich, the Secretary of State for the Colonies.\(^{15}\) Bounty immigrants, sponsored by colonists who received a bounty on every approved man or woman, were assured employment on arrival. The British Government meanwhile started a scheme by which it took up immigrants and paid £12 towards the passage cost of £17. The immigrants were expected to find the remaining £5.\(^{16}\) In 1831, 34 immigrant ships arrived from Britain and Ireland, followed by 63 the following year. When the emigrant ship *Canton* arrived in Sydney in 1835 with fourteen cases of smallpox on board, it went into quarantine for thirty-five days. But the cause of quarantine was strengthened by the arrival in 1837 of the immigrant ship *Lady Macnaghten*, which brought the largest complement of children ever to sail to Australia. Of the 111 children aged less than seven years on board, forty-nine died. Causes of death

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\(^{14}\) The first cholera outbreak in Britain was in 1831 and lasted through the following year.


\(^{16}\) Marjorie Barnard. *A History of Australia.* Angus and Robertson 1976, p 582-583
included diarrhoeal disease, scarlet fever and typhus. A number of passengers died, including the ship’s surgeon, after they disembarked in Sydney in March 1838. By May 1838, a permanent quarantine station was erected at North Head, initially guarded by the military, after 1860, by the Sydney police.

As separate colonies were established in Australia, quarantine became a matter for each individual colony. In 1896, an Australasian Quarantine Conference\(^\text{17}\) was held in Melbourne. Conference recommended that colonial quarantine laws should be uniform and that three fully qualified medical men, experts in the diagnosis and treatment of quarantinable diseases, be appointed as ‘Federal Medical Officers’, based in the three major ‘first ports of call’, Albany, Adelaide and Thursday Island. Most of the resolutions dealt with the problem of smallpox vaccination, supplies of lymph and expenses. The resolutions were largely accepted by the Conference of Premiers held the same year in Sydney, though New Zealand and Tasmania refused to join in the agreement.\(^\text{18}\) In 1908, the Federal Government enacted its own \textit{Quarantine Act}, which was ‘framed with exact regard to the narrower and time honoured function of quarantine— that was the protection of the country against invasion by any infectious disease not already present in the country.’\(^\text{19}\) Those designated quarantinable diseases were smallpox, plague, cholera, yellow fever, typhus fever and leprosy. Endemic diseases arising within states would not be subject to quarantine regulations.

\(^{17}\) Neither Tasmania nor New Zealand were represented at this conference.

\(^{18}\) Q.S.A. PRE/G1, out-letter 98/801 from Chief Secretary, Queensland, 19 September, 1898.

6.2.1 Quarantine in Queensland

During the four month voyage of the emigrant ship *Fortitude* to Brisbane, arriving in January 1849, there were eight deaths on board, including one from typhus fever.\(^{20}\) The ship was placed in a quarantine that lasted for sixteen days.\(^{21}\) The same year, Captain Wickham, the government resident at the Moreton Bay penal settlement, searched for a suitable site for a quarantine station. The following year, a part of North Stradbroke Island was gazetted as a place for quarantine,\(^{22}\) in time for the arrival of the ship *The Emigrant*. This ship arrived in Moreton Bay in August 1850. Eighteen people died of typhus fever on the journey, and a further eighteen died while held in quarantine at Dunwich, including Dr David Ballow, the Brisbane surgeon who volunteered to care for the sick. Because of on-going disease, the passengers from this ship were held in quarantine for over two months. By 1852, a quarantine station was operating in Moreton Bay. One of the first acts of the Queensland Legislative Assembly was to pass its own *Quarantine Act* in 1863. Quarantine in Queensland, as in New South Wales, took two forms. If the ship came from an infected port, it was detained in quarantine. The act also authorized the health officer to enquire about the health of passengers; had there been sickness on board, the officer had to determine its nature and recommend or refuse pratique\(^{23}\) accordingly. Ships surgeons—and masters—sometimes provided inaccurate

\(^{20}\) Typhus fever is an acute febrile illness of humans, caused by *Rickettsia prowazekii* and transmitted by the body louse.


\(^{23}\) Pratique: a license granted to a ship to have dealings with a port.
information about the health of crew or passengers.\footnote{See, for example, the case of Dr Sandiford, a ship’s surgeon, who gave false answers to the health officer’s questions, for which he was sentenced to six months imprisonment with hard labour. \textit{Brisbane Courier}, 17 June, 1864. In 1863, the master of the ‘\textit{Hannah More}’ said his passengers were in good health and denied any sickness on board, when in fact during a journey lasting 130 days, there had been 35 deaths on board.} Health officers had to be men of integrity and character.\footnote{Douglas Gordon. \textit{The Waiting Years} – 1842-1859. \textit{Medical Journal of Australia} 1966:1; 249-253.} In 1869, Sub-Inspector James Wassell of the Water Police recommended the prosecution of the master of the steamship \textit{City of Brisbane} for ignoring his refusal to grant pratique, though the result of this is uncertain.\footnote{Q.S.A. CRS 186, a legal brief dated 1 March, 1869.} Section 18 of the act gave powers to the police to arrest any person escaping from quarantine.

Ships and their complements were quarantined in a haphazard manner. Quarantine was not restricted to exotic diseases such as plague, typhus fever, yellow fever, cholera or smallpox. A ship carrying individuals infected with scarlet fever, for example, might or might not be quarantined, despite the fact that scarlet fever was known to be endemic in Queensland.\footnote{Q.S.A. COL/A188, the \textit{Friedeburg} was quarantined for scarlet fever. \textit{The Great Queensland} with scarlet fever on board, was not quarantined. \textit{Brisbane Courier}, 5 December, 1874.} When the ship \textit{Friedeburg} was quarantined in 1873 because of scarlet fever, the passengers were quarantined on Peel Island. Wassell and two constables supervised and helped the landing of stores on the island. Wassell marked out a place for one constable to pitch a tent and left him on the island to enforce, as much as possible, the strict observance of quarantine regulations.\footnote{Q.S.A. COL/A188, in-letter 2434 to Commissioner of Police, 25 August, 1873.} Furthermore, the sick were not isolated from the healthy while in quarantine, and therefore the healthy continued to be at risk.
In 1877, Henry Herbert, fourth Earl of Carnarvon, the British Secretary of State for the Colonies, attempted to replace strict maritime quarantine in Australia by a system of medical surveillance, as recommended by the British Local Government Board. Queensland’s Central Board of Health was initially enthusiastic, and recommended that quarantine become a matter for the Board, but Dr H. Challlinor,\textsuperscript{29} who was then the Health Officer for Brisbane, objected strenuously to the idea.

"The Queensland Central Board of Health is essentially an honorary Board, the only remuneration its members are entitled to being a guinea a sitting each. It is therefore practically an irresponsible Board, for it is not legally liable for maladministration of its functions, and all that the Government could do in such a case would be to supersede them either individually or collectively. But what is the loss of a guinea a sitting to gentlemen connected with pastoral or mercantile pursuits, or to medical men engaged in extensive private practice?"\textsuperscript{30}

Queensland (and the other Australian colonies) refused to accept the recommendations of the British Local Government Board, despite the fact that here quarantine, as in Britain, was not a popular measure. Any hindrance to the free movement of goods or people could have significant financial implications, while perishable goods were at immediate

\textsuperscript{29} Challinor had come to Queensland as an emigrant on the \textit{Fortitude}. Perhaps his experiences made him more certain of the value of, and need for quarantine.

\textsuperscript{30} Q. V. & P., Quarantine Matters 1878: 1; 455. Challinor’s dislike of the Central Board of Health may have started the previous year when, as Port health officer, he placed the emigrant ship \textit{Windsor Castle} in quarantine because of a case of convalescent typhoid fever on board. The ship’s surgeon appealed to the government, which referred the matter to the Board of Health, which revoked Challinor’s orders. See \textit{Brisbane Courier}, 21 September, 1877.
risk. In 1886, a new Quarantine Act was introduced in Queensland, replacing the act of 1863. It made no fundamental changes.

6.3 Smallpox

The first and only epidemic of smallpox in Queensland occurred between 1824 and 1830, as the Moreton Bay penal colony was being established, and affected the Aboriginal population only.\(^{31}\) Though ‘malignant cholera’ was the greatest perceived threat to the early colonizers of Australia, this disease never materialized to any significant extent.\(^{32}\)

The greatest anxiety of the Queensland government and the Central Board of Health was the constant threat of smallpox, a disease affecting the southern colonies on a regular basis. Despite this concern, no consistent vaccination policy was ever introduced, reliance being placed almost entirely on maritime quarantine. The Colonial Secretary appointed vaccinators in the early 1850s, initially in Brisbane, but later at major ports. Uptake of vaccine was generally poor unless a threat seemed imminent.\(^{33}\)

Historian Alison Bashford suggests one reason for the absence of a consistent vaccination policy is that vaccination, challenging medical and lay sensibilities, did not separate clean from

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\(^{32}\) At the end of 1885, panic arose in Queensland when the steamship *Dorunda* arrived in Queensland, with a number of cases of severe diarrhoea, of which eighteen terminated fatally, on board. An enquiry by the Central Board of Health concluded that the disease was ‘Asiatic’ cholera; the board hastily developed a set of regulations for the treatment and prevention of the disease,\(^{32}\) but feared it was already too late, as a number of passengers had been disembarked at Cooktown. The town was declared an infected port (even though there had been no cases among the passengers disembarking in Cooktown.) Q.P.P.1886:3;747

\(^{33}\) Patrick. *Health and Medicine in Queensland* 1987, p 34.
That smallpox never materialized in any significant way in Queensland was due more to luck than good management. According to public health physician John H. L. Cumpston, prior to 1850, no cases of smallpox occurred in the British colonists of Australia. Between 1857 and 1926, twenty-three outbreaks of the disease occurred, of which sixteen were minor (involving only a handful of people) and seven were significant. Queensland was largely spared: in 1865, the ship Hannah More arrived in Brisbane with smallpox on board but the press in general showed no interest, apparently putting great faith in quarantine. The Brisbane Courier however urged the need for compulsory vaccination. Six years later, the arrival of the emigrant ship Shakespeare with six cases of smallpox on board prompted the Brisbane Courier to again extol the virtues of vaccination. From then on, concerns were frequently raised by reports of the disease in other Australian colonies, or countries within a short sailing time of the continent. When smallpox threatened again in late 1876, the board of health held a


35 John H.L. Cumpston (1880-1954) joined the Australian Federal Quarantine Service in 1908, and became the first Director-General of the Australian Department of Health in 1921.

36 Cumpston. Health and Disease in Australia Introduced and edited by Milton Lewis Australian Government Printing Service, Canberra, 1989, p 180 He does not comment on smallpox in Aboriginal communities, particularly the epidemics of 1789-90 around Sydney and the more extensive outbreak of 1828.


38 Brisbane Courier, 16 March, 1865.

39 Brisbane Courier, 4 March, 1871.
meeting in January 1877 at which it made a number of generally appropriate resolutions, dealing with the proclamation of the northern ports under the Health Act of 1872 (which would lead to the formation of a local board of health) and with vaccination. The board also resolved the Chinese ports be declared infected with smallpox (adding a rider that it would not be amiss to warn the government of the danger of the importation of the loathsome disease of leprosy). It reported that vaccination was being widely carried out, and asked that the board be also appointed a board of quarantine. Nothing came of these resolutions. No Vaccination Act was introduced into Queensland before 1900, though public vaccinators were appointed in Cooktown, Townsville, Bowen and Rockhampton, as well as Brisbane. Cumpston says vaccination was carried out on a large scale, though Patrick, correctly, suggests otherwise. The board otherwise ignored the disease, though others took an interest. In April 1877, a Chinese gardener saw a man he thought had smallpox in a shop. Uncertain what to do, he went to a nearby hotel, where he saw a policeman, and reported his suspicions to him. The constable reported to his sergeant within a short space of time, the building was surrounded by police. Fortunately, the


41 These were quarantine matters. Historian Enid Barclay suggests the government was not keen for the board to interfere in quarantine matters. Barclay J. Aspects of Public Health in Queensland, 1859-1914, M.A. Thesis, University of Queensland, 1978, p 224.


43 Patrick. A History of Health and Disease in Queensland, 1987, p 208. See also Q.S.A. COL/G138, out-letter 99.12849 from Home Secretary to Secretary of the Central Board of Health, complaining that Dr K.I. O’Doherty had been appointed a public vaccinator for Brisbane in 1896, a chamber had been rented and advertisements published, but the public response was so poor, the Home Secretary called the position a sinecure. Q.S.A. COL/A316. Dr Hobbs says ‘…Public Vaccination has hitherto been a failure and will continue to be so until an Act is passed making provision that all who avail themselves of Public Vaccination should be compelled to send their children on the day appointed to allow some of the lymph to be taken from the arm of the children.’ 18 July, 1881.

44 Brisbane Courier, 30 April, 1877.
case proved not to be one of smallpox. Likewise, in 1885, a Filipino was suspected to have smallpox. Sergeant Charles Savage of the Thursday Island police was asked to investigate:

‘On the matter being reported the Sergeant proceeded to the place and examined the man from a distance, the exposed parts of his body, face, neck, arms and hands presented the appearance of having been covered with minute boils or pustules, most of which had healed up, some remained on the ears and side of neck, from which a slight discharge issued. The Sergeant had the place isolated... (a ship's doctor) examined the man and gave as his opinion that he was afflicted with some skin disease, not infectious or contagious, but as a precaution, it would be advisable to disinfect the house and goods by fumigation and isolate the man until the fourteenth day from the commencement of his illness.’\(^\text{45}\)

These measures were duly carried out. Sergeant Savage noted a slight scare among the populace, which soon abated.

However, after the steamship \textit{Oroya} arrived in Sydney from England in June 1892, some passengers left for Brisbane before an outbreak of smallpox was noted. The Colonial Secretary’s office instructed the Commissioner of Police that he should ‘endeavour to identify all persons arriving in the colony overland, by train or otherwise,’ who had been passengers on the ship. The commissioner immediately ordered police at Wallangarra, on the only railway line between New South Wales and Queensland, to watch closely for

\(^{45}\) Q.S.A. COL/A347, in-letter 5959 to Commissioner of Police, 21 August, 1885.
any arrivals by train that might have been on the *Oroya*. He suggested a close inspection of luggage would be useful. 46 Constable Daly noted a tin box marked ‘William Dix, passenger per *SS Oroya*’ on a train from Toowoomba to Roma Street. He questioned Dix, who said he had been on the ship twelve months previously. Meanwhile, some passengers had reached Brisbane by the steamship *Bunyong*. The passengers were all quarantined at Peel Island on 21 June, 1892. One passenger, Thomas Ives, a professional singer from Islington, London, fell ill on 24 June. Four days later he was isolated from the other passengers when it was decided he had smallpox, despite having four distinct vaccination scars on his left arm. He died on 3 July, and was buried at Dunwich the same day. 47

Regulations for dealing with smallpox were proclaimed in 1892 following the case of Ives. The regulations referred mainly to shipping, made no mention of public vaccination, but did authorize the Medical Officer of Health, Police Magistrate, Officer of Customs or Officer of Police to whom a report of smallpox was made to make provision to prevent any person from leaving the premises or ship until the person has been cleared, and to use such force as necessary to prevent the person leaving the premises or ship. 48

46 Q.S.A. A/45275, in-letter 06207 to Commissioner of Police, 22 June, 1892.

47 Q.S.A. COL/287, a series of letters dealing with this case.

48 Q.G.G. 30 June, 1892 Smallpox regulations.
In March 1901, Sergeant T. Head and a large number of other police spent a considerable amount of time making ‘searching enquiries’ for a number of passengers who came to Queensland after smallpox was discovered in passengers from the ship *Euryalus*, from Calcutta to Melbourne.\(^{49}\)

The development of smallpox in a Pacific Islander who had travelled from Cleveland to the Immigration Depot (and thence to the Brisbane Hospital) led to those who had been in close contact with the man being detained in their homes under police guard.\(^{50}\)

Smallpox had little impact in Queensland, in contrast to the epidemic of bubonic plague that affected the State in 1900.

### 6.4 Bubonic plague

Plague, an acute bacterial disease of man and mammals caused by the bacterium *Yersinia pestis*,\(^{51}\) is primarily a zoonotic infection of rodents, among which it may be endemic or epidemic. The infection is maintained in animal reservoirs by fleas, most effectively by *Xenopsylla cheopis*, but also by ingestion of diseased tissue. Man is generally an accidental host, by the bite of the infected flea. Epidemics in man usually occur after

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\(^{49}\) Q.S.A. A/45275, in-letter 4699 to Commissioner of Police, 29 March, 1901.


\(^{51}\) The Swiss French bacteriologist Alexander Yersin discovered the organism contemporaneously with the Japanese Shibasaburo Kitasato in Hong Kong in 1894.
epidemics in rodents lead to large rat ‘die-offs,’ the infected fleas then looking for alternative sources of blood on which to feed.\textsuperscript{52}

In humans plague is a disease of protean clinical manifestations. After a bite from an infected flea, organisms travel to the regional lymph glands and there multiply. The glands (most commonly in the groin) become enlarged and exquisitely tender (this is the ‘bubo’). Associated symptoms include fever, prostration and often some degree of restlessness. During this period, bacteria are periodically shed into the blood (‘bacteraemia’), and if immune responses are inadequate, the bacteraemia may overwhelm the patient, leading to rapid death. This catastrophic event may even occur before a bubo has developed. Bacteraemic plague is sometimes associated with the development of dark coloured haemorrhages in the skin (‘purpura’), which some claim is the source of the name ‘the Black Death’. From the blood, the bacteria may also settle in the lungs leading to secondary pneumonic plague. As \textit{Y. pestis} is then expelled in the respiratory discharges, person-to-person spread is then possible, with the subsequent development of primary pneumonic plague.

The incubation period of plague is about a week, though pneumonic plague has a much shorter incubation period, often only a few hours. Untreated, plague has a mortality of about 50\%, though the bubonic form has a better prognosis than the bacteraemic or the pneumonic forms, where mortality approaches 100\%. The overall mortality in an epidemic will therefore depend on the relative proportions of these different forms. It

\textsuperscript{52} The role of the flea in the transmission of plague was first suggested by the French researcher Paul-Louis Simond, who showed that plague was a zoonotic infection of rats in 1896.
was this rapid and high mortality which contributed largely to the terror plague inspired in the western psyche.

6.4.1 Plague epidemics

The outbreak of plague that started in China, in the late eighteenth century is generally considered to be the third pandemic of the disease. An account of the first and second pandemics (the Plague of Justinian from the sixth to the eighth centuries, C.E. and the Black Death from the fourteenth to the eighteenth century) is given in appendix 5.

There is, according to biographer and historian Philip Ziegler, little evidence of the use of the term ‘the Black Death’ during the epidemic outbreak in the fourteenth century. He believes the term came into general currency in Britain during the seventeenth century, to distinguish the earlier epidemic from the outbreak of 1665.53 The term, however, would be used occasionally in the context of the twentieth century epidemic in Australia,54 as well as later during the epidemic of ‘Spanish’ Influenza in 1919.

The third epidemic that started in Yunnan was initially confined to the province, but spread after the dislocation of the population consequent upon a Muslim rebellion against

54 See, for example, The Northern Territory Times, 20 April and 4 May, 1900. The Brisbane papers appear to have been more circumspect.
the Qing Dynasty in the middle of the nineteenth century.\textsuperscript{55} Plague went with the dispersed people (and the troops sent to quell the rebellions), many to provincial towns and larger urban centres. By the 1860s plague began to appear in Guangxi and Guandong provinces. From about 1871, foreign observers, mainly French, American and British commented on the existence of plague, which spread to the Pearl River Delta by the 1890s. In 1894 a severe outbreak in Canton killed 60,000 people within a few weeks and Hong Kong was affected shortly after. From Hong Kong and Canton plague dispersed along shipping routes to other continents. Bombay was affected in 1896, Calcutta in 1898, Alexandria in 1899.

Conventional wisdom at the time was that plague was a ‘filth disease’. ‘The special conditions under which the disease flourishes are fatigue, destitution, filth, poverty, and overcrowding,’\textsuperscript{56} said the \textit{St James Gazette} in 1899. The responses of the Chinese and the British to the 1894 outbreaks differed significantly. The Chinese in Canton based their management on care of the sick and dying, and repatriation of dead bodies to ancestral lands for burial. They did not believe in isolation. There was no sanitary board in Canton, much to the disgust of local Europeans.\textsuperscript{57} No attempt was made to quarantine, or throw a ‘\textit{cordon sanitaire}’ around, the town. The British, educated in sanitary theory, and convinced that this was, indeed, a disease of filth, espoused a more active management. Anti-plague policies centred on the apprehension and control of Chinese

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\textsuperscript{56} \textit{St. James Gazette}, quoted in \textit{The Argus} (Melbourne) 11 October, 1899.

\end{flushleft}
residents afflicted by the disease, segregation of native from European, and vigorous sanitary programs, including the use of troops for the cleansing or destruction of Chinese residences and fumigation or burning of material thought to be infected. Since plague had spread to Hong Kong from contiguous areas of China, no quarantine measures were enforced in Hong Kong either. The British efforts were as distasteful to the Chinese as the Chinese efforts were to the British. 58 When plague reached Bombay, the British authorities in general agreed with their counterparts in Hong Kong. Worried that plague would lead to quarantine, the medical establishment initially denied the presence of the disease in Bombay, but it soon became apparent a major epidemic was under way. The Venice International Sanitary Commission of 1897, convened specifically to deal with the problem of bubonic plague, and critical of the way Britain had managed the epidemic in Bombay, imposed a quarantine on Indian goods. This led the British sanitary authorities, fearful for the future of Indian trade, to institute a program of identification, isolation and disinfection ultimately similar to that of Hong Kong. 59 In Australia, fear of oriental germs strengthened the belief in quarantine.

As Ashburton Thompson, President of the New South Wales Board of Health said in 1885, quarantine had little effect if used alone. It could not prevent a disease from spreading, only slow its progress. What was also needed was a system of ‘internal sanitation.’ 60 This was not in place in Queensland. When plague struck, a system of

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internal quarantine was instituted, in which the police would enforce sanitary cordons around houses where patients with plague, or their contacts would be held, until either the alarm subsided or the patient was taken to a plague hospital, with or without a police escort. In Sydney the Board of Health established a more draconian system of internal quarantine for plague, with the police setting up barricades and guarding the entrances to entire districts in which cases had been discovered.  

6.5 Bacteriology of plague

By the end of the nineteenth century, germ theory of disease was generally accepted, and miasmatic models of epidemic disease discredited. The plague outbreak in Hong Kong provided an opportunity for experts in the new science of bacteriology to study the disease. In 1894, the Japanese Shibasaburo Kitasato and the Swiss-French Alexander Yersin independently discovered the organism, now known as *Yersinia pestis*, which causes plague in both man and rats. Yersin subsequently raised an antiserum in horses, of uncertain value in the treatment of plague, which was used in Queensland. Three years later, working in Bombay, the French bacteriologist Paul-Louis Simond demonstrated that plague was a disease of rats, and suggested the role of the rat flea, *Xenopsylla cheopis*, in the transmission of plague from rat to man. The suggestion was received with scorn. Confirmation of Simond’s theory first appeared in Sydney with the

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discovery of infected fleas feeding off plague infected rats. By the time of these discoveries rat-infected shipping had spread the disease to Bombay, regions of Java, Asia Minor, South Africa, and even California, where its existence was vigorously denied. Those who sought to prove its presence and combat it were denounced by local politicians and business leaders. W. M. Haffkine, a Russian bacteriologist, was invited to Bombay in 1896, where he rapidly developed a vaccine derived from heat-killed cultures of *Y. pestis*. The vaccine had severe side effects, but anecdotal reports suggested it was effective in preventing plague.

Though the importance of rats in the genesis of plague was accepted by 1900, the role of the flea remained uncertain. Sir James Cantlie, in an article written shortly after the arrival of plague in Portugal (September 1899) and published in at least one Queensland newspaper in January 1900 said that the rat was the host by which the disease was conveyed to man. He suggested contamination of food by the urine or faeces of infected rats was sufficient to cause the disease. Alternatively, decomposing rats, dead from plague, became contaminated with insects, which either became infected themselves, or passively conveyed the infection. The answer to an outbreak of plague was the control of

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65 Q.S.A. COL/154, in-letter 10316 to the Chief Secretary 27 July, 1900, from the Consul-General in San Francisco includes a report on plague in San Francisco written by Dr C. J. Fagan, Secretary of the British Columbia Board of Health, who visited San Francisco to determine whether plague existed or not. He was certain that it did, and had been there since at least March 1900.
By virtue of its tendency to create major epidemics in human populations and its appalling mortality, the threat of plague was enough to cause considerable anxiety in western minds. It was yet another oriental disease (like ‘Asiatic cholera’) threatening the health of European people.

6.6 The International Sanitary Conference of 1897

Nine International Sanitary Conferences were held between 1851 and 1894, dealing largely with questions relating to cholera and to quarantine. The Tenth International Sanitary Conference, held in Venice in 1897, was precipitated by the development of plague in Hong Kong followed by its occurrence in ports and localities on the western coast of British India. The conference continued the discussions on cholera and quarantine, but also focused on the subject of plague. Participants agreed the incubation period of plague—the time between infection and the development of clinical symptoms—was generally only three or four days, but could be as long as eight or nine days. Despite objections from the British and French delegates, (who wished for a shorter period) the convention accepted, by a large majority, a ten day period as the maximum limit of the incubation period, that is, if a case had not occurred within ten days of exposure, then plague would not develop. Vessels arriving in Europe would be classified as ‘infected’ if a case of plague had occurred within the past twelve days: as ‘suspected’ if plague had occurred on the vessel, but no cases had been seen for twelve days: or ‘healthy’ if no cases had occurred. In the case of ‘infected’ vessels, the sick

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66 *Evening Observer*, 17 January, 1900.
were to be landed and isolated, while contacts were to be ‘observed’ or placed under ‘surveillance’ for up to ten days. Disinfection and fumigation of ships were to be carried out. In the case of ‘suspected’ vessels, passengers and crew were to be subject to ‘surveillance’ for ten days from the time of arrival in the European port and the ship was to be fumigated and disinfected. ‘Healthy’ ships would be granted immediate pratique (a licence for a ship to have dealings with a port), though licence was given to local authorities to insist on the disinfection of certain articles. The conference either did not appreciate the role of the flea, or failed to understand the ecology of the flea, which was the most important vector for the transmission of bubonic plague. The conference was critical of Britain’s stance because of its waywardness with respect to the Indian outbreak of plague. The Plague recommendations made notification of the first case of plague mandatory on all signatories, thus establishing an international system of plague surveillance. The Conference ended with the development of General Sanitary Regulations relating to Bubonic Plague. The British Secretary of State for the Colonies sent copies of the Regulations to the Australian Colonies, asking them to ratify these. After discussion with his fellow colonial leaders, Premier H. M. Nelson informed the Governor that Queensland would not adhere to the Convention. He had, he said later, asked his central board of health for an opinion. The board thought there was no immediate necessity for the colony to subscribe to the convention.\textsuperscript{67} When Britain again asked for ratification, the matter was referred back to the board of health, and then to the public health section of the Intercolonial Medical Congress, due to meet in Brisbane in September 1899. The Queensland delegate at this meeting was Dr W. Love, the secretary

\textsuperscript{67}Q.V.& P. 1900: 5; 1157-1182.
of the board of health. The meeting objected only to one issue, namely the statement that ‘persons arriving on suspected ships should be dismissed to their destinations, there to be kept under surveillance for ten days.’ The experts at the Intercolonial Congress felt, under the conditions then existing in Queensland, this was insufficiently stringent. The remainder of the regulations were acceptable.\(^{68}\)

One can assume therefore that the issue of bubonic plague was one with which the board of health, at least, was familiar, before the disease actually threatened, or arrived in, Australia, though how the disease was transmitted still remained uncertain. Since the disease appeared to be spreading along shipping routes, Australian authorities anticipated that efficient and stringent quarantine would prevent the disease from taking hold on the continent.

### 6.7 Preparations for plague in Queensland

On 2 June 1894, the *Brisbane Courier* reported the presence of bubonic plague in Hong Kong. It appeared, the newspaper said, the disease was little known to the European doctors, but was well known in Russia. Plague, the report said, appeared amid the squalor and dirt of crowded Asiatic cities. It was a highly contagious disease, communicated by breath, by fomites\(^{69}\) and by inoculation.\(^{70}\) The brief report made no

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\(^{68}\) Q.V.& P. 1900: 5; 1157-1182.

\(^{69}\) Fomite: an inanimate object or substance capable of transmitting infection from one person to another.

\(^{70}\) *Brisbane Courier*, 2 June, 1894.
mention of rats. Four days later, the newspaper repeated the opinion of local scientists in Hong Kong that it was decidedly a filth disease, induced by poverty and lack of sanitary requirements.71 An editorial, quoting the Hong Kong Daily Press said, ‘the Australian colonies would scarcely be justified in (imposing a ten day quarantine), taking into account the length of the voyage, but they are notoriously particular in these matters, and might prescribe quarantine for a short period.’72 The editor hoped this would be done, a curious sentiment since the same paper had noted a week earlier the issue of a special Government Gazette on 7 June, declaring Hong Kong a plague infected port and proclaiming all vessels from that port had to undergo quarantine until granted pratique by the health officer.73 Newspaper reports said that, in Hong Kong, a number of police, including the Captain Superintendent of police, had been enrolled as sanitary officers and were conducting house-to-house inspections of infected Chinese quarters.74

Two years later, the arrival of plague, with a high mortality, in Bombay was noted after several Europeans had died of the disease.75 On 11 December, 1896, the Brisbane Courier reported ‘an excessively high mortality’ from plague in Bombay. The Queensland authorities had no reason to be unaware of the problem of plague, nor to be surprised by the appearance of plague in Australia.

71 Brisbane Courier, 6 June, 1894. Queensland Government Assistant Geologist S. J. B. Skertchley, who lived in Hong Kong in 1894, told The Queenslander (6 March, 1897) that plague was a disease of filth, that the germ could infect rats, but also that the bacteria could be found in soil.

72 Brisbane Courier, 15 June, 1894.

73 Brisbane Courier, 8 June, 1894.

74 Brisbane Courier, 9 June, 1894.

75 Brisbane Courier, 7 December, 1896.
Though Australian authorities were suspicious New Caledonia might have plague cases, there was, by the end of 1899, no official intimation of this.\textsuperscript{76} On 1 January, 1900, the Chief Secretary of Queensland received a copy of a despatch from the British Consul in New Caledonia to the British Foreign Secretary, reporting several cases of plague in Noumea. The Consul, J.G.Haggard, commented that the French authorities were contravening the regulations of the Venice Convention by not notifying other governments of the development of plague and even more, did all they could to prevent the knowledge getting out, even to the extent of stopping telegrams, including official ones, which mentioned the word plague.\textsuperscript{77} However, censorship proved ineffective, and by 4 January, the \textit{Brisbane Courier} was reporting the outbreak with anxiety, noting:

\begin{quote}
‘an opening has been made for a visitation from the dreaded disease by the strange apathy or negligence of French officials. Although the plague has been existent for some time close to this continent, it is only within the last week or so that definite word has come to us, and meanwhile passengers from New Caledonia have arrived and landed in Sydney without being detained in quarantine,’
\end{quote}

and again linked the spread of the disease to the unsanitary conditions prevailing in Asian cities.\textsuperscript{78}

\textsuperscript{76} \textit{Brisbane Courier}, 28 December, 1899.

\textsuperscript{77} Q.S.A., COL 244, in-letter 04771 from the Secretary of State for the Colonies, Joseph Chamberlain to the Chief Secretary, 12 March, 1900.

\textsuperscript{78} \textit{Brisbane Courier}, 4 January, 1900.
On 15 January, 1900, the *Brisbane Courier* reported the suspected appearance of bubonic plague in Adelaide, South Australia. The patient was a deserter from the steam ship *Formosa*, whose death from plague on 13 January was confirmed by a post mortem examination. This prompted one member of the Queensland Central Board of Health, Dr J. Thomson, to question whether steps should be taken to alleviate public anxiety. One other member, Dr F.G.Connolly, argued that the existence of the disease was unconfirmed and implementing measures designed to calm the public would create a panic instead.\(^{79}\) At the same time, the board recommended compulsory notification of suspected cases, and urged the need for authorities to inspect ‘alien’ quarters in seaside towns. The following day, the *Brisbane Courier* opined that the greatest duty of the people was removing the condition of uncleanliness under which, *alone*, the disease took hold. Plague, according to the paper, had shown no particular affinity for coloured people as such. It took people

‘in the state of semi-civilisation in which they herded together in great cities, whilst being complete strangers to principles of sanitation...The greatest danger lies with those who from their racial habit or for cheapness huddle together in filth. The low class Chinaman, the Indian or Syrian hawker, in less degrees perhaps the walk about Kanaka, want our first attention.’\(^{80}\)

\(^{79}\) *Brisbane Courier*, 18 January, 1900.

\(^{80}\) *Brisbane Courier*, 19 January, 1900.
However, within a week, fear of plague had become widespread in Brisbane as evidenced by the speed with which purveyors of patent medicines began investing in advertising highlighting the plague preventative qualities of products such as ‘Vitadatio, the Great Tasmanian Herbal Remedy.’ At the same time, the *Evening Observer* questioned whether the ‘South Sea Island traffic’ should be temporarily halted. Prompted by media concern, the Central Board had no option but to hold a special meeting on 23 January after news arrived of a confirmed case of plague in Sydney, Australia’s largest and busiest port. The Board decided to send a circular to all local authorities about the disease, outlining the clinical features and recommending the immediate cleansing of refuse, drains, dirty tenements and yards. Reflecting ingrained racist belief of the time that Chinese and Indian communities would prove particularly susceptible to plague because of their supposed unsanitary habits, the circular suggested they should pay particular attention to those localities ‘where coloured races congregated.’

Dr Sandford Jackson, the medical superintendent of the Brisbane Hospital, echoed these views, warning a strong possibility existed that the disease would come to Queensland, where it would first affect ‘Asiatics and Syrians’ living in overcrowded quarters of the town, and would therefore most likely be misdiagnosed. He demanded compulsory notification of suspected cases. The *Brisbane Courier* concurred with Jackson’s assessment, declaring, ‘we have Asia actually in our midst,’

81 *Sydney Morning Herald*, 27 February, 1900.

82 *Evening Observer*. 16 January, 1900.


84 *Brisbane Courier*, 26 January, 1900.

85 *Evening Observer*, 11 January, 1900.
and urging the Home Secretary, Colonel Justin F.G. Foxton, to get to grips with the problem.\textsuperscript{86} The editor of the \textit{Cairns Daily Times} wrote,

\begin{quote}
This matter of alien plagues...demands our attention. The extension of British trade and commerce in the East has brought with it disadvantages as well as advantages...European administration and example have in some instances had some good results but...plague among these people of the East is now fraught with considerable danger to Western races...but the real danger lies in the immigrants who have been drawn to countries occupied by Western races. In some of the northern centres there are considerable congregations of these Asiatics...We in Cairns have these defects before our eyes every day, and thus it behoves us to keep a watchful eye not only on these aliens among us, but on the East.\textsuperscript{87}
\end{quote}

On 24 January 1900 Premier Robert Philp sent a letter to the Health Officers in the four ports where the largest numbers of Pacific Islanders arrived to work in the sugar plantations, urging them to make the most careful inspection of all labour vessels and other ships coming from infected or suspected islands, and to impose a period of quarantine for those infected or suspect of twenty one days.\textsuperscript{88} The suggestion for this action came from a meeting of the Central Board of Health on 17 January (which agreed special inspections of labour vessels should be made), but the period of quarantine was

\textsuperscript{86} \textit{Brisbane Courier}, 11 January, 1900.


\textsuperscript{88} Q.S.A. COL 154, in-letter 01237 to Home Secretary, 24 January, 1900.
declared to be fourteen days.\textsuperscript{89} Dr Jefferis Turner who had trained in bacteriology at University College, London, and had clearly kept up to date with scientific thinking about plague, wrote to the Central Board on 26 January emphasizing the absolute necessity for a thorough examination of rats found dead in the city, and offering his services which were accepted,\textsuperscript{90} but only after he and C. J. Pound, the Director of the Bacteriology Laboratory, had been vaccinated with Haffkine’s vaccine. Turner was appointed a health officer of the Central Board of Health and dispatched to Rockhampton and Townsville to organise plague preparations there. Also on 24 January, the Commissioner of Police, W. E. Parry Okeden, wrote to the Home Secretary to ask if he should arrest persons crossing from New South Wales into Queensland.\textsuperscript{91}

A newspaper editorial in early February highlighted the uncertainties concerning the powers of the Central Board under the \textit{Health Act} of 1884. Comparing the Queensland board with the New South Wales board, the \textit{Brisbane Courier} argued:

\begin{quote}
‘instead of a company of medical men, all of them (secretary included) busily occupied with private practice, and with whom the work of the board is only incidental, the sister colony has a Health Department with permanent heads who devote the whole of their time to its business. Dr Ashburton Thompson, president of the Board, is an expert in the science of public health. The Inspector of Police is associated with the Board...surely the time has come for
\end{quote}

\textsuperscript{89} Q.S.A. COL 154, in-letter 00897 to Home Secretary, 18 January, 1900.

\textsuperscript{90} Q.S.A. COL 238, (The Turner Plague Papers).

\textsuperscript{91} Q.S.A. HOM B/5, in-letter 1177 to Home Secretary, 24 January, 1900.
Queensland seriously to consider whether she should not put the public health on a footing more nearly approaching that of New South Wales.'

The Brisbane Courier also urged Foxton to give the board all the powers it needed to deal with the emergency, claiming it would be his responsibility for any failure to deal with the plague.

The board backed away from blaming Asians for the plague and came to appreciate the problem of rats. In February, it urged the Brisbane City and South Brisbane Municipal councils to start de-ratting procedures, a duty which the councils undertook with enthusiasm. The Brisbane Courier, which had suggested this program earlier in the month noted the action with approval, and urged northern ports to start work straight away. However, in Townsville newspapers accentuated the alleged threat from Asiatics and Polynesians, while the Mackay Chronicle called for its South Sea Islander population to be kept on the plantations, allowed off only with signed passes and after being thoroughly washed, a suggestion giving rise to great amusement in the anti-alien paper The Bulletin.

92 Brisbane Courier, 6 February, 1900.
93 Brisbane Courier, 25 January, 1900.
94 Brisbane Courier, 6 February, 1900.
95 Brisbane Courier, 27 February, 1900.
96 Brisbane Courier, 7 February, 1900.
'Poor, poor Mongrelia! It has filled its country with the scum of Asia; it has imported the leper from Hong Kong and cherished the poor tuberculous heathen from the New Hebrides; it has taken to its odoriferous bosom the Javan, the Filipino and the Jap—and now it wants to set matters right by washing its kanaka! Wash' em? Yes, by all means!\textsuperscript{97}

In Cairns, the mayor and a pair of aldermen constituted themselves a ‘subcommittee to immediately inspect and report on...the present unhealthy condition of Chinatown.’\textsuperscript{98}

The first formal action of the Central Board of Health in respect of plague was to issue regulations under Section 109 of the Health Act. These made plague and suspected cases of the disease notifiable conditions, to be reported to both the local authority and the Central Board (or should this prove impossible, to the nearest police magistrate or officer of police) by the person in charge of the house, a doctor or the master of a ship. The health officer, police magistrate or officer of police to whom the notification was made was then to make immediate provision for the quarantine of premises or ship. They could use force to prevent any unauthorised person from entering quarantined premises or ships.\textsuperscript{99} Clause 8 of the regulations allowed the Health Officer to examine the suspected case and other contacts. Contacts would be allowed to leave the premises after giving their names and addresses, and after disinfection of their persons and effects. At the end of April, clause 8 was amended, allowing contacts to spend five days of quarantine, or

\textsuperscript{97} The Bulletin , 24 March, 1900.

\textsuperscript{98} Richards. The People Must Save Themselves, 2007.

\textsuperscript{99} Q.G.G. 1900: 73;771-773.
discharge themselves after disinfection of their persons and effects, so long as they reported to the Health Officer for a period of five days. In either case any breach of these conditions could lead to arrest without warrant by any policeman.\textsuperscript{100} All these regulations were combined and tightened on May 19, 1900. (For example, the original regulations merely stated that a guard ‘may be stationed on or near the premises.’ In May, this was amended to: ‘the Local Authority, health officer, police magistrate, officer of Customs or member of the police force shall also prevent, by force if necessary, any person from entering such premises…’)

On 2 March, 1900, Sydney was declared an infected port, and all ships coming from Sydney had to go into quarantine until granted pratique by the Health Officer.\textsuperscript{101} This came several days after Home Secretary Foxton had held a meeting with Dr Love, the Secretary of the Central Board of Health and with the mayors of several of the metropolitan councils, at which it was decided to form a Joint Local Authority to deal with plague under section 113 of the \textit{Health Act} of 1884. This board would be known as the Metropolitan Joint Board for the Prevention of Epidemic Diseases (M. J. B.), commonly abbreviated by the newspapers to ‘the Epidemic Board.’ However, spurred by the outbreak of plague in Sydney, the Home Secretary issued a ‘very urgent’ circular on 7 March advising that, to deal with a possible outbreak of bubonic plague, an order-in-council would be immediately issued forming a Metropolitan Joint Board for the Prevention on Epidemic Diseases. The board would consist of nine members selected

\textsuperscript{100} Q.G.G. 1900: 73; 1227.

\textsuperscript{101} Q.G.G. 1900:73: 771.
from elected, and therefore unpaid, members of all twenty-two local councils of metropolitan Brisbane. The mayor of Brisbane City would be the first chairman of the Metropolitan Joint Board, pending elections for the positions on the board. Funding was to come from financial contributions (called ‘precepts’) levied on all the constituent local authorities according to the local population (later changed to rateable value). The revenue, termed the Metropolitan Joint Health Fund, would be used to appoint temporary medical officers, to engage shipping inspectors, to establish a plague hospital (for which the government would bear two thirds of the cost), and for rat control. The Metropolitan Joint Board could, if it so wished, take over all sanitary and scavenging work for the area, or could leave it to the component local authorities. Matters relating to maritime quarantine would not be within the realm of the Board. The role of the shipping inspectors was always likely to be a problem, as both the Brisbane Government Medical Officer (Dr Hill Wray) and the water police were also responsible for ensuring the various shipping regulations were carried out. Subsequently, Joint Boards were formed in the larger seaports of Queensland, with the exception of Maryborough. Some raised precepts on population, some on rateable value. A week after the gazetting of the plague regulations the Central Board, in response to a letter from Hill Wray asking for a camp to be prepared for suspect cases, advised the Home Secretary that a temporary tented hospital, surrounded by barbed wire, should be set up in Victoria Park for the reception of suspect cases of plague: the quarantine station at Peel Island be put into a state of readiness for plague patients: provision for the isolation of contacts be made: a medical man and nurses, inoculated with prophylactic, be retained, and steamers should be

102 Q.G.G. 1900: 73; 821-824.
prohibited from going beyond Pinkenba. If barbed wire was to be used, the implication is that a guard would be put on the camp, and though not specified, the police would presumably undertake this task. Foxton agreed to these recommendations, asking the Central Board of Health to state what steps were to be taken in respect of steamers to transport patients to Peel Island and in providing staff. He further advised that any charges should be paid by the M. J. B. In due course, the M. J. B. requested the government to provide a steamer to take suspects to the station. The Board’s letter was passed to the Premier, who replied he had no steamers to spare. The Home Secretary likewise replied his department’s steamer could not be spared, and the portmaster had no steamers available. The recommendations stirred immediate controversy. Neither the Trustees of the Victoria Park nor the local authorities were prepared to have a suspect hospital in the park. Some individuals even threatened injunctions against the board. Hill Wray took objection to Peel Island being used as a plague hospital, since it could not be used for other quarantinable diseases if plague was already there. Peel Island, furthermore, was 36 miles by water from Brisbane, and it would be too dangerous to carry sick persons that distance. The Venice convention required a ten day period of quarantine for plague, the Central Board recommended fourteen, while Hill Wray suggested twenty-one days.

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103 Q.S.A. COL 286, in-letter 03439 to Home Secretary, 9 March, 1900.
104 Q.S.A. COL 286, in-letter 04550 to Home Secretary, 30 March, 1900.
105 Q.S.A. COL 286, in-letter 03786 to Home Secretary, 14 March, 1900.
106 Q.S.A. COL 286, in-letter 03776 to Home Secretary, 14 March, 1900.
Plague hospitals were a fundamental part of the preparations for an outbreak, and the Joint Boards were expected to establish these. Three levels of hospital were required: one for plague patients, one for suspects, and one for contacts\textsuperscript{107}. For obvious reasons, it was considered these should not be at the same place. As the site for a proposed hospital in Victoria Park was said to be over-run with rats, this proposal was abandoned, as was the plan to use Peel Island. In Brisbane the first contact hospital was set up on vacant land bought by the government at Cairncross, on the south side of the river, and today the site of the Cairncross Dry Dock.

Despite considerable opposition from local residents, and a plea from Mr. J. Dickson, the recently retired Premier and Member for Bulimba, that a site in the bay islands, away from population and industry, should be sought,\textsuperscript{108} plans for a plague hospital, Colmslie, at Bulimba, a short distance from Cairncross, were drawn up. However, controversy over the plans led to delays in starting construction. Once more, the Home Secretary obfuscated, saying he would like the opinion of a medical man in a permanent and official position in order to avoid the differences of opinion that seemed to exist among medical men. The Government, he said, was prepared to provide and equip the hospital in accordance with the views of the Joint Board, and to pay one half of the cost of maintenance, but only after he had satisfied himself that the proposed expenditure was

\textsuperscript{107} Since plague is primarily a disease of rats, humans are not involved in transmission. Isolation of contacts was both a waste of time and money. Suspect cases, likewise, unless they have pneumonic symptoms, are not vectors of disease. However, given the uncertainties existing at the time about how plague was transmitted, this degree of preparation was inevitable.

\textsuperscript{108} Q.S.A. COL 244, in-letter 03850 to Chief Secretary, 6 April, 1900.
necessary. Once the decision to build the two hospitals was taken, work commenced and proceeded apace, though neither was ready by the time the first case was diagnosed on April 27, 1900. The government paid for the erection of hospitals, under the watchful eyes of Government Medical Officers. Once the hospital was built, it was handed over to the local Joint Board. Government also agreed to pay one half of the cost of maintenance but only from the time the first patient was admitted. The early hospitals were tented affairs, though later built of wood and canvas, and furnished with rough and inexpensive furniture. For financial reasons, only one plague hospital would be built for each Joint Board region, generally close to the principal centre of population. The medical officer, of the Joint Board or the local council in the absence of a joint board, managed the hospitals.

On 8 March, 1900, the Central Board of Health issued regulations for preventing the landing of rats from vessels which caused numerous problems with shipping companies concerned with maintaining schedules, dependent, in some ports, on the tides. One regulation stated ships could only be inspected by the medical officers between the hours of sunrise and sunset. A week later, the government sent a letter to all shipping companies requiring fumigation and systematic cleansing of bilges. Companies were, in general, happy to comply, but as other colonies had similar regulations, endless disputes arose about whose regulations had priority. Fumigation was to be done at the expense of

109 Q.S.A. COL 286, in-letter 05504 from MJB to Home Secretary, 14 April, 1900.

110 Q.S.A. COL 246, from Home Secretary’s Department to Mayor of Mt Morgan, 16 May, 1900.

111 Q.G.G. 1900: 73; 921.
the shipping companies, both before loading, and immediately after discharging cargoes, by means of steam sulphur fumes passed into the ship under pressure. (This system generates sulphur dioxide, an effective poison for rats and also a mild antiseptic.) The fumigation of cargoes was not provided for in the regulations, and this sometimes caused problems. Shipping was of fundamental importance to the economy of Queensland because local, intercolonial and international trade depended on it. Anything delaying ships led to financial penalties. Ships’ masters sometimes deliberately flouted the regulations. The steamship *Maranoa* managed to travel up the river to the city wharves, where cargo and passengers were discharged despite the presence on board of a steward who was so sick that Dr P. Bancroft, to whom he was taken, made an immediate clinical diagnosis of plague.\(^\text{112}\) At this point the *Maranoa* was isolated and anchored in midstream. The Premier, Robert Philp, on a tour of northern areas in June 1900, realised his steamer was likely to reach Cooktown after sundown. His Under Secretary wired the Home Secretary to ask the Health Officer to pass the steamer, notwithstanding its late arrival, on a certificate by the captain that there was no sickness on board. Foxton agreed but thought a bad precedent had been set.\(^\text{113}\)

**6.7.1 Plague in Queensland**

On 20 April, 1900, C. J. Pound reported that from 10 March to 20 April, he had carefully examined large numbers of rats in Brisbane and found no signs of plague (although there

\(^\text{112}\) *Brisbane Courier*, 1 May, 1900.

\(^\text{113}\) Q.S.A. COL 240, in-letter 08915 to Home Secretary, 15 June, 1900.
is a suggestion he may have found plague bacilli in a dead black rat as early as 5 March.\textsuperscript{114} Whatever the case, on April 19 he received a rat discovered in a washbasin in one of the Brisbane offices of the Adelaide Steamship Company’s wharf. He found plague bacilli, not only in the blood of the rat, but also in the alimentary canal of several fleas.\textsuperscript{115} Several days earlier, the chief steward of the \textit{Burwah}, steaming from Sydney to Rockhampton via Brisbane, was reported to have suspicious symptoms three days after leaving Brisbane and five days after leaving Sydney. Numerous dead rats were found on the ship, but whether infected in Sydney or Brisbane was unclear. However, a second case of suspected plague was reported in Rockhampton on April 20. A week later, on 27 April, the first Brisbane case was notified. The victim was a recently married carter, twenty-one years of age, who had been employed to remove goods from the wharves where dead rats had been found. The Chief Secretary wired the Agent General in London, asking him to notify the Imperial Government of the existence of plague in Brisbane. Though the plague hospital was not yet completed, the carter was taken there, leading to a short strike by the workers erecting the hospital,\textsuperscript{116} and giving the \textit{Brisbane Courier} another opportunity to emphasise the need for the Board of Health to be in supreme control. In the meanwhile, the chairman of the Epidemic Board, Mayor J. Nicol Robinson, its medical officer, Dr Thomas Bancroft and Dr Wilton Love, the Secretary of the Central Board of Health, had all been vaccinated with Haffkine’s prophylactic, and all three were sick. Not surprisingly, when a second case of plague was diagnosed in

\textsuperscript{114} B. Burnet Ham. \textit{Reports on the Epidemic of Plague in Queensland, 1900-1907}. 1907.

\textsuperscript{115} Q.S.A. COL 286, in-letter 05692 to Home Secretary, 20 April, 1900.

\textsuperscript{116} \textit{Brisbane Courier}, 30 April, 1900.
Brisbane, no one knew quite what to do, as Foxton had said the hospital would not be ready for another two or three days. The patient was taken to Bancroft’s house, but he refused him admission, and examined him outside, before returning him to his house.

The following day, the patient was transferred to Bulimba. At the same time, officers of the joint board found it hard to get transport to take them to the scene of the second outbreak, as owners of vehicles refused to run the risk of themselves being isolated. The board consequently had to purchase a horse-drawn bus. When the numbers of contacts became too great, some were housed in empty cottages on vacant land adjoining the Cairncross hospital for contacts. This practice ceased after the landlord threatened to take action against all parties for damages.

Contrary to expectations, the outbreaks of disease did not start in Chinese quarters, but in areas close to wharves, or in people who worked on the wharves, or on ships. Apart from a single, unusual case in Mount Morgan, all cases occurred in ports (including Ipswich) (see table). The epidemic in Queensland waxed and waned, recurring every year till 1907. Brisbane had the highest caseload, with 384 of 464 cases (82.7%). The overall death rate was 195 out of 464, or 42%. Males outnumbered females by over two to one, a reflection of the occupational hazards of working close to or on the wharves.

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117 Q.S.A. A/45275. Police were escorting two ‘lunatics’ from Townsville to Brisbane on the steamer Arawatta when plague broke out. The police and the ‘lunatics’ were taken to the Brisbane Watch house. Here the police were given a bath, and the clothing worn by them was burned.

118 Plague is a disease of marked seasonality, dependent on the ecology of rats and their fleas. In general, plague is less common during periods of intense heat, such as the Queensland summers.
Table 6.1

Plague in Queensland

<table>
<thead>
<tr>
<th>Year</th>
<th>Cases</th>
<th>Deaths</th>
<th>Brisbane</th>
<th>Townsville</th>
<th>Rockhampton</th>
<th>Cairns</th>
<th>Other towns</th>
</tr>
</thead>
<tbody>
<tr>
<td>1900</td>
<td>136</td>
<td>57</td>
<td>56</td>
<td>37</td>
<td>36</td>
<td>5</td>
<td>2</td>
</tr>
<tr>
<td>1901</td>
<td>36</td>
<td>12</td>
<td>36</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>1902</td>
<td>91</td>
<td>26</td>
<td>81</td>
<td>7</td>
<td>-</td>
<td>-</td>
<td>2</td>
</tr>
<tr>
<td>1903</td>
<td>29</td>
<td>17</td>
<td>21</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>1904</td>
<td>35</td>
<td>12</td>
<td>30</td>
<td>-</td>
<td>-</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>1905</td>
<td>56</td>
<td>33</td>
<td>28</td>
<td>6</td>
<td>-</td>
<td>2</td>
<td>20</td>
</tr>
<tr>
<td>1906</td>
<td>32</td>
<td>12</td>
<td>11</td>
<td>-</td>
<td>11</td>
<td>10</td>
<td>-</td>
</tr>
<tr>
<td>1907</td>
<td>49</td>
<td>19</td>
<td>36</td>
<td>1</td>
<td>-</td>
<td>-</td>
<td>11</td>
</tr>
</tbody>
</table>

In 1905, ten cases occurred in Maryborough, eight of which involved one family and their carers. These were all cases of pneumonic plague and only one patient recovered.

In 1907, ten cases occurred in Mossman.\(^{119}\)

6.8 The role of the police

The plague regulations of March 1900 made plague a notifiable disease, to be reported to the local authority and the Central Board of Health, otherwise to a Police Magistrate or officer of police. The police occasionally notified cases of plague, but did so to the Commissioner of Police, not the Boards. In addition they notified the Commissioner of suspected cases, and of deaths from bubonic plague, even if such cases had been known to the Central Board or a Joint Board.

\(^{119}\) From, Ham. Reports on the Epidemic of Plague in Queensland, 1900-1907. 1907 Despite good clinical, pathological and bacteriological evidence that the disease which swept through Queensland was, indeed, plague, there were doubters. Dr Thomas Pennington Lucas, famous for making a pawpaw ointment that still bears his name today, was such a one. See Q.S.A. COL 238, in-letter 14354, 3 September, 1901, to the Home Secretary from Lucas, enclosing a pamphlet entitled Twenty-Five Reasons why the Australian Epidemic is not Plague.
The order-in-council establishing the Metropolitan Joint Board on 8 March, 1900 consisted of thirty-seven sections. Section 34 stated it was the duty of every officer of police who found any person committing a breach of any of the provisions of the order, or any regulations of the Central Board of Health, to take the person’s name and address and to report the breach to the clerk (presumably of the M. J. B., but perhaps the local council, it is not clear which.)

6.8.1 The water police

The first police priority was shipping. The regulations made by the Central Board of Health on 21 March, 1900 said all vessels must be kept off wharves by a distance of at least four feet by means of fenders: each rope or hawser was to be either tarred or have a brush, bristles or a funnel to prevent rats getting ashore: any nets between ship and wharf were to be tarred, and all gangways were to be drawn up between 6.0 pm and 5.0 am and tar to be applied to each gangway when down.\(^{120}\) The policing of these regulations was in the hands of both shipping inspectors\(^ {121}\) appointed by the Epidemic Board, and of the water police. Throughout the period 1900 to 1907, the Commissioner of Public Health regularly asked the Police Commissioner for the cooperation and assistance of the Water Police in the management of the shipping regulations. Keeping ships at least four feet

\(^{120}\) These regulations were superseded by more stringent and detailed regulations published on 19 May, 1900.

\(^{121}\) Q.S.A. COL 238, in-letter 08194 o Home Secretary says the function of the board shipping inspectors was ‘to educate shipping companies and officers of vessels about the new regulations before instituting any prosecutions.’
from wharves proved a constant battle. In the early days, fumigation certificates were
given to the Health Officer who examined passengers and crews. Once the need for the
examination was put aside, the water police were given the task of collecting all
fumigation certificates. If the vessel had no certificate, then the ship was to be anchored
in midstream. Ships’ masters sometimes refused to obey the water police. In one case,
the portmaster told the Commissioner of Police the Water Police had no authority to
order the disposition of any vessel. The pilot was within his rights in refusing to allow
any interference in the navigation of any vessel. Fumigation certificates came and
went with the outbreaks of plague, both in Queensland and in the other colonies.
Disputes occasionally arose if the water police showed ignorance of the current or most
recent regulations. In later years ships’ masters received berthing certificates certifying
the ship was clean on departure from a port. Without a berthing certificate, a ship was
not allowed to berth at her port of arrival. However when the Chillagoe arrived at the
Railway wharf in South Brisbane without a certificate, Constable Bycroft merely
informed Commissioner of Public Health Ham, who allowed the ship to berth.

6.8.2 Land police

If a case of suspected plague was notified, but for some reason or other the patient could
not be moved immediately to the hospital for suspects, a police guard, generally of two
constables, was placed on the premises, to prevent both egress and ingress of

122 Q.S.A. A/45276, in-letter 12668 to Commissioner of Police, 30 August, 1901.
123 Q.S.A. A/45275, in-letter 14849 to Commissioner of Police, 17 September, 1904.
unauthorized personnel (figure 6.2). No one, except certified and inoculated medical men, was allowed to leave the house of such a patient, and if any unauthorized person went in, they would stay there for the whole period of quarantine. Guarding such homes could lead to acute shortages of manpower. Inspector Alexander Meldrum, from Townsville asked the Commissioner to send four additional constables. The police were rendering assistance to the health authorities, but shortages of resources meant he could not give all the necessary assistance, and cases were occurring in all parts of the town and its suburbs.¹²⁴

Unfortunately, no men were available, and Meldrum was told to draw men from Charters Towers, otherwise he was to request the authorities to appoint men for the duty. In May

Figure 6.2 Police guarding a plague house in Woolloongabba (John Oxley Library)

¹²⁴ Q.S.A. A/ 45275, in-letter12236 to Commissioner of Police, 1 August, 1900.
1900, the Secretary of the Cairns Health Board wrote to Inspector Charles Marrett, authorizing him to enforce quarantine, and to take on extra men to guard all quarantined premises. Marrett took on four special constables, but took care to inform the Commissioner that he had done so, and asking how to defray the expenses of the specials. Commissioner of Police Parry Okeden’s response was brisk. ‘What does this mean? I know nothing re: ‘specials’ being engaged.’ Marrett reported these were not sworn as police, but rather four men from the local naval brigade, employed to guard quarantine premises. Once again he asked how the men were to be paid, and Parry-Okeden said it had nothing to do with the police department. In Rockhampton, in May 1900, with six places under quarantine, each taking three constables, a substantial burden was placed on local resources. A Chinese man found to have plague in Maryborough in 1902 was removed to the plague hospital on an ambulance stretcher under the supervision of the police — presumably to ensure he went there — and a police guard was placed over the plague area.

If a ‘suspect’ was subsequently shown to be a true case of plague, then the person would be taken to the plague hospital. Occasionally, plague patients objected to being removed from their homes to hospital. In July 1900 Marrett wired the Commissioner of Police to advise that the husband of a patient was objecting to his wife being taken to the quarantine hospital and asking what steps should be taken in case of dissent. Parry-Okeden advised the inspector to consult with the Health Officer and then be guided by their instructions.

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125 Q.S.A. A/45275, in-letter 09146 to Commissioner of Police, 25 May, 1900.

126 Q.S.A. A/45275, in-letters 16694 dated 13 October, 1902 and 15 October, 1902.
The most serious example of resistance to medical authority occurred in Townsville in September 1900. A young man named Cockerill (or Cockerell) was taken ill. He summoned his lodge doctor, Dr Linford E. Row, who suspected plague, took appropriate specimens and gave these to Dr Turner, who reported the presence of plague bacilli. The two doctors visited the patient, and recommended (or ordered him to) the plague hospital. Cockerill’s father objected noisily to the diagnosis, and demanded a second opinion from a prominent local surgeon, Dr William Bacot. Row meanwhile ordered the house quarantined, and constables were summoned. As Bacot approached, Row told him the house was quarantined, but Bacot ignored the warning, only retreating when told off by the constables. To ease the situation, Turner agreed to let Bacot into the house, so long as he came with an open mind, and not merely to dispute the diagnosis. The surgeon found the tone of the letter from Turner insolent and refused to see the patient. On the afternoon of 16 September, Row ordered the ambulance cart to remove Cockerill to the plague hospital. Cockerill senior threatened resistance, and was supported by a crowd gathered outside the house. Row and the ambulance retreated, accompanied by hoots from the crowd.\(^{127}\)

The following day, Row, in company with Sub Inspector Martin Breene of the local police force, visited the house, where they found the patient in a serious condition, and resolved to leave him at home. The mayor of Townsville, who had been in Brisbane, returned on the 21 September, and immediately tried to get Bacot in to see the patient, without asking the permission of either Turner or Row. Claims and counter claims of lies and untruths followed and the situation deteriorated. Finally,

\(^{127}\) *Brisbane Courier*, 17 September, 1900.
Turner determined to send Cockerill to the plague hospital, as his condition had improved. On 26 September, Inspector Alexander Meldrum, accompanied by Breene, Sergeant James Moylan and several constables, and Doctors Turner and Row, went to Cockerill’s house. A small crowd was present, and, despite some heckling, no actual resistance to the removal of Cockerill junior to the plague hospital occurred.\textsuperscript{128}

Occasionally, police guarding a house where a suspect died were asked by the undertaker for assistance in lifting the body into the coffin, which the police refused. Chief Inspector Douglas confirmed they were to stay outside the house, while the undertakers would have to make their own arrangements.\textsuperscript{129}

Plague could kill rapidly, or death might occur some days after the onset of symptoms. In cases where death occurred with devastating rapidity, either no doctor was called, or he was called too late. If the attending medical practitioner (had there been one) was unwilling to issue a death certificate, the police arranged for the body to be taken to the morgue, arranged a post mortem examination, and gave the results to the local Police Magistrate, who then decided whether an inquest was required. A number of cases of bubonic plague fell into this category, and generally, if the diagnosis seemed certain, no further action was taken.\textsuperscript{130} In cases where the disease killed more slowly, the doctor might have managed the patient as, for example, a case of typhoid before considering an

\begin{footnotes}
\item[128] Q.S.A. A/45275, in-letter 16382 of 10 October, 1900 from Inspector Meldrum to Commissioner of Police. This episode forms the basis for Queensland journalist Ian Townsend’s novel, Affection, Harpercollins, Pymble, N.S.W.2005
\item[129] Q.S.A. A/45276, in-letter 05271 to Commissioner of Police, 4 April, 1902.
\item[130] See Q.S.A. A/45276, for a number of these cases.
\end{footnotes}
alternative. Again, if doctors were unwilling to issue a death certificate, it was the duty of the police to inform the Police Magistrate, who would order a post-mortem to be performed by the Government Medical Officer. It was the duty of the police to attend the post-mortem.

The police noted the existence of panic in some of the ports affected by bubonic plague. The scare, alarm and excitement of the populace over the existence of plague in Queensland\(^\text{131}\) led to the enactment of a new Health Act in November 1900. The act provided for the appointment of a Commissioner of Public Health, an expert in sanitary science, to oversee the Central Board of Health. The board would now be composed of three medical men, a person with experience of local government, and one representative from trade and commerce and would be entirely advisory. The powers and duties of the chair of the old board were now transferred to the new Commissioner of Public Health.

In 1902, under the regulations of the new Health act, the Joint Boards were disbanded, and reconstituted as boards for the prevention of infectious diseases. However the serious exotic diseases, plague, cholera and smallpox would be managed by the Commissioner of Public Health.

Police involvement continued throughout the eight years of the outbreaks. An eruption of plague in the sugar town of Mossman north of Cairns in 1907 caused the police to hastily scramble to deal with some two hundred and fifty contacts. On 23 January, 1907,
Commissioner Cahill ordered Inspector Hugh Malone of the Cairns Police to send at least six men, (or as many as he could spare) to Port Douglas to assist in enforcing the quarantine of the plague contacts. As there was no plague hospital, let alone a contact hospital in the area, Malone set about trying to organize a tented hospital. He bought seventy tents (at a considerable discount after some hard bargaining). Accompanied by a sergeant and four men, Malone took ship to Port Douglas, dropped the tents there, and then took the sugar tram to Mossman. Unfortunately, the contacts, mostly employees of the Mossman Sugar Mill, had already been laid off by the mill owners. Many were in a drunken state. With considerable difficulty, the police rounded up fifty-six contacts, herded them onto the tram, and took them to Port Douglas, where, with the assistance of a few helpful contacts, the police erected a tented camp on the beach. All told, sixty-six contacts were isolated. Despite a constant police presence, many of the occupants managed to get into town to buy liquor. Most of the contacts thought the whole experience something of a joke. Only forty tents were erected. After 4 days, the camp was vacated, at which point the police found four flys for the tents were missing, presumed stolen by some of the contacts. Malone was then given the task of trying to sell the tents, at cost price less ten percent, initially to the original vendors, then to anyone who would buy them, but nobody wanted them. The Burns Philp manager said, probably correctly, it would harm their business if it became known they had tents that had been used for plague contacts. After long and protracted negotiations, Police

132 Q.S.A. A/45276, in-letter 003122 to Commissioner of Police, 12 February, 1907.

133 Q.S.A. A/45276, in-letter 005065 to Commissioner of Police, 20 March, 1907.
Commissioner Cahill finally allowed the tents to be distributed to various police stations, to be carefully stored for later use.

The tables were occasionally turned on the police. Constable Hornibrooke was on lunatic escort duty with a special constable on the steamship *Arawatta*, sailing from Townsville to Brisbane, when plague broke out on the ship. The constables, along with the passengers, underwent quarantine on the ship in the Brisbane River. When they finally arrived at the Brisbane Watch House, the constables were ordered to have a hot bath, while their boots and uniforms were burned. The lunatics meanwhile were held in the watch-house until they could be transferred to the asylum. The police rapidly received compensation for the health risk to which they had been subjected.\(^{134}\)

After 1909, no cases of plague occurred in Queensland, until August 1921, when a man died of plague in the Brisbane Hospital. Dr John Moore failed to notify the other states and only notified the Director of Quarantine some three weeks later.\(^{135}\) The outbreak led to one hundred and sixteen cases with sixty-three deaths. On 21 September the first Epidemic Diseases Regulations were proclaimed for all Local Authority areas in Queensland.\(^{136}\) Section 3 of these regulations gave powers to any health officer, with such inspectors as might be necessary to inspect premises specified by the Commissioner of Public Health. ‘Inspectors’ were not defined. On 3 December, a Metropolitan Joint

\(^{134}\) Q.S.A. A/45275, in-letter 09065 to Commissioner of Police, 29 May, 1900.

\(^{135}\) *The Queenslander*, 24 September, 1921.

\(^{136}\) Q.G.G. 1921:118; 849-850.
Health Board was once again formed\textsuperscript{137} for the purpose of carrying out the Rat, Flea and Plague Carrying Insects Prevention and Destruction Regulations proclaimed the previous day.\textsuperscript{138} These regulations say nothing about ‘inspectors’, but were amended in January 1922 when an ‘inspector’ was defined as ‘any health inspector, or local authority inspector, and any other person assisting or acting as such under due authority in the execution of the regulations. On 2 December, virtually the entire Brisbane Police contingent, including the Criminal Investigation Branch and the Traffic Branch were appointed inspectors for the purposes of the Health Acts.\textsuperscript{139} The Rat, Flea and Plague Carrying Insects Prevention regulations dealt largely with making sure the environment, houses, shops, drains and sewers were kept in such a state as to deter rats from foraging. The penalty for leaving material around that could be used for rat food was two pounds, raised to ten pounds by an amendment of the regulation in early January 1922. The police role in this last gasp outbreak of plague is unclear. The Commissioner of Public Health makes no reference to either the police, or the regulation appointing them as inspectors under the Health Acts of 1900 to 1917.

The experience of bubonic plague proved useful when Queensland again faced a potential epidemic, not of a bacterial disease, but of a viral infection, spread directly from person to person, the ‘Spanish’ Influenza pandemic of 1919.

\textsuperscript{137} Q.G.G. 1921: 117; 1835-1836.

\textsuperscript{138} See the Annual Report of the Commissioner of Public Health, for the year 1921, for the regulations introduced to deal with this fresh outbreak of bubonic plague.

\textsuperscript{139} Q.G.G. 1921:117; 1837.
6.9 Spanish influenza.

Influenza is an acute infection of the respiratory tract caused by a variety of influenza viruses. These organisms have a great capacity to undergo mutations which can cause immune responses to an earlier infection to be ineffective in later infections. Influenza is generally a mild disease, though the very young, the elderly, and those suffering from significant cardio-pulmonary disease are at risk of serious illness and death. Influenza may occur sporadically, or in epidemics, or world-wide, a form of epidemic known as a pandemic. The most important pandemic of influenza to date has been the outbreak of 1918 to 1919, sometimes known as the Spanish Influenza pandemic,\footnote{The name ‘Spanish ‘Flu’ was given to the epidemic after the King of Spain contracted the disease in 1918. Spain, not a belligerent in the War, was not subjected to the strict newspaper censorship that characterized the belligerent nations. In Australia, the preferred term was Pneumonic Influenza, sometimes abbreviated to ‘pneuflu’.} which caused over a thousand deaths in Queensland, with particularly high death rates in some Aboriginal communities. At the time, the cause of influenza was unknown, though a bacterial cause was suspected by some.

Much of the popular historiography of the great influenza pandemic of 1918/1919, mostly of North American origin, has focused either on the clinical, epidemiological and demographic impacts of the disease, or on scientific efforts to determine the nature of the virus, or viruses, that caused so many deaths,\footnote{Alfred W. Crosby. \textit{America's Forgotten Pandemic}, Cambridge: Cambridge University Press, 1989; John M. Barry \textit{The Great Influenza}. Penguin Books, New York and London, 2004; Giona Kolata \textit{Flu The Story of the Great Influenza Pandemic of 1918 and the Search for the Virus that Caused it}. Simon and Shuster, New York, 1999.} rather than political or public reaction to
the epidemic. A notable exception to this is the work of Geoffrey Rice\textsuperscript{142} on the epidemic in New Zealand, which covered these aspects in great detail. The extraordinary number of deaths world-wide from this pandemic – some say 24 to 39 million people, others suggest at least 50 million, and maybe twice this number, mostly occurring within a few months of the start of the pandemic—make it probably the single biggest cause of epidemic death to date. Standard texts of the history of public health make either no mention, or only passing mention, of the great pandemic. Medical historians Dorothy Porter,\textsuperscript{143} Peter Baldwin\textsuperscript{144} and George Rosen\textsuperscript{145} ignore it altogether, while Roy Porter only briefly describes the epidemiology of the pandemic.\textsuperscript{146} The memory of the pandemic, which had largely faded from the collective memory, has recently been revived as the world prepared for outbreaks of avian (in 2006) and then swine (in 2009) influenza which alarmists suggested might be as devastating as the pandemic of 1918. What little evidence there is suggests the virus of 1918 was not an avian virus, rather a mutated human/swine virus,\textsuperscript{147} which explains some of the anxiety surrounding the 2009 pandemic.

\textsuperscript{142} Geoffrey Rice with assistance from Linda Bryder \textit{Black November: the 1918 influenza pandemic in New Zealand}. Canterbury University Press, Christchurch, New Zealand, 2005


\textsuperscript{145} Rosen. \textit{A History of Public Health} 1993.


Observers agree influenza reached Australia late as a consequence of strict maritime quarantine, and was generally milder than in many other countries. J. H. L. Cumpston, Australia’s first Director of Quarantine, devotes a chapter to the Influenza Pandemic in his book, *The Health of the People*.\(^{148}\) He writes from the perspective of the Commonwealth and is critical of what he sees as the intransigence of the States in the matter of quarantine. Influenza in Sydney received careful analysis from McCracken and Curson,\(^{149}\) while McQueen’s review of the political, medical and social aspects of the pandemic in Australia focuses principally on New South Wales and Victoria.\(^{150}\) Anthea Hyslop has painted a broad picture of the relationships between the States and the Commonwealth during the crisis, looking particularly, but not exclusively, from the point of view of the Commonwealth.\(^{151}\) The political and medical impact of the disease in Queensland has received only cursory mention as part of more general histories of medicine or disease in the State.\(^{152}\) Yet the epidemic, while not as lethal as in New South Wales, Victoria or the rest of the world, led to over a thousand deaths in Queensland. The epidemic in Queensland was also characterised by a serious dispute between the State and the Commonwealth over States’ rights, with particular respect to quarantine.


There was also significant involvement by the Queensland police, without whose assistance the effects of the pandemic may well have been much worse.

Influenza was not unknown in either Australia or Queensland prior to the great outbreak of 1918/1919. According to Cumpston, influenza was first recorded in Australia in 1820 and in Queensland in 1832.\(^{153}\) In 1847, an epidemic affecting practically every household hit Brisbane, and also affected other Australian colonies.\(^ {154}\) From about 1860 onwards, general epidemics of influenza occurred, often during years of high world prevalence. A major epidemic in 1891, commonly known as Russian Fever, led to over two thousand deaths in New South Wales and Victoria. Queensland, despite large numbers of cases, was spared a significant mortality.\(^ {155}\) Conventional wisdom at the time suggested the disease was spread on the wings of the wind, though J. Ashburton Thompson, the New South Wales Chief Medical Officer, writing of the 1891 outbreak, thought it more likely the infection spread directly from the sick to the healthy.\(^ {156}\) Though these epidemics caused considerable morbidity, and sometimes mortality, they were largely ignored as public health problems. It has been alleged influenza was one of the most important medical causes of the decline of Aboriginal populations, though clinical evidence to support this is lacking.\(^ {157}\) Cumpston quotes the Sydney Almanack of


\(^{154}\) *Brisbane Courier*, 30 October, 1847.


1834, which noted of the 1820 outbreak of influenza, ‘[g]reat numbers of the poor [A]borigines fell victim to this novel and severe distemper’.\textsuperscript{158} Whether the distemper was truly influenza will never be known. These epidemics also occurred before Federation, which gave the individual States, then colonies, a free rein to do what they thought necessary. Federation placed a higher authority over the States, and it was that authority which would be challenged by the influenza pandemic.

### 6.9.1 Influenza, a viral infection

The existence of viruses, organisms smaller than bacteria, had been postulated, though neither seen nor propagated, before the great pandemic. The viral cause of influenza was not positively established until 1933.\textsuperscript{159} In 1892, the German bacteriologist Richard F. J. Pfeiffer announced that the cause of influenza was a bacterium. He named this organism \textit{Haemophilus influenzae}.\textsuperscript{160} More than a quarter of a century later, the \textit{Medical Journal of Australia} reported that the Medical Research Committee of the British National Health Insurance doubted the causal role of Pfeiffer’s bacillus in the causation of epidemic influenza.\textsuperscript{161} Despite the uncertain status of the organism, it came to be an important constituent of the vaccines manufactured to control pneumonic influenza.

\textsuperscript{158} Quoted in: Cumpston. \textit{Health and Disease}, 1989. p 313.

\textsuperscript{159} Smith W., Andrewes C.H. and Laidlaw P.P. A virus obtained from influenza patients. \textit{Lancet} vol 2, 1933, pp 66-68.

\textsuperscript{160} Douglas Guthrie. \textit{A History of Medicine}. Thomas Nelson and Sons Ltd. London, 1945, p 287.

Clinically, influenza is characterised by great variability in morbidity and mortality. The incubation period is generally short, from 2 to 4 days, and in some cases of pneumonic influenza, even shorter. It was this very short incubation period that justified quarantine for only seven days. If an exposed person remained well for seven days (in the absence of any further exposure), that person would not be incubating influenza. Uncomplicated influenza generally has an abrupt onset. Symptoms include fever, chills, headache, and aches and pains. These often persist for a few days, and then subside spontaneously. A dry cough, nasal discharge and irritation, and redness of the eyes are common. Mortality is low, but is highest in the very young, the aged and those with chronic cardio-respiratory conditions. The 1918/1919 epidemic was characterised by a relatively high mortality, affecting not only the at-risk ages, but also young adults aged 20 to 40 years. During this epidemic, respiratory complications were severe. Breathing became more laboured, the patients expectorated blood, or purulent sputum, and cyanosis was a common terminal event. Healthy young adults particularly died rapidly, often within a few hours of the onset of the illness. These most likely succumbed to primary influenza viral pneumonia. A further group of patients died a few days after the onset of the disease. In these patients, death was usually due to a secondary bacterial pneumonia, caused by such different organisms as the pneumococcus, Pfeiffer’s bacillus or golden staphylococci. Treatment recommended by Cumpston was simple. Bed rest, fresh air and abundant food, with Dover’s powders for the relief of pain, though numerous

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162 Hence the occasional reference to ‘the purple death’.

163 Brisbane Courier, 18 November, 1918. Dover’s Powders, medication consisting of powdered opium, powdered ipecachuana and potassium sulphate, developed by Dr Thomas Dover in 1732.
other remedies were used or tried by a medical profession keen to demonstrate its scientific expertise.

6.9.2 The looming threat

As the Great War was coming to an end, newspaper reports appeared in Spain of an epidemic of influenza that was wreaking havoc in Europe and America. Initially mild, the epidemic had, since August 1918, become increasingly virulent and lethal. By September 1918, cases of ‘ordinary’influenza were recorded in Melbourne. The Federal authorities were uncertain whether the outbreak was due to the so called Spanish influenza, or merely the ‘normal’ form of the disease. At the same time the Brisbane Courier noted Spanish influenza was having a devastating effect in South Africa, with an appalling mortality among coloured people. The newspaper called for the most stringent precautionary measures before the disease reached Australia.\textsuperscript{164} A further report from South Africa stated that in twelve days, 1600 people had died of influenza in Johannesburg, of whom 400 were white persons. By November 1918, when the war finally ended, it was evident a virulent form of influenza was fast spreading around the world. In that month, the Governor-General of South Africa belatedly cabled his opposite number in Australia to warn of the existence of a terrible epidemic which was highly infectious, produced an appalling death rate among coloured people and natives, and was ‘even killing white people’.\textsuperscript{165}

\textsuperscript{164} Brisbane Courier, 9 October, 1918.

\textsuperscript{165} Quoted in: Cumpston. The Health of the People, 1978, p 34.
On 18 October, the Commonwealth government put into place a strict system of seven day quarantine for all ships arriving in Australian waters from infected countries. No one was permitted to leave quarantine without first passing through an inhalation chamber for at least ten minutes each day for three successive days. The inhalation consisted of a fine spray of a 2.5% solution of zinc sulphate, a mildly irritant and antiseptic agent, used by the Australian Army as a prophylactic against cerebro-spinal meningitis, and also, in 1915, to prevent influenza. Its value was anecdotal, and no controlled trials of the inhalation were ever carried out. Though Cumpston believed the epidemic in Australia was not introduced by overseas shipping, this seems highly unlikely, especially as Cumpston himself complained medical officers on troopships sometimes falsified records in order to avoid quarantine.\textsuperscript{166} Several instances of troops breaking quarantine also occurred, the most significant of which led to the court martial of ‘Gunner’ Yates, a Labour M.H.R. from South Australia, on 10 February, 1919.\textsuperscript{167}

On 14 November, William A. Watt, the Acting Prime Minister\textsuperscript{168} wired the Queensland Premier, T. J. Ryan, that a serious form of epidemic influenza was prevalent in New Zealand, presenting unusual features of virulence and fatality, and advising States to


\textsuperscript{167} Quoted in: McQueen . “Spanish Influenza” 1975 See also The Advertiser (Adelaide, South Australia, 11 and 12 February, 1919.

\textsuperscript{168} W. M. Hughes, the Prime Minister was absent during most of the period of the Australian epidemic, attending the Imperial War Conference and then the Peace Conference in Paris. Watt was his recently appointed treasurer.
make advanced preparations.\textsuperscript{169} Yet by late November, the \textit{Brisbane Courier} was chiding the Queensland State government for its indifference to the potential threat.\textsuperscript{170} Home Secretary J. S. Huxham, (Figure 7.1) whose responsibilities included both health and the police, was optimistic there would be no outbreak. He was more concerned about causing a panic. That the pandemic was spreading at an aggressive rate was apparently lost on the Home Secretary.

Concerned by the potential threat to the country, the Commonwealth authorities arranged a conference at the end of November to discuss public health management of the epidemic should it reach Australian shores. W. Massy Greene, the Commonwealth Minister for Trade and Customs, chaired the conference. The resolutions of the conference were of great importance, as the later breach of them would cause considerable strains in State/ Commonwealth relations. In brief, the resolutions were: in view of evidence that the spread of influenza coincided with the rate of human travel, attempts to check public travel, through an efficient system of quarantine, should be the first step. As soon as a case of pneumonic influenza was diagnosed, the Director of Quarantine should be notified. He would then proclaim the State an infected State, and all interstate traffic should be suspended until a contiguous state was proclaimed. The quarantine however excluded residents within ten miles of each side of a border. Once a State was proclaimed as infected, the Commonwealth would take complete control of all interstate traffic, by land and by sea, and States were to do all they could to cooperate

\textsuperscript{169} Q.S.A. COL 251 in-letter 12902 to Premier of Queensland, 14 November, 1918.

\textsuperscript{170} \textit{Brisbane Courier}, 21 November, 1918.
with the Commonwealth. No restrictive measures should be applied to goods or mail, provided care was taken to prevent personal contact between persons handling goods. Each State would have powers to enforce local isolation and quarantine, but only the Commonwealth would have powers to repeal proclamations. The conference

Figure 6.3 Sir John Huxham, Home Secretary in 1919 (John Oxley Library)

recommended the immediate establishment of vaccine depots: of special hospitals and the organization of ambulance crews: of medical and nursing assistance: and the provision of advice to local authorities through the press and circulars. In the event of an outbreak of pneumatic influenza, it was deemed advisable to close all public places and to prevent
public meetings. The conference also suggested the establishment of an Advisory Council, consisting of the Chief Health Officer of the State, and senior members of the British Medical Association. The Queensland representatives to the conference were the Home Secretary, the Commissioner of Public Health Dr J. Moore and Dr J. Maclean, the medical superintendent of the Brisbane General Hospital. The following day, Watt wired Ryan, saying the Commonwealth had adopted the resolutions of the conference and urging Queensland give the matter its urgent consideration. Cumpston said all State Governments accepted the resolutions without dissent or qualification,\(^{171}\) which might have been true of the delegates. The Queensland government however never made any formal comment. On 30 January, 1919, after New South Wales told the Director of Quarantine Pneumonic Influenza was in the State, Watt again wired the Queensland Premier to complain he had not yet received formal acceptance of the resolutions from the government, and in the absence thereof, the proclamation of New South Wales as an infected state and the operation of the agreement would be difficult, if not impossible.\(^{172}\) It soon became apparent the sticking point for adopting the resolutions by Queensland was the question of the ten-mile buffer zone.

Following the November Conference, a public meeting was held in Brisbane’s Lyceum Theatre, at which ‘prominent’ medical men spoke of the disease. The Deputy Director of Health, Dr J. Booth-Clarkson stated there was no need for panic, since maritime quarantine would effectively prevent the disease arriving in Australia. But, should it


\(^{172}\) Q.S.A. COL 253, in-letter 00946 to Premier, 30 January, 1919.
arrive, ‘then very drastic and complete measures, as in such diseases as cholera, yellow fever and plague, would have to be taken.’ If the people were not frightened before, the conjunction of pneumonic influenza with the dreaded Asiatic diseases, and especially plague, which had caused several hundred deaths in Queensland only a few years previously, must surely have raised the levels of concern.

Brisbane’s *Daily Standard* questioned whether there really was ‘pneumonic plague’ in Australia, referring to the situation in Melbourne where influenza was raging but the authorities were slow to diagnose ‘pneumonic influenza’, and later talked about ‘pneumonic influenza, alias Spanish ‘flu plague, alias the Black Death’. *Life Magazine* talked of the ‘Australian variety’ of the plague, and even a medical man wrote to Huxham about ‘Spanish Influenza - or Black Plague.’ The plague metaphor would be widely used by the press, despite comments in the *Medical Journal of Australia* that ‘our hysterical journalists apply that name of awful omen (plague) to the comparatively harmless disease’ that had so far been kept at bay by skilful maritime quarantine. Meanwhile, an editorialist for the medical press suggested the most useful single

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173 *Brisbane Courier*, 3 December, 1919.


176 *Life*, 1 June, 1919, p 419.

177 Q.S.A. COL 256, in-letter 01309 from Dr H.I.Jensen to Home Secretary, 3 February, 1919.

precaution, should the disease breach the quarantine, would be the isolation of suspected cases. Masks, he believed, would be a waste of time.\textsuperscript{179}

Hearing of cases of pneumonic influenza in New South Wales, the Queensland Government decided that, if New South Wales was proclaimed, it would close the border between the two states, with no ten-mile buffer zone. At the same time, it set in motion preparations for the erection of a quarantine camp at Coolangatta. New South Wales was proclaimed an infected state on 27 January, 1919 and Victoria the following day. The delay in notifying cases in Victoria highlighted one problem of the Commonwealth authorities, namely, they could not challenge the diagnoses made by State health authorities. Consequently they always had to wait until the States notified themselves. On 28 January, 1919, the border between Queensland and New South Wales was sealed.

6.10 Interstate quarantine

The following day, Queensland declared ‘pneumonic influenza to be an infectious disease within the meaning of the Health Act within the areas of all Local Authorities in the State’ and introduced the Pneumonic Influenza Regulations. These applied particularly to authorized medical practitioners, who would be responsible for diagnosing and notifying cases of pneumonic influenza, and gave them powers to force patients into isolation, either at home or in hospital. In addition the doctor was given authority, if an individual was at risk of influenza, of detaining the individual and forcibly treating him,

\textsuperscript{179} Anonymous. The Need for Caution Medical Journal of Australia vol 1, 1919, pp73-74.
by spending ten minutes each day for three days in an inhalation chamber, and by inoculation with anti influenza vaccine.\textsuperscript{180} To give teeth to the regulations, on 31 January, Moore published an order to members of the Police Force. This order is not mentioned in the \textit{Police Gazette} of the time. The order gave medical officers powers to cause ‘any member of the police force to use such reasonable force to take hold and remove to a place of isolation or detention any person whom such Health Officers… may order to be isolated.'\textsuperscript{181} On 6 February, the Commissioner of Police issued a circular asking the police to comply with a request from ‘the Acting Chief Quarantine Officer General of the North Eastern Division’ to prosecute any person who crossed from New South Wales into Queensland in contravention of regulations.\textsuperscript{182}

On 6 February, a further regulation banned people from entering Queensland from an infected state unless they had also been in isolation for seven days, received two doses of vaccine, and undergone three days of inhalation.\textsuperscript{183} The new regulation also gave powers to the Commissioner of Public Health or the Health Officers to appoint guards in order to enforce the regulations, and such guards could use such force as might be necessary to prevent a breach of the regulations.

\begin{footnotes}[180]{Q. G. G. 29 January, 1919.}
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\begin{footnotes}[181]{Q.G.G. 31 January, 1919.}
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\begin{footnotes}[182]{Q.S.A. POL6A/A1, circular 1086 from Commissioner of Police, 6 February, 1919.}
\end{footnotes}
\begin{footnotes}[183]{Q.G.G. 6 February, 1919.}
\end{footnotes}
Meanwhile, the Home Secretary circulated a memorandum to all the town clerks within the metropolitan region, giving instructions for the cleansing of all premises within their areas, paying special attention to the Chinese quarters.\textsuperscript{184}

The government’s border protection plan now was the single most important means of keeping influenza away, despite the generally accepted opinion that land quarantine was ineffective. The immediate result of the closing of the border was the stranding of many Queenslanders in New South Wales, most in Sydney, but some also in Victoria.

6.10.1 Land quarantine.

The main sticking point in the arguments between Queensland and the Commonwealth about land quarantine related to the ten-mile border zone which the Melbourne Conference had suggested be excluded from quarantine. Commonwealth Statutory Rule 21, issued on 27 January, 1919 stated ‘no person was permitted to cross the borderline of a Quarantine Area into another State of the Commonwealth, provided that the regulation would not apply to \textit{bona fide} residents of a district where no case of pneumonic influenza had occurred, whose place of residence was within 10 miles of the borderline between the Quarantine Area and an adjoining State’. The Queensland Government resolutely refused to give way on this issue. There were insufficient numbers of police to patrol the border, and a number of surreptitious crossings were made.\textsuperscript{185} The reason the Acting

\textsuperscript{184} Q.S.A. COL 256, circular dated 10 February, 1919.

\textsuperscript{185} \textit{Daily Standard}, 31 January, 1919.
Premier gave for refusing to accept the Commonwealth plan was the impossibility, in Queensland eyes, of patrolling a ten-mile strip on each side of the border. The dispute between State and Commonwealth continued until Queensland was proclaimed an infected state in May 1919.

B. M. Mathieson, the Director of the Queensland Intelligence and Tourism Bureau in Sydney, estimated about seven hundred Queenslanders in New South Wales required repatriation. Within a matter of days, quarantine camps were established at Tenterfield, followed by Coolangatta (February 8th) and Wallangarra (February 15th) (figure 7.3). Those wanting repatriation would register with Mathieson, who would arrange for batches of people to be sent to the camps, by train or by ship. They would spend seven days there, be vaccinated on the first and seventh day, have three days of inhalations, and if all was well, be then discharged. For the privilege, they would be charged £2-12-6d, reduced to half for those between two and twelve years of age. Infants under two were not charged. Six hundred people were stranded in Tenterfield. An initial camp was established there, with considerable assistance from the New South Wales government, in the form of police supervision, at which 414 people were processed. Under regulations published on February 5th, those isolated at Tenterfield were permitted to enter Queensland via Wallangarra, Coolangatta, or other border towns, so long as they had complied with the Queensland standard.

Because of the number of Queenslanders awaiting repatriation, Mathieson was ordered to prioritise their dispatch back home. First priority was to be given to those stranded in
Southern States before the proclamation: then to those who had to leave the State on legitimate business or urgent circumstances: then officials from other States who had to visit Queensland on urgent official business, and lastly, to those who had left Queensland since the introduction of the embargo, people the government called ‘pleasure seekers.’ If individuals in the highest priority group chose not to avail themselves of the opportunity of returning, they would be regarded as pleasure seekers.\(^{186}\) It must have

**Figure 6.4** Temperature parade at Wallangarra (John Oxley Library)

been an unenviable task for Mathieson. Crowds demanding instant repatriation besieged his office, yet the camps could only take limited numbers. He generally managed to ship the Queenslanders in batches of 250, but his task was made no easier by a constant

\(^{186}\) Q.S.A. COL 258, unnumbered draft letter to Mathieson, 11 April, 1919.
stream of telegrams from the Home Secretary’s office, ordering him to expedite the transfer of people who had complained to influential politicians back home. Following accusations of incompetence in the Tourist Bureau a police investigation confirmed that delays and difficulties in obtaining permits had led to unnecessary expenses. Suggestions that money changed hands to expedite passages also demanded investigation, but most people interviewed declined to give signed statements or be further mixed up in the matter, so nothing came of this. At the same time, Huxham also received letters from members of the public praising the work of Mathieson, the Bureau and the staff of the camps. By the 22 July, 1919, 5,321 people had passed through the camps, the majority (3,715) through Wallangarra, considerably more than the seven hundred who were estimated to be stranded in Sydney and the six hundred in Tenterfield.

In March, Huxham considered all Queenslanders who so wished had been repatriated. Hoping to save money, he prepared to close the camps at Coolangatta and Wallangarra camps. The Brisbane Courier denounced this folly in the strongest terms, and the camps remained open. No cases of influenza occurred in the camps. This was a matter of self-congratulation for the health authorities, though others suggested that obviously, the camps had done no good at all. By the same token, had cases occurred in the camps, devastating epidemics might have spread through them.

\[187\] Q.S.A. COL 256, in-letter 0857 to Police Commissioner, 10 June, 1919.

\[188\] Q.S.A. COL 256, unnumbered letter, 22 July, 1919.

If the quarantine charge could not be paid, the authorities expected individuals to sign an undertaking, ideally before a justice of the peace, though these were not always readily available, that they would refund the quarantine charge once they returned home. Some did not. By 8 June, 1919, a sum of £2,440-10-3d was outstanding. A month later the Home Department decided it would take legal proceedings against those who had signed but not paid up.\textsuperscript{190} This entailed considerable extra work for the police, who spent time chasing up defaulters, interviewing them, and then making recommendations. The situation was made even harder for the police in the case of returned soldiers, many of whom came back to Queensland by rail through Wallangarra, at the time, the only interstate rail link. If the troops had been discharged from the army before they went into quarantine, they were responsible for the costs, but if they had not been discharged, the Department of Defence bore the costs.\textsuperscript{191} In general, the Home Secretary proved to be hard on defaulters, though some leniency was occasionally shown. By 15 December, £3,405-7-2d was still outstanding from a total claim of £9,423-6-2d.

Attempting to cross the border without official sanction was illegal, and much frowned upon by local citizens who complained to the police if a suspicious individual was seen who might not have been quarantined. Some crossed because police were uncertain of the regulations, especially in the first few days of the embargo. Those who crossed illegally were rounded up, quarantined, inoculated and passed through the inhalation

\textsuperscript{190} Q.S.A. COL 259, in-letter 06983 to Crown Solicitor, 26 July, 1919.

\textsuperscript{191} See, for example, Q.S.A. COL 253 in-letter 19.6751 to Home Secretary, September, 1919 for an account of Major A.W. Joss, whose appointment in the Australian forces was terminated on 20 February, 1919. He travelled to Queensland on 7 March, 1919. The Defence Department therefore stated that it was not responsible for his quarantine charges.
chambers. Some were subsequently charged and fined.\textsuperscript{192} James Haig, his wife and three children deliberately flouted the regulation, saying he would rather pay the fine. He and his family lived two hundred metres south of the border, but worked for an employer who had land on both sides. The employer asked for a remission of the fines (of £15 for Haig and his wife) but this was refused.\textsuperscript{193} Occasionally, the police permitted people to cross the quarantine line, so long as they isolated themselves at home.\textsuperscript{194}

Additional crossing points, under the control of the police, were established at Mungindi\textsuperscript{195} and Hebel.\textsuperscript{196} \textit{Bona fide} Queenslanders had to give written undertakings that they had not been to any place affected by pneumonic influenza within the past seven days. Only small numbers of people used these crossing points, which were established primarily to facilitate the management of cross border pastoral stations.

The camps may have delayed the appearance of pneumonic influenza in Queensland, but they did not prevent it. However, given the absence of any knowledge about the nature of the influenza viruses, the absence of any diagnostic tests and uncertainties about how transmission was effected, it is difficult to see what else could have been done. In 2009, the Australian Government Strategic Framework for Pandemic Influenza recognised that

\begin{footnotesize}
\begin{itemize}
\item \textsuperscript{192} Q.S.A. COL 254 contains details of a number of cases of quarantine breakers who were dealt with by the courts. The ten-mile zone recommended by the Commonwealth Government was ignored in these proceedings.
\item \textsuperscript{193} Q.S.A. HOM/J301, in-letter 19.6306 to Home Office, 20 May, 1919.
\item \textsuperscript{194} Q.S.A. COL 254, in-letter 02121 to Commissioner of Police, 18 February, 1919
\item \textsuperscript{195} Q.S.A. COL 254, in-letter 02915 to Home Secretary, 6 March, 1919.
\item \textsuperscript{196} Q.S.A. COL/254, out-letter 19.1490 from Under Home Secretary to Sir A.G.Gould, 26 March, 1919.
\end{itemize}
\end{footnotesize}
an important operational objective was border quarantine to prevent the entry of new viruses into Australia. This was all that Queensland tried to do with its camps.

6.10.2 Sea quarantine

The war in Europe had been over only for ten weeks by the time New South Wales was proclaimed an infected State. However, it seems likely that troopships, and other shipping, brought influenza with them from late in 1918, when the disease was already spreading rapidly around the world. Troopships for the east coast stopped first in Melbourne and Sydney, before proceeding north. The landing of troops at Lytton, near Brisbane, would prove to be the second point of contention between the Commonwealth and Queensland.

The States accepted that the Commonwealth had, since 1901, full control of shipping quarantine. By 1919, the major quarantine station for Moreton Bay was at Lytton, at the mouth of the Brisbane River, and only a few miles from the city. Control of shipping quarantine in Queensland was in the hands of Dr A. Paul, Cumpston’s deputy.

By the time the New South Wales border was closed, troopships, bringing returned servicemen from Europe, had arrived in Melbourne and Sydney, and some were on their way to Queensland. The Commonwealth authorities proposed to use Lytton as the main troop quarantine area. The acting Premier, J. McE. Hunter, wired Watt saying Lytton

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was not acceptable, as it would be extremely difficult to prevent the troops breaking quarantine if they landed, and recommending they stay on the ships for the quarantine period.\textsuperscript{198} Watt refused to allow troopships to be used as quarantine stations. Shipping was at a premium, keeping ships in quarantine for several days raised costs and threatened cargoes, especially of perishable goods. Watt offered to return the troops by train, but Hunter rejected his proposal, and repeated his request that quarantine be effected on board ships. Following further disagreements, the Queensland Government applied to the High Court for an injunction restraining the Commonwealth from landing troops at Lytton, claiming the regulations issued by the State of Queensland were valid and binding. On 10 February, Mr Justice Duffy, with the plaintiff’s approval, adjourned the application, saying the case was weak on law, but of too great importance to close on the material before him. Despite the disagreements, troops were landed at Lytton, and what Hunter feared, happened. Four soldiers broke out of quarantine, and went to Brisbane by train.\textsuperscript{199} The police recaptured and took them back to Lytton.

It was perhaps not so easy for maritime passengers to evade quarantine, though some did. Four passengers on the steamship \textit{Leitrim}, from Sydney, left the ship without first passing through Lytton. The police arrested and prosecuted all for breach of the regulations. Though convicted, the police magistrate thought it was all a misunderstanding, but agreed it was necessary to impose a penalty to make an example of them. Three defendants received fines of £10 and one £5. Queensland relied heavily on quarantine as its first

\textsuperscript{198} Q.S.A. COL 253, unnumbered telegram from Hunter to Watt, 1 February, 1919.

\textsuperscript{199} \textit{Daily Standard}, 6 February, 1919.
line of defence against the introduction of pneumonic influenza, but eventually the line was breached, and influenza came to the State.

### 6.11 Influenza in Queensland

These were troubled times. Not only was there the overriding fear of influenza, but the general political situation in Australia was difficult. Manning Clark called this period the age of the rootless man, the age of the kingdom of nothingness.\(^{200}\) Workers and unemployed returned servicemen were rebellious, and the establishment was fearful of the future. Bolshevism and influenza became conflated into parallel scourges, requiring similar, drastic remedies. Anxiety about influenza precipitated a maritime strike which, coupled with some staff who worked in food processing establishments being on sick leave, led to severe food shortages in some towns. Curiously, the Queensland Governor-in-Council made an order in February, just after the case against the Commonwealth in the High Court was adjourned, making pneumonic influenza an industrial disease for which workers compensation could be claimed for hospital staff or ambulance crews, for those working at quarantine stations, for those employed in loading, unloading or coaling any ship coming from an infected state or port, but deliberately excluding officers or crews of such ships,\(^{201}\) who were covered by the Commonwealth *Seamen’s Compensation Act* of 1911.

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\(^{201}\) Q.G.G. 22 February, 1919.
6.11.1 The metropolitan epidemic

After New South Wales was declared an infected state, it was inevitable that the risk to Queensland would rise. An influenza hospital was established in the grounds of the National Agricultural and Industrial Association of Queensland.\footnote{Q.S.A. COL 255, in-letter 1231 to Home Secretary, 31 January, 1919.} No rent was to be charged, but the government agreed to pay all municipal rates and taxes, and fire insurance. Local businesses donated much of the equipment for the hospital. Nurses from the Brisbane Hospital, the Diamantina and the Children’s Hospitals, would staff the Exhibition Hospital, with the help of volunteers. Despite the advanced warning, the Exhibition Hospital was not ready by early May, when the need became urgent. A temporary Hospital was also created in the St Laurence Christian Brothers School, under the control of the Sisters of Mercy. On 1 February the Stanthorpe Town Clerk wrote to the Home Secretary, asking who would bear the costs of the epidemic. Huxham’s Under-Secretary replied that the whole cost of administering the regulations would be borne by the State Government. This commitment was repeated by Moore, who, in a circular to all Town Clerks, said the State Government would bear the whole cost of administering the regulations and in combating any outbreak that may occur.\footnote{Q.S.A. COL 257, circular memorandum from Moore to all Town Clerks, dated 30 January, 1919.} However, on 13 May, Huxham had an extraordinary change of mind, throwing the financial burden for the administration of the influenza regulations onto the local authorities.\footnote{Daily Standard, 14 May, 1919: Brisbane Courier, 14 May, 1919.} The government, he said, would do everything necessary for pneumonic influenza, but ‘ordinary’ influenza
was a problem for the local authorities. If no cases of pneumonic disease developed, the local authority would have to carry the entire financial burden.\textsuperscript{205}

In a newspaper article on 17 April, Moore said the influenza season had arrived, made some recommendations for the management of cases, and recommended further influenza vaccinations. Evidently Cumpston saw the article, for he wired Moore to tell him the Commonwealth had discarded the term ‘pneumonic influenza’, and was using the name ‘influenza’ only. Furthermore, the symptoms Moore described were identical to the majority of cases occurring in Sydney and Melbourne, and was there a problem in Queensland, as the question of proclaiming the State infected would need to be considered? Moore replied that there was no epidemic in Brisbane, there was no pneumonic influenza, and no influenza except in the quarantine areas under Cumpston’s control.\textsuperscript{206} On May 3, only two days later, Moore was forced to recant, when the Acting Premier, now E. G. Theodore, issued a statement announcing the discovery of influenza of a highly infectious nature, associated in some cases with pneumonia, in the Brisbane General Hospital. The thirty-one patients included one doctor and twenty nurses. The disease, Theodore thought, originated with four sick wardsmaids transferred from the Kangaroo Point Military Hospital.\textsuperscript{207} Blaming the military confirmed the effectiveness and justification for the land quarantine, which would be continued. Colonel A. Sutton, the Principal Medical Officer of the Kangaroo Point Hospital, and also the then president

\textsuperscript{205} Brisbane Courier, 15 May, 1919.

\textsuperscript{206} Brisbane Courier, 1 May, 1919.

\textsuperscript{207} Brisbane Courier, 3 May, 1919.
of the Queensland branch of the BMA, firmly denied the wardsmaids had become infected in the hospital, claiming the evidence pointed to them getting it outside. He believed Queensland had been infected with influenza for at least two, if not three months, and indeed, the *Daily Standard* had published a story about suspected cases in Windorah in February 1919. On May 3, after his embarrassing error, Moore issued new influenza regulations requiring the notification of influenza and the isolation of suspects and contacts. Section 9 gave powers to the Commissioner of Public Health to state the manner in which disinfection, inhalation, inoculation and cleansing were to be carried out, while section 11 dealt with the closing of public places, such as schools, theatres, cinemas, public libraries and public halls. On the same day he ordered all these regulations to apply to the Brisbane Metropolitan Region.

Watt told Theodore that medical experts believed Queensland was infected with pneumonic influenza, and probably had been since at least January 1919 and said he wanted to know the exact position. Theodore immediately said pneumonic influenza appeared to have broken out in Brisbane, but declared that he proposed to continue with quarantine in the hope of confining the epidemic to Brisbane. On 7 May Watt wired back, acknowledging the Commonwealth had not interfered in Queensland’s policy of blockade, but since Queensland had notified cases of epidemic influenza, the policy was clearly ineffective. The Commonwealth was therefore proposing to proclaim Queensland

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208 *Brisbane Courier*, 8 May, 1919.

209 Q.S.A. COL 253, in-letter 04022 from Watt to Theodore, 3 May, 1919.

210 Q.S.A. COL 253, unnumbered telegram from Theodore to Watt, 3 May, 1919, and SEC.95 of 8 May, 1919.
an infected State, to take control, and hoped for cooperation from the State Government. Theodore thought it inadvisable to relax the regulations. Six days later Watt said he thought the epidemic would last many months, that the Queensland border quarantine could not be maintained for that length of time, land quarantine anyway could not prevent the spread of influenza, but would seriously disrupt national commerce without any corresponding benefits. Since influenza was prevalent in Brisbane, and experience had shown it was impossible to distinguish those forms that would remain ‘simple’ from those that would become pneumonic, the Commonwealth Government was preparing to proclaim Queensland as infected and to take control of interstate rail and sea traffic.\(^{211}\) Theodore protested emphatically, urging Watt not to supersede the State Government in this matter, but Watt resisted. On May 16\(^{th}\) Queensland was proclaimed an infected State, and Watt told Theodore the Commonwealth Government would carry out its original proposal to bring Commonwealth regulations into effect in three days’ time. He asked Theodore if his government would impose restrictions of any kind on persons holding Commonwealth permits who arrived in Queensland by land or sea, or whether Queensland would cooperate with the Commonwealth.\(^{212}\) If the Queensland Government persisted in attempting to keep the border closed in defiance of the Commonwealth, an immediate appeal to the High Court would be made to decide the relative powers of the State and the Commonwealth.\(^{213}\) The following day, Theodore ceded, saying since the Commonwealth insisted on taking control, the State Government

\(^{211}\) Q.S.A., COL 253, in-letter 04296 from Watt to Theodore, 13 May, 1919.

\(^{212}\) Q.S.A. COL 253, in-letter 04399 from Watt to Theodore, 16 May, 1919.

\(^{213}\) Brisbane Courier, 17 May, 1919.
would cooperate, and on 19 May, 1919, the proclamation came into effect. The number of cases admitted to hospital rose rapidly. By 5 May, 70 cases had been admitted to the General Hospital, now including 29 nurses. Ten days later the hospitals around Brisbane held 462 influenza patients, and 1100 cases had been notified in the city. Five deaths had occurred, but some authorities still denied Queensland had a problem of pneumatic influenza. The demand for inoculations rose dramatically, and places of entertainment were closed. State schools within a five mile radius of the General Post Office were closed, though some small private institutions were permitted to stay open so long as teaching took place out of doors. Church services were permitted, so long as they were limited to forty five minutes only, overcrowding was prohibited, only alternate seats were to be occupied, while no one suffering from a cold or a cough was permitted to attend. The medical advisory committee repeated its call for the compulsory use of masks, but regulations giving the Commissioner of Public Health power to order the public to wear them were not published until 21 May. Failure to abide by the regulation could attract a fine of fifty pounds or up to six months imprisonment.\textsuperscript{214} The Regulation was, however, never proclaimed, though many people tried to set an example by wearing masks whenever they went outside. The situation in Queensland was quite different from that in New South Wales, where the wearing of masks was enforced, and people not wearing them in public places risked a fine.\textsuperscript{215} In the execution of the regulations, the police were required to assist the local authorities, or, in the case of Brisbane, a Joint Board of local authorities, formed by Huxham in early May.

\textsuperscript{214} Q.G.G. 21 May, 1919, p 1469.

\textsuperscript{215} Daily Standard, 14 February, 1919.
The police were also called by people in financial difficulties who could not access a doctor. In May, a friend contacted the police on behalf of a Mrs Lily Barton, who was very sick and too poor to summon medical assistance. The police called the local authority health officer, who refused to visit but suggested that the Government Medical Officer, Dr E. Dods, be summoned. Dods saw the lady and asked the police to render what assistance they could. Sergeant Conway provided food for Mrs. Barton’s children, and arranged for a prescription to be filled with the cost being sent to the Health Department. The department refused to pay, and sent the voucher for the medicines on to the police.\textsuperscript{216}

Despite Watt’s fears that influenza was going to be a protracted affair, the epidemic swept through Brisbane, and then disappeared almost as rapidly as it arrived. By May 27\textsuperscript{th} 4452 cases of influenza had been notified in the metropolitan region, and 312 cases from country areas. On May 29, new tramcar regulations came into force, giving powers to conductors, guards, and members of the police to remove people from overcrowded tramcars.\textsuperscript{217} During the quarter ending 30 June, 270 influenza deaths were reported, representing 28% of all deaths in the region.\textsuperscript{218} By the middle of June, the newspapers reported a consistent decline in the number of cases notified or hospitalised, and the numbers of deaths. The ‘overcrowding’ regulations were repealed for the metropolitan

\textsuperscript{216} Q.S.A. COL/256, in-letter 24481 to the police department, 26 July, 1919 is the top letter in a series of reports dealing with this matter.

\textsuperscript{217} Q.G.G. 29 May, 1919.

\textsuperscript{218} Q.S.A. COL250, in-letter 10173 from Registrar-General to Home Secretary, 19 September, 1919.
region, Ipswich and Toowoomba on 9 July, 1919. The Exhibition Hospital was closed on 31 August, when influenza was removed from the category of an Infectious Disease under the Health Act.

6.11.2 Influenza in country Queensland.

Though cases of ‘normal’ influenza were recorded in country areas during the epidemic in Brisbane, the force of the epidemic struck the rest of the State as it was dying down in Brisbane, though cases occurred in Rockhampton and some other places early in the course of the epidemic (Table 6.1).

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>Metropolitan</th>
<th>Country</th>
</tr>
</thead>
<tbody>
<tr>
<td>1918/19</td>
<td>9,570</td>
<td>11,099</td>
</tr>
<tr>
<td>1919/20</td>
<td>1,483</td>
<td>17,319</td>
</tr>
<tr>
<td>Total</td>
<td>11,053</td>
<td>28,418</td>
</tr>
</tbody>
</table>

39,471

In the quarter to the end of 19 June, 1919, 350 deaths from influenza were reported outside the metropolitan region, representing 21% of all deaths. Moore offered assistance with establishing inoculation depots, supplying vaccine, and paying the two guinea fee to medical officers for three hours’ work, so long as it was understood that the depot must be closed if the numbers of people offering themselves for vaccination was insufficient to

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keep the doctor fully occupied.\textsuperscript{220} In Mackay, between 19 May and 1 June, 1170 people received the first dose of vaccine, but only 704 returned for the second dose a week later. As intra-state shipping was stopped, more and more people travelled overland. In mid May, the Mackay Town Clerk informed Moore that infected people were coming to the town from Rockhampton and other infected places. He wished to know whether his council had powers to detain such people outside the area of the Hospital Board. Moore replied that he was not aware of any such powers.\textsuperscript{221} The mayor of Mackay was clearly irritated. In a telegram to Moore, he demanded that overland travellers be compelled to report to the health officer before leaving Rockhampton, obtain a certificate, and also report to the health officer in Mackay for three days after arrival. Receiving no reply, he wired W. Forgan Smith, the Member for Mackay, saying,

\begin{quote}
\textquote{wired commissioner week ago asking for restriction overland travellers, no reply: result has been six cases overland from Rockhampton wired four days ago asking close schools no reply wired yesterday asking instructions re boarding vessels from north no reply total cases twenty two.}'
\end{quote}

A fortnight later, Forgan Smith replied that regulations would be issued requiring medical examination of overland travellers arriving in Mackay, for closing schools and places of entertainment, and for dealing with intrastate sea travel.\textsuperscript{222} On 4 July the Gazette carried a regulation under the \textit{Health Act} forbidding people to enter the town of Mackay from

\textsuperscript{220} Q.S.A. COL 260, circular memorandum from Home Secretary to Town Clerks, 5 May, 1919.

\textsuperscript{221} Q.S.A. COL 260, in-letter 07350 to Health Commissioner, 12 May, 1919.

\textsuperscript{222} Q.S.A. COL 260, in-letter 19.5299 from Forgan Smith to Hucker 2 June, 1919.
Rockhampton without an approved certificate. This regulation was repealed three weeks later. By September 1919, notifications of influenza reached 2,563 cases in northern Queensland (including 2,321 in Charters Towers alone), but only 464 in the metropolitan region. Influenza hospitals or wards were established in local hospitals, schools, show grounds, redundant plague hospitals and parish halls.

Regulations for closing schools and places of entertainment did not apply to the whole State, but followed the spread of the disease. Meetings of Local Authorities, of Committees of Associations or societies, or Boards of Directors, were exempted from the overcrowding regulations, so long as less than twenty persons were present. On 4 June, 1919, the Tambourine Shire Clerk wrote to the Home Secretary’s Department to say their medical officer of health was seriously ill with influenza, and asked for advice. The Departmental response was simple. The Commissioner of Health regretted to hear of the illness of their medical officer, and enclosed some pamphlets dealing with influenza. That was all they could offer.

Realizing the speed with which the infection could travel, and departmental responses often lagged behind the epidemic, some enterprising medical officers ordered the closure of bars and hotels before the necessary regulations had been published. Dr Nye, in Tarzali, reported an outbreak of influenza and ordered the Tarzali Hotel bar closed. He was subsequently informed by the Home Department that he had no powers to do so.
Nye threatened to resign, but not before the Atherton police had been asked to investigate the bar’s closing.223

In the country, as in the metropolis, money was a constant problem. Sick ratepayers had no interest in paying their levies, while Government never rushed to pay its dues.

In all, 1,030 deaths were attributed to influenza and pneumonic influenza in 1919, a mortality rate of 2.5% of notified cases, but almost certainly an overestimate. The total Queensland mortality rates for the years 1916 to 1920 per thousand of population were 11.09, 9.63, 10.4, 12.43 and 10.7 respectively. Clearly, 1919 was an exceptional year.224 Moore, in his Annual Report for the financial year ending 1920, says of the epidemic, ‘a pleasing feature [of the epidemic] was the kind assistance rendered by all the Local Authorities and public bodies, who cheerfully responded to the ever increasing calls made on them in connection with the fight against the spread of the disease.’225 What Moore ignored was the impact of the disease on young adults. Of 269 deaths from influenza in the metropolitan region between April and June 1919, 133 (49.5%) occurred in adults in the age group 20 to 40 years. Despite this, there is little evidence the epidemic had more than a minor and temporary effect on the population or the economy.


6.12 Influenza in Aboriginal communities

Early reports about the impact of European settlement on Aboriginal populations are littered with assumptions that influenza was catastrophic for Aborigines, though the evidence is scant. Acting Sergeant P. Walsh reported in 1898 from Birdsville that he had visited a ‘Blacks camp’ and found about twenty people suffering from what appeared to be influenza. He did not say how many people lived in the camp at the time, but did note that five people died. Apart from those living in missions or reserves, most Aborigines lived in small rural areas or bush camps, which would have rendered them less prone to the disease. The concentration of this population into the missions, relief depots, government settlements and confined living areas caused problems. Historian Thom Blake notes the perception at the time that one of the principal reasons for establishing reserves was to ameliorate the condition of the Aboriginal population. Yet in the settlement at Barambah (later renamed Cherbourg), founded in 1904, the birth rate exceeded the death rate only from the mid 1920s. The first evidence of an outbreak at Barambah during the Pneumflu epidemic occurred on 25 May, 1919. Within three days,


227 Q.S.A. COL 144, letter to Inspector of Police at Longreach, 7 December, 1898.

228 In the latter half of the nineteenth century an increasing number of Aborigines also came to live in camps on the fringes of white townships, which would have rendered them susceptible to ‘European’ diseases, but also led to accusations of transmission of disease from black to white.

229 Q. P. D., 1897:78; 51540.

influenza had claimed thirty-five lives.\textsuperscript{231} Sixty-nine deaths occurred during the 1919 outbreak, which affected 596 people, while only ten remained free of the disease.\textsuperscript{232} In contrast to the situation in the non-Aboriginal population, the greatest mortality was in the aged, the infirm or the diseased.\textsuperscript{233} The final reported death toll was eighty-seven, giving an overall mortality of 14.3\%, about seven times the mortality of the non-Aboriginal population, and was apparently made worse by malnutrition—thirteen died from complications of beriberi.\textsuperscript{234} At the same time, the settlement Medical Officer, Dr David Junk, told the Commissioner of Public Health that he felt the disease was ‘not of a very severe type’ and suggested many died of ‘simple funk.’ What he might have considered severe was not mentioned. At the same time, reports from stations and the outback indicated numerous cases and deaths among Aborigines from influenza.\textsuperscript{235}

6.13 Conclusions

Plague came as a shock to Australia. The belief that the disease was one of overcrowded and insanitary oriental cities was widely held. A writer in the Melbourne \textit{Argus}
expressed this well, saying, ‘the danger of infection seemed so very remote that the average Australian was so convinced of the safeguard of his own personal cleanliness that the mention of plague had little terror.’

It soon became apparent that rats were important in the spread of the disease, though how this happened was not immediately apparent. The first line of prevention had to be quarantine, and for this an energetic water police was necessary to ensure adherence to all the regulations issued by the Central Board of Health. Once the disease came to shore, the possibility of spread from human to human meant cases of the disease and suspect cases had to be isolated in their homes. To ensure this happened, police guards were stationed outside such houses. The police role was not as draconian as in Sydney, where whole districts were cordoned off, but nonetheless, the police were prepared to use force if necessary to ensure health regulations were carried out.

The Queensland experience of bubonic plague was useful when, at the end of the Great War, an outbreak of influenza threatened the country. Once again, great faith was placed in maritime quarantine. Once the maritime quarantine was breached, first in Melbourne, then in Sydney, a vigorous—but ultimately unsuccessful—system of land quarantine was put in place. The water police, and the land police, played important roles in protecting the borders. Without their assistance, it is likely that influenza would have arrived more quickly.

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236 *Argus*, (Melbourne) 11 April, 1900.
The lessons of plague and Spanish influenza were: 1) a quarantine, no matter how rigidly enforced, cannot guarantee public safety behind a state or nation border. Additional measures need to be established in advance to deal with disease once quarantine fails. 2) Quarantine that depends largely on an untrained police force will never be as efficient as a quarantine bureaucracy. 3) The purpose of quarantine must be clearly established before being put in place. Quarantine for plague and influenza are two different things. Quarantine for plague aims to keep rats away from ships, or from going from ships to shore, and provide an opportunity for the fumigation of ships. The isolation of plague patients, (except for cases of pneumonic plague), assuming the absence of rats and their fleas in hospital settings, is unnecessary and is carried out to protect the public from the anxieties that such cases engender. Quarantine for influenza, since transmission is from human to human, and can occur at the very onset of symptoms, will never be entirely successful. Isolation of clinical cases is required. Had cases of influenza occurred in the crowded and tented quarantine camps at the Queensland border, the disease could have spread with great speed, since no provision was made for isolation of cases.

In all, over a thousand Queenslanders died from pneumonic influenza. By way of comparison, between May and October 2009, there had been forty-one deaths from swine flu in Queensland, a disease causing considerable alarm. When the cruise ship *Dawn Princess* arrived in Sydney in May 2009 with two individuals exhibiting flu-like symptoms, the ship was quarantined in Sydney Harbour for several hours. Passengers were then allowed to disembark, but ordered to remain in isolation until tests for swine
flu were completed. What would have happened if the cases proved to be swine flu is uncertain.

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7.0 Conclusions

In the course of reviewing archival material dealing with disease in nineteenth century Queensland, I was struck by the frequency with which the police were involved in matters which seemed purely medical, and hence the thesis was born. I also realized that the police were undertaking numerous other extraneous duties, mostly of a clerical nature. The participation of the police in ‘health’ matters reflected an increasing involvement of the state in matters of public health. The Woogaroo Asylum, the first government institution to deal with a medical problem, was followed by lock hospitals, then a leprosy lazaret, then, in 1900, a sanatorium for the treatment of tuberculosis, all funded entirely by the Queensland government. The plague epidemic hastened the appointment of Queensland’s first Commissioner of Public Health.\footnote{In 1934, the Commissioner was replaced by a Director-General, Sir Raphael Cilento, charged with overseeing the reorganization of health and hospital service in Queensland. The Health Act of 1936 finally established a proper department of health under a minister for health.} The Health Act of 1872 dealt mainly with sanitation and the prevention of contagious diseases. Subsequent legislation, such as the Sale of Food and Drugs Act of 1881, the Undue Subdivision of Land Act of 1885, the Dairy Produce Act of 1904\footnote{\textit{The Sale of Food and Drugs Act} was designed to protect the population from adulterated food. Sir Samuel Griffiths introduced the \textit{Undue Subdivision of Land Act} as a public health instrument, to prevent the development of overcrowded and ill ventilated slums that would increase the risk of transmission of tuberculosis. \textit{The Dairy Produce Act} was designed specifically to control diseases such as typhoid, brucellosis and tuberculosis, all of which had been shown by 1904 to be bacterial diseases.} came as the bacteriological revolution showed that it was not merely the environment that was risky to health, but people (or animals) who carried the germs of disease. However, much of the burden for executing the regulations of public health legislation fell on poorly funded local authorities with
limited resources. It was only in 1936 that central control over matters of health and medicine was established.  

As the colonial populations spread across the face of Queensland, the main government agency keeping pace with the expanding frontier was the police force, which came within the political control of the Colonial Secretary. In line with the accretion of extraneous duties, the police role in public health was largely limited to those diseases or conditions of specific interest or concern to the government. Sanitation was a problem for the local authorities, and so the police took little interest in this matter, despite the appalling death rates due to poor sanitation. The later role of the police in the management of infant lives came at a time when it was becoming increasingly clear that the health of the nation depended on a complex matrix of social, economic and political issues. Infant mortality rates were extremely high in colonial Queensland, but started to decline in the early years of the twentieth century. It was only in 1894 that the Colonial Secretary ordered the police to enquire into the deaths of children possibly caused, directly or indirectly, by neglect. How this was to be done was not stated. The management of the Infant Life Protection Act, introduced into the Legislative Assembly in November 1905 and designed to regulate ‘baby farms’—places where infants, often,

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4 The Queensland Police Force changed its title to the Queensland Police Service in 1990, after the Fitzgerald Inquiry.

5 Dorothy Porter. *Health, Civilization and the State*, 1999 p. 123. There was also a eugenic concern that feeble babies would give rise to a degenerate race.


7 Q.S.A. POL11/A1, circular 188, 1 January, 1894.
but not always, illegitimate, were boarded out— was placed in the hands of the police, only because a more effective supervising authority would have been too expensive. Perhaps wishing to show that they were conscious of their duty, Chief Inspector Frederick Urquhart suggested in 1906 that ‘the moral guilt of mothers who are physically able to afford natural sustenance to their offspring and who do not do so is enormous’ and went on to suggest that such women should be held guilty of a crime, which no doubt the police would prosecute.

The public health role of the police was another form of control, for medical conditions with the potential to threaten public order interested the police most—lunacy, venereal diseases and prostitution, leprosy and the problem of the Chinese, plague and influenza and the risk of public panic. Exotic or imported diseases, such as leprosy, plague, smallpox or cholera caused more anxiety, and therefore police scrutiny (though neither smallpox nor cholera became a problem in Queensland) than tuberculosis, a disease that killed more Queenslanders than any of the exotic diseases. Typhoid fever, which was both endemic and erupted occasionally into significant epidemics, was largely ignored by the police.

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8 This was purely for financial reasons. Home Secretary Peter Airey recognized that medical men, or nurses, would do the job better, but that would require money. The police did it for free. See also: Lee Butterworth. Infant Deaths in Queensland and Maternal Nursing Homes, 1900-1910. Honours Thesis, Griffith University, Brisbane, 2005, for a detailed account of baby-farms in Queensland.

9 Q.S.A. JUS/N354/230/06, an inquest on an illegitimate child boarded out in a ‘baby farm’. Urquhart’s moral outrage is curious, since he was in charge of detachments of Native Police at a number of killings of Aborigines. Urquhart’s moral outlook was constrained by the prevailing attitudes of racism (against Aborigines) and genderism (women were inferior to men) of the times. See Jonathan Richards. The Secret War, 2008, p 265 for a summary of Urquhart’s police career.

10 Though the police, as protectors of Aborigines, reported suspected cases of typhoid fever in Indigenous people to the police commissioner.
The prime function of the police was to establish public order in public places, but also, ‘as one of the earliest offices of government in the colonies, police provided an essential aid to administration’.\textsuperscript{11} The police were an important part of the ‘pioneering structure’. The priority given to charging drunks and other public order offences was justified by the mandate of preserving the peace and bringing a veneer of civilization to a difficult environment.\textsuperscript{12} The police were often the first persons to be called to sick or dying people. Concepts of ‘public health’ were limited to sanitary matters in the larger towns. There was little health bureaucracy outside Brisbane. (The role of the police as inspectors of slaughter houses was largely to ensure that cattle taken for slaughter were not stolen cattle.) Government Medical Officers did no public health work, which was largely devolved onto inadequately funded local councils. Historian Alison Bashford has made the point that in the latter part of the nineteenth century, ‘public health’ came to mean ‘the ordering of categories of clean and unclean, normal and pathological, healthy and unhealthy, self and others.’\textsuperscript{13} The police were well placed to distinguish the normal from the abnormal. In medical matters they distinguished the mad from the not mad, the prostitute from the respectable, the syphilitic from the clean and the leprous from the non-leprous. Yet, despite an extensive involvement in ‘medical’ matters, the Commissioner of Police never mentioned medical issues in any of his annual reports to the Parliament, despite often complaining about the numbers of other extraneous duties.

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\textsuperscript{12} Finnane. Police and Government 1994, p 97.

\textsuperscript{13} Bashford. Foreign Bodies Vaccination, contagion and colonialism in the nineteenth century, 2001 p 39.
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his men performed. One possible reason for this omission can be traced back to the English 1839 County Constabulary report. In this report the authors noted that the rural police might usefully undertake a number of humanitarian duties, including caring for the destitute, saving life when possible, and caring for those suddenly taken ill.\textsuperscript{14} The police in Queensland undertook all these duties, which they saw as social and regulatory, rather than the more ‘clerical’ other extraneous duties that they were asked to perform.

One of the earliest threats to public peace and order in the Australian colonies, including Queensland, was the person of unsound mind, dangerous or not. The management of the dangerous lunatic was a task falling on the police, though there is no evidence of police involvement in making policy with regard to lunatics (or indeed, any other medical condition with which they became involved.). The role of doctors throughout the nineteenth century was minimal. They examined the lunatics and provided the certificates for the person to be sent on to the reception house and from there, if necessary, to the Mental Asylum. (Woogaroo Asylum, opened in January 1865, was for many years the largest ‘medical’ charge to the Queensland government and one of the largest in the Southern hemisphere). The police, frequently the first point of contact with a person of unsound mind, arrested them, looked after them while getting the doctors to examine and certify, then escorted them to the Reception House and, later, to the asylum. The police sometimes acknowledged publicly that lock-ups and cells were far from ideal places to keep persons of unsound mind, but they had few alternatives, the hospitals,

especially, being unwilling to accept such patients. Police also provided medical care to lunatic patients on the sometimes long journeys between the lock-up and the reception house or asylum. Police concern, however, was limited to lunatics in public places. The mad, kept at home, forcibly or otherwise, were of no interest to the police.

The adverse impact of alcohol on social, physical and mental health was well recognised. The large numbers of people arrested for public drunkenness reflected the fear of the authorities that alcohol was at least one cause for the increasing number of lunatics, but at the same time, governments were unwilling to control alcohol too much. Significant revenue was (and still is) derived from the alcohol industry. The police indirectly assisted the temperance movements—by controlling public intoxication and by policing ‘sly grog’ sales—which were concerned about alcohol, mental health and other social issues.

If a suicide was reported, the police investigated the circumstances surrounding the death, and reported the matter to the Police Magistrate for a magisterial inquiry. Those who attempted suicide were also a responsibility for the police, who made inquiries into the causes of the attempts.

Convicts, soldiers, sailors and free settlers brought venereal diseases to colonial Australia, including Queensland. The effects of these appeared insignificant compared to other, more immediate threats to health, until the middle of the nineteenth century, when the problem of the ‘social evil’ came to be publicly debated. In Britain, the Contagious
Diseases Acts were designed to protect the military, but, though introduced into Queensland as a result of military pressure, the Queensland legislation was never intended to protect the military. Politicians and the medical profession, informed by gender stereotypes and keen to protect public health and promote civilization in a frontier state, saw the need to introduce controls, albeit inadequate ones.

As a result of the Queensland Contagious Diseases Act, the police tried to take control of prostitution, while the medical profession took control of the prostitute’s diseased state. Yet this division of labour led to neither a good public health response, nor control of the social evil. The involvement of the police in the confused nexus between prostitution and venereal disease was to have significant ramifications one hundred years after the second bill to repeal the CD act of 1886 was defeated, leading directly to the Commission of Inquiry into Possible Illegal Activities and Associated Police Misconduct, (the Fitzgerald Inquiry) of 1987. The Fitzgerald Inquiry, established by Acting Premier Bill Gunn after media revelations about police corruption and allegations of police involvement in illegal gambling and prostitution, led to the establishment of the Criminal Justice Commission (later the Crime and Misconduct Commission) and to significant reforms of the Police Service.

Though Dr William Hobbs, the Brisbane Health Officer and a member of the Legislative Council, believed the CD Act was a public health act, it clearly was inadequate as such. It dealt neither with men who might be infected, nor with women who became infected through their partners, but were not prostitutes. The act ignored the problems of many of
the coastal towns of Queensland (Mackay, Townsville, Cairns etc, let alone the mining towns) where prostitution was known to exist, and completely ignored the problem of Aborigines suffering from venereal infections. As a means of controlling prostitution, the act (and its successors, the *Health Acts* of 1900, 1911, 1917 and 1937) was inadequate, failing to define a prostitute, or what evidence would be needed to convict her.

Once the question of Aboriginal venereal disease came to the attention of the authorities in the eighties, it became, not a matter for the public health authorities, but for the police and, after 1897 when the Police Commissioner became the Chief Protector of Aborigines, protectors of Aborigines. The problem of venereal disease in the Aboriginal population was both overstated and under managed, with regrettable consequences for both black and white populations.

Among the contentious arguments about leprosy in the nineteenth century was the question of heredity versus contagion as the cause of the disease. The possibility that leprosy was hereditary, with its immediate implication of a genetic transmission of the disease, raised anxieties at a time when the issue of racial purity was being widely discussed. However, the Queensland Central Board of Health was in no doubt. The Chinese spread the disease, so it could not be hereditary.

The epidemiology of leprosy in Queensland is complex. There is no skeletal evidence to suggest the disease existed in Australia prior to European colonization. The public health physician Cecil Cook believed that the Chinese introduced leprosy, passed it, through co-
habitation, to Aborigines, who in turn passed it on to the white population.\textsuperscript{15} Despite the objections of Police Commissioner W. E. Parry Okeden to Chinese-Aboriginal liaisons, and his desires to prevent them if possible, it is clear they occurred,\textsuperscript{16} and the police knew of cases of white men who cohabited with leprous Aboriginal women. The possibility also existed that the Pacific Islanders introduced the disease. However, there is, in my opinion, insufficient evidence to conclusively agree or disagree with the various propositions about its introduction to the Australian continent.

Racism, the idea of human biosocial inequality, was widespread in the Australian colonies in the last two decades of the nineteenth century. The Intercolonial Trades’ Union Congress mentioned the Chinese as corrupters of girls and women, as ‘some link necessary to complete the Darwinian theory,’ a race that would supplant white labour, and one practising infanticide. The concept of the yellow peril, or the yellow agony, was very strong in Australia, and the threat of leprosy strengthened the concept.\textsuperscript{17} That the Chinese should be the first leprosy patients to be isolated, on a deserted island devoid of any amenities in the Torres Strait, is no surprise. (Colonial Secretary Horace Tozer made it clear that white patients would not, under any circumstances, be sent to either Dayman Island, between 1889 and 1892, or Friday Island, from 1892 to 1907). If, therefore, the

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Cecil Cook. \textit{The Epidemiology of Leprosy in Australia}. Commonwealth of Australia Service Publication Number 38, printed by Authority, Canberra 1927.\textsuperscript{15}
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Chinese were to blame, isolation was the only answer. Segregation had the sanction of Holy Writ, had been widely used in Mediaeval Europe, and was being used in places like Canada (Tracadie) and Hawaii, where well publicized outbreaks of leprosy had occurred. G. H. A. Hansen’s discovery of the leprosy bacillus in 1873, though not universally accepted for many years, provided a logical basis for isolation. The anomaly was that Robert Koch’s discovery of the tuberculosis bacillus in 1882 was rapidly accepted, yet did not lead to pleas for the isolation or seclusion of all the tuberculous white populations of Australia. Sinophobia and its associated racism explained the paradox.\textsuperscript{18} Alison Bashford points out that as the nineteenth century progressed, ‘the meaning of institutionalization and/or isolation of people with leprosy shifted broadly from being primarily religious, philanthropic or therapeutic to being primarily preventive and protective of the community at large.’\textsuperscript{19} The police, who patrolled large areas of Queensland where Chinese, Pacific Islanders and Aborigines were living, would provide an invaluable resource for controlling the spread of the disease. After 1907, when the Peel Island Leprosarium opened for all Queensland’s leprosy patients, the numbers of Pacific Islanders and Chinese were already diminishing rapidly. Aboriginal patients would take their place. On Peel Island not only were the (white) sexes separated, but the


races were also separated, the whites living in sturdy wooden huts, the Aborigines in cheap iron humpies.  

Maritime quarantine was not appropriate for such a chronic disease as leprosy, with a long incubation period. Internal quarantine would be the answer, and the police would act as agents of the colony to ensure this was undertaken. During the debate on the Leprosy Bill in 1892, it was understood the police were already involved in the management of leprosy, though this fact generated no specific comment by the legislators. It is also evident the involvement of the police in the public health management of leprosy was somewhat more than implied in Ross Johnston’s account, namely the detention of lepers and acting as escorts to Peel Island.  

No intermediate health bureaucrats existed in the colony, so the police undertook work that today would be done by public health physicians, by social workers, by nurses, and by quarantine officers. The problem lay in the management of the patient during the often long interval between the time the suspicion of leprosy was raised and the diagnosis was established. Once the diagnosis was confirmed, the police had to organize transport to whatever lazaret was determined by the Colonial Secretary. The process could be, and frequently was, very slow. In the meantime, many hospitals refused to admit leprosy patients. In the absence of any facilities or authority other than the police, it fell to them to undertake the sometimes disagreeable tasks of managing the patients. This they

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apparently did with remarkable care and concern—though this was not a universal feature—and their efforts deserve greater credit than they have generally received.

One aspect of police involvement in leprosy work that has previously received no mention relates to suspected cases of Indigenous leprosy. Clauses in both the Leprosy Act of 1892 and the preceding Regulations of 1891 stated that if there was reason to believe or suspect that a person was suffering from leprosy, the case was to be notified to a Police Magistrate or to the Central Board of Health. Indigenous patients and aliens were arrested on suspicion, treated as criminals, and taken, by force if necessary, to a Government Medical Officer. Resistance was to no avail. If a ‘suspect’ escaped, then the police went after him or her. The Aboriginal Protection and Restriction of the Sale of Opium Act of 1897 gave no extraordinary powers to the police to arrest suspected cases of ill-health. Such patients were treated in an extra-legal manner.

The number of leprosy patients was small compared to the numbers of those suffering from tuberculosis, another chronic, infectious disease, but one in which the police took little interest (except, at the beginning of the twentieth century, to get involved in anti-spitting campaigns). It can be argued that it was the small size of the problem which allowed the situation to develop. Employing full time Health officers to do the work the police did could never be justified at any time during the colonial period, but especially in the 1890s, when the Queensland economy underwent a serious downturn. By the time economic recovery took place, the police had established a well-rehearsed precedent, and government saw no need to change the status quo. The expanded role of the police in the
management of leprosy provided a useful paradigm when, in 1900, bubonic plague struck Queensland.

Apathy, an unwillingness to spend money in advance of an outbreak, and a mistaken belief in the power of maritime quarantine to prevent the spread of disease to the colony characterized the preparations for an outbreak of bubonic plague in Queensland. Though some observers spoke of panic when the first cases were recognized, there is no evidence this led to disorders requiring police control. The case of the Townsville patient Cockeyill was an isolated one, and made worse by disagreements between the local joint board and the mayor, animosity among the medical fraternity, and expressed doubts about whether plague was indeed a problem in Townsville.

Two things stand out. Firstly, the first Central Board regulations dealing with plague refer to the ‘use of such force as may be necessary,’ and this seemed to justify a degree of police involvement. Secondly, despite anxious predictions of disaster, the number of cases of plague did not overwhelm the authorities. Contrary to expectations, outbreaks did not start in ‘Asiatic’ areas, rather in those areas close to wharves, or in people who worked on the wharves. In the first year of the outbreak, there were 136 cases, with fifty-seven deaths. In subsequent years the number of cases was much less, due no doubt to the promptness with which de-ratting procedures were carried out, especially after the passage of the Health Act of 1900, which gave broad powers to the new Commissioner of Public Health, Dr B. Ham, to deal with local authorities. The experiment with Joint

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Boards must be considered a failure, and Ham was justified in taking over personal control of plague matters. The government treated the Joint Boards parsimoniously, but the boards also spent much time bickering about local issues, rather than getting on with the work.

Whether a police presence was really necessary cannot be determined. The alternative, employing casual men to guard properties, would have cost money. The police provided their service free.

The epidemic of influenza in Queensland in 1919 was interesting for a number of reasons. The population of Queensland at the end of 1919 was approximately 740,000 people. Almost 40,000 cases of influenza were notified, a likely significant underestimate for two reasons: firstly, in the early stages, only pneumonic influenza was notifiable. It was only in May 1919 that all cases of influenza were to be notified, and then to the local authority, not directly to the Health Department. Secondly, some cases of influenza were obviously mild, and were not likely to be notified by medical practitioners struggling to cope with an overwhelming epidemic.

The willingness of the medical profession and the health authorities to compel citizens to undergo procedures that were at best experimental, and may have been largely a waste of time and money, was, to say the least, curious. The doctors at the forefront of the epidemic, in the hospitals and camps, worked extraordinarily hard, under difficult circumstances. Many doctors and nurses themselves fell ill with influenza. Those in authority appeared to believe medical science would have the answers. Luckily for them,
the epidemic was over as quickly as it arrived, otherwise their confidence in their abilities and their prescriptions might have been badly shaken. Sutton, in his valedictory address as President of the Queensland branch of the BMA in 1920 suggested the BMA was being blamed for all the difficulties the epidemic raised.23

The semantic posturing by which Home Secretary Huxham abandoned his position on who would be responsible for the costs of the influenza program was astonishing. After initially agreeing to bear the costs of treating influenza patients, he later changed his stance, saying government would only pay for those with pneumonic influenza, while ‘ordinary’ influenza would be a cost to the local authorities. Pneumonic influenza, translated into merely influenza, was no longer a major problem for government.

The opposition of Queensland (and other States) to the actions of the Commonwealth in the early days of the epidemic in Australia did not reflect mere parochialism. The war had shifted the centre of political power from the States to the Commonwealth. Dr Cumpston, the Director of Quarantine was convinced that, if the Commonwealth had responsibility for imposing restrictions, it should have the freedom to investigate the reasons for them (and not have to wait until a state had admitted it had a problem) and use its discretion in their application.24 The states, however, felt that the Commonwealth had failed in its quarantine efforts, and refused to give away further powers.


The police played an important role in the management of the epidemic. They patrolled borders, chased up those who crossed illegally, questioned those who did not pay their quarantine fees, and provided back up, if required, for health officers. Their role was unrecognised and unreported, yet without the cooperation of the police, ‘pneuflu’ might have come earlier to Queensland, and perhaps led to even more deaths.

Nineteenth century Queensland changed in fifty years from a land of a hard, self-centred and often undisciplined mob of settlers to a civilized, quiet and industrious colony. Increasingly, both settlers and Indigenes were ‘disciplined’ by law and the police. Foucault says,

‘the process by which the bourgeoisie became the politically dominant class was masked by the establishment of an explicit, coded and formally egalitarian juridical framework, made possible by the organization of a parliamentary, representative regime. But the development and generalization of disciplinary mechanisms constituted the other, dark side of these processes. The general juridical form that guaranteed a system of rights that were egalitarian in principle was supported by these tiny, everyday, physical mechanisms, by all those systems of micro-power that are essentially non-egalitarian and asymmetrical that we call the disciplines."

The police constituted the most important branch of government dealing with social discipline. With time they attempted to enforce, with varying degrees of success, the

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government’s view of what was ‘acceptable behaviour’, and what was ‘an acceptable person’, through control of drunks, lunatics, prostitutes, those with leprosy, plague and influenza.

The variability of responses to disease raises a number of questions: who or what determines how a particular problem is dealt with: what are the limits that can be placed on the ‘preservation of the public health’: what are the best agencies for dealing with a public health problem: what are the constraints on the management of these? What is clear is that the government’s responses to important health issues were reactive rather than proactive. There was nothing unusual about this. Liberal orthodoxy of the time held that the primary responsibility for a person’s health or fate rested with the individual. This enduring belief explained the antipathy in Britain to the Public Health Act of 1848, which, to many, suggested intolerable state interference.27

Early Queensland governments took a non-interventionist approach to social policies. The destitute, the Queensland equivalent of England’s undeserving poor, were sent to benevolent asylums that were anything but benevolent. Unemployment relief was parsimonious, irregular, and often accompanied by moral opprobrium. At the same time, the government did not have to struggle with the political economy of a ‘state in transition’, such as in those European states undergoing massive industrialization and urbanization during this period. Though Queensland was primarily an agrarian and mining society, the needs of these enterprises stimulated a brisk industrial development, employing mostly men, that kept pace with the growth of the population and the towns,

and did not overwhelm them. Furthermore, despite some anxieties posed by the threat of smallpox and cholera, the social problems associated with these diseases in Europe and America were kept in check by efficient quarantine, by water supplies that were not subjected to the possibility of gross contamination (as happened for example in London), by a relatively sparse population, and by a large amount of luck.28

The primary concern of the government of the new colony of Queensland was to build a ‘nation’. To do this it needed money that would have to come from the expansion of exports, especially wool, other pastoral and agricultural resources, the products of mining, and from overseas loans. The growth of population was an essential component of the development of both the agrarian and the urban economies, with a preponderance of males among migrants. What role this gender imbalance played in the epidemiology of sexually transmitted diseases has not been investigated.

If asked to describe the purpose of the police, most people would suggest the prevention of crime, the protection of property, or the detection, capture and prosecution of those who commit crimes (or a combination of these). Yet the amount of crime-related work undertaken by the police in Queensland in the nineteenth century was relatively small. The bulk of their functions was regulatory as they struggled to impose a new urban

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28 Michael Durey. The Return of the Plague. British Society and the Cholera 1831-2, Gill and Macmillan, Dublin 1979, p 50. According to Durey, cholera is unlikely to spread quickly where the weather is cold and crisp, when there is a filtered and reservoired water supply free from the discharges of sewers, and the population is able to live hygienically. In Queensland, only the second note prevented the cholera becoming endemic.
discipline on the population. Such regulatory functions were often combined with coercive functions (the arrests for drunkenness, profanity, street gambling etc), but coercion was used in a discretionary manner. In the health area, lunatics were arrested if deemed a danger to themselves or others, not for merely behaving in an odd way. Prostitutes were moved on if they caused disturbances, but not if they were orderly. Leprosy patients, especially Aboriginal patients, were rounded up in a random manner. The guarding of quarantine borders to prevent the spread of plague or influenza could never be complete.

In the absence of intermediate levels of functionaries in much of Queensland, the police and magistrates were essentially the only representatives of government in these areas. Without the assistance of the police, the administration of public health, such as it was, would have been worse. The accounts of police assistance in the management of many patients suggest that the police did the best they could under difficult circumstances. They often showed more concern and compassion for the people they managed than the local doctors. They undertook duties that were more onerous than the local doctors, many of whom had to be persuaded to visit undesirable patients; they put up with abuse from local citizens and (sometimes) patients; if things went awry, the blame fell on them rather than the medical profession. They became, in effect the ‘meat in the sandwich’ in the battle between the needs of the public health, and individual freedoms. But are these the proper functions of the police?

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The extraneous duties carried out by the Queensland Police were not unique to the colony. The example was originally set by the performance of extraneous duties by the police in England and Wales. Police in New South Wales\textsuperscript{30}, Victoria\textsuperscript{31} and South Australia\textsuperscript{32} undertook similar duties, though sometime the detail differed.

A modern statement of the functions of the police puts ‘serving the community’ first, before the prevention of crime or detection and apprehension of offenders,\textsuperscript{33} though there are singularly few well-developed concepts of the functions of a civil police force. The first functions of the Queensland police were stated in 1996 to be ‘the preservation of the peace and good order’, and ‘the protection of all communities…from any unlawful disruption of the peace.’\textsuperscript{34} How good order was to be defined is not stated, but clearly the functions of the police have changed over the years.

The Queensland Police were (and are) the eyes, the ears and the strong arm of government. Their primary loyalty was and still is to legitimate authority, namely government. They necessarily imbibe the moral and social values of government. The

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hundred and fifty years of Queensland’s existence have seen a continuous and consistent attempt by government to ‘discipline’ its deviant populations, the drunk and disorderly, the blasphemers, those who violated the Sabbath and those who neglected their spouses or children, as well as the criminals and fraudsters. Equally, the police are generally the only branch of government with extreme power to detain, restrain and curtail freedoms. These powers need to be exercised carefully, honestly, fairly and lawfully. This has not always been the case.

In my introduction, I asked two questions. What did the police do, in terms of the public health, and why did they do it? I believe I have given an adequate description of the public health duties the police carried out. The answer to the second question is simple—there was no one else to do the work, and the employment of specialist bureaucrats would have led to costs the government was not prepared to pay. The police provided all their extraneous duties, including their public health roles, for free. They acted on their own judgment and used their discretion, while at the same time operating within a highly hierarchical, para-military, organization. This role deserves recognition.
Appendix 1  Miasma Theory

A curious feature of the movement towards ‘sanitary science’ in the western world was its basis, not in bacteriology, but in ‘miasmatism’, a theory of Hippocratic origins.\(^1\) Miasmatism held that danger to health came, not from dirt and faecal pollution of water supplies, but from the smells that emanated from these and other rotting organic material.\(^2\) The theory declined with the decline of Greek scholarship but never disappeared completely and was revived in the eighteenth century. Among the promoters of miasmatism was the Italian Francisco Torti, who coined the term ‘malaria’ (bad air) in 1718 to name a fever that he believed originated in the noxious effluvia from the marshes. Giovanni Lancisi, whose 1717 publication, *De noxiis paludum effluvis* (Of the noxious effluvia from swamps) noted the association between fevers and swamps, focused also on mosquitoes as the means of transmission. There was much uncertainty whether ‘fever’ was the disease itself, or a symptom of disease. Observers described different types of fevers, continuous, remittent (the temperature fell during periods of twenty four hours, but never to normal) and intermittent (feverish illnesses characterized by periods of complete absence of fever), each of which had a different cause and prognosis. In 1885, the Queensland committee investigating cholera on board the SS Dorunda asked Dr Hickling, the ship’s surgeon, whether ‘Batavia fever’ was malaria. ‘Yes’, said the surgeon, ‘but not typho-malaria,’\(^3\) the reply typifying the semantic confusion that the word malaria engendered.

Miasma theory formed the basis for Edwin Chadwick’s preventive and sanitary concepts of public health. The remedy for disease attributed to miasma lay in a system of drains, backed by a plentiful supply of water to flush away the filth and associated poisonous smells.

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\(^3\) Q.S.A. COL 287  The ‘Dorunda Inquiry, p 7, question 277.
Putrefaction was associated with warmth and moisture, and the increasing interest in the early nineteenth century in miasma was paralleled by an epidemiologic interest in medical climatology which examined the relationship between disease and climate. Miasma theory, dependent on environmental contamination, was always in controversy with contagion theory, which held that disease was passed from one individual to another, though not necessarily by germs. Though some suggest that germ theory has an ancient tradition, it is unlikely that those who spoke about disease being caused by ‘minute creatures invisible to the naked eye’ imagined the true nature of microbiology. Early work on ‘germs’ was associated with industrial and agricultural problems, not human disease. However, as the nineteenth century progressed, an appreciation of the role of germ theory in human disease gradually increased while the weight miasma theory carried diminished. The process of acceptance of germ theory was nonetheless slow and erratic. In 1877, a subcommittee of Queensland’s Central Board of Health, set up to investigate the cause for the prevalence of typhoid fever in Toowoomba wrote,

‘It is admitted on all sides that faecal matter becomes very much more dangerous after it undergoes putrefactive change…support the belief that typhoid fever can originate from the gases and matters generated during decomposition. If then the discharges of healthy subjects are productive of so much evil, how much greater must be the danger when the evacuations of typhoid patients…are stored up to rot and putrefy in our midst.’

An important corollary to miasma theory was the theory of spontaneous generation. Spontaneous generation refers to the idea, which dates back to at least Roman days, that complex living organisms may arise from non-living material, especially decaying material. By 1864, Louis Pasteur effectively proved that spontaneous generation could not occur in controlled situations, though he never said that spontaneous generation could never occur. As the Central Board of Health said in 1884:


\[Q.\ V.\ &\ P.,\ Report\ of\ the\ Board\ appointed\ to\ enquire\ into\ the\ causes\ of\ the\ prevalence\ of\ Typhoid\ Fever\ at\ Toowoomba,\ and\ the\ best\ means\ to\ adopt\ for\ the\ suppression\ of\ the\ same.\ 1878:2;\ 767-781.\]
‘Any enquiry as to the exact cause or origin of typhoid fever’ was futile, as we are still in the dark on the subject of the spontaneous origin of typhoid fever, but the evidence went to show that mere sewage did not give rise to the disease. The committee could only account for the spread of the disease by the fact that the poison, having once found conditions favourable for its propagation, spreads among the population…that beyond all doubt, it is a filth fever, and thus reduces the question to the removal of all kinds of filth.’

The Queensland Registrar-General defined miasmatic diseases as ‘a class of diseases that are frequently preventable, because they are the outcome very generally, of impurity and may be greatly lessened…by a rigid adherence to cleanliness.’ By 1900, he was still classifying deaths in groups that included ‘miasmatic diseases.’

During the century, the great stimulus to the study of germs came, not from the study of human diseases, but from the study of the process of fermentation. Ferments became part of the lore of the time, analogous in some respects to putrefaction. Thus, Erasmus Wilson, the first specialist British dermatologist, wrote of the aetiology of leprosy that it was caused ‘by an animal poison, generated in, or received into the blood, accumulated therein by a process analogous to fermentation, to the point of saturation, then acting as a morbid stimulant, or irritant…’

Before the nineteenth century and the resurgence of miasmatism, the major public health strategies in most European countries were those of exclusion or quarantine. Exclusion applied largely to those who suffered from leprosy (and, more recently the insane.) Quarantine came into being in the fourteenth century, when the Venetians segregated suspect ships, goods and personnel in order to prevent the entry of plague

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6 Q.V.& P. The Prevalence of Typhoid Fever in Brisbane and the Suburbs, 1884: 3; 885-886.


coming from the Orient. The period of segregation varied from State to State, but was extended to forty days, hence the term quarantine. While contagionists believed that quarantine was the most effective way of preventing person-to-person communication of disease, miasmatists believed that the primary need was to clean up the community, not to segregate people or goods. In 1866, the British medical pioneer of the sanitary movement Thomas Southwood Smith wrote that true safeguard against pestilential diseases was not quarantine, but sanitary measures. Quarantine was unpopular with merchants, owners of shipping lines and others whose livelihood was put at risk by unnecessary delays in the movement of goods and people. The British experience was carefully scrutinized by the Australian colonies, adapted to local needs and sometimes used to form the basis of colonial public health measures.

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Appendix 2 Lunacy

The nineteenth century saw an alarming increase in the number of insane people known to the state, from a rate of 2 or 3/10,000 of population in the early part of the century to about 13/10,000 by 1845, the year the Lunacy Act was passed, to about 30/10,000 in 1890 when a new Lunacy Act was enacted. As the numbers of people incarcerated grew, much argument arose about whether the growth was due to increasing civilization, whether social instability and maladjustment were the root causes, or the increase was due to better reporting. Alienists often found themselves in difficult situations, some of it of their own doing. They worried about moral management; if it truly worked, they might find themselves relegated to being mere custodians of the insane. They therefore constantly tried to expand the definitions of insanity, adding to the symptoms indicating insanity. Medical men, they hoped, would be the only ones able to recognise these symptoms as indicators of mental ill-health. They attempted to show they were the arbiters of mental normalcy, and equated normalcy with behavioural acceptability. At the same time, their increasing encroachment into the field of care of the mad received legal support in the 1845 Insanity Act, which required certification of insanity by two medically qualified practitioners.

One of the great hallmarks of the moral revolution was the development by the increasingly powerful middle classes of the philosophy of respectability. Through their representatives in Parliament and local government and through their growing social power, the middle classes remade the country. The Nonconformist conscience ruled all. Within the narrow constraints of middle class Puritanism, (espoused and

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1 Quoted in: Joseph Melling & Bill Forsythe. *The Politics of Madness*, 2006 p 1 In Ireland, admissions to Asylums increased from 7.9/100,000 mid-year population in 1844 to 70.7 in 1904 (Mark Finnane *Insanity and the Insane in Post Famine Ireland*, 1981, p 232-233.


supported by none less than Queen Victoria herself), sexually transmitted infections—particularly syphilis—and the risk to the nuclear family from extramarital sexual connections, threatened the very foundations of the family. Immorality and anti-social behaviour became intimately conflated, by respectable, middle class doctors seeking to broaden the scope of alienism beyond the reach of moral managers, with insanity. It was alleged sexual vice, including masturbation, not only led to insanity, but was itself a symptom of either insanity, or incipient insanity (though the alienist J. G. Millingen doubted this and suggested it was an effect, not the cause, of insanity.\(^5\)) Many alienists, convinced the morally depraved would become insane, recommended they be treated as insane, and confined.\(^6\)

In the eighteenth century, it was widely understood that lunacy was sometimes associated with criminal behaviour, generally defined as *dementia* or *furore*. The courts discharged persons arrested for a crime who could be shown to suffer from one of these. In addition to their normalising role in respectable society, the police also took an interest in the problem of mental health in relation to their work in solving crime and apprehending criminals. The 1807 act was extended not merely to the insane, but also to the criminally insane. However, neither the police nor the magistrates had powers to make lunacy arrests, which remained with the Poor Law authorities.\(^7\) The police, though, could arrest the apparently insane on suspicion of having committed a crime, or under vagrancy laws. It was then up to others to prove that the offender was insane. The situation was different in Ireland where the police were often the people to whom relatives turned for help. It was then the job of the police to get doctor and magistrate to attend to the patient and commit him or her.

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More than in England, the police controlled lunatics on the streets, recaptured escaped detainees, undertook surveillance of discharged alleged dangerous lunatics, and escorted lunatics from court to asylum. Most of these duties would be replicated in Queensland.

Much of the history of insanity during the nineteenth century has been explored through studies of admissions to asylums. The case books of the Woogaroo Asylum, later the Goodna Hospital, are available from the opening of the asylum in 1865. Psychiatric diagnoses were largely limited to the broad groups dementia, mania, melancholia, idiocy and imbecility. Some attempts were made to offer a cause for the mental breakdown. The majority of patients who were admitted to the asylum were there as a result of police activity. Persons suspected to be of unsound mind were arrested by the police, taken to the lock up. Here the police arranged for certification by two medical men, and the case was then presented to the local bench of magistrates who decided whether to discharge the prisoner, send him or her to gaol, or to the asylum.

Admissions to the institution offer some indication of the frequency of not only mental ill health, but also some of the causes that were of interest to the police, especially alcohol. The association between spirituous liquors and delirium tremens had already been shown in 1838. Some patients who attempted suicide ended up, not in prison, but in the asylum. The French venereologist Fournier had shown the association between a particular form of insanity, General Paralysis of the Insane, (GPI, or General Paresis, originally described by the French physician. B. Bayle in 1822) and syphilis in 1868, though the proof of this would need to wait till tests for syphilis became routinely available. I have therefore looked at the admissions to Woogaroo for the ten years 1865 to 1874 inclusive and the four years 1905 to 1908 inclusive. The latter period was chosen as by 1905 it had been shown that syphilis was a bacterial disease, while in

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10 See, for example, Melling and Forsythe, *The Politics of Madness* which is largely based on admissions to Devonshire asylums, both private and public.
the following year, a test for syphilis, the Wasserman reaction, had been invented. A number of insane patients, previously incarcerated in Brisbane gaol, were transferred to Woogaroo in January 1865, when the institution opened; these have been excluded from the analysis.

Period 1, January 1865 to December 1874. Admissions 462
Period 2, January 1905 to December 1908, admissions, 896.

<table>
<thead>
<tr>
<th></th>
<th>Period 1</th>
<th>Period 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Males</td>
<td>283</td>
<td>573</td>
</tr>
<tr>
<td>Females</td>
<td>179</td>
<td>323</td>
</tr>
<tr>
<td>Rate/10,000 population/annum, males*</td>
<td>4.09</td>
<td>4.65</td>
</tr>
<tr>
<td>Rate/10,000/annum, female</td>
<td>3.89</td>
<td>3.15</td>
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*based on mid period populations

<table>
<thead>
<tr>
<th>Admissions for: **</th>
<th>1865-1874</th>
<th>1905-1908</th>
</tr>
</thead>
<tbody>
<tr>
<td>Melancholia (%)</td>
<td>9.5</td>
<td>11.7</td>
</tr>
<tr>
<td>Mania</td>
<td>28.6</td>
<td>45.2</td>
</tr>
<tr>
<td>Dementia</td>
<td>54.4</td>
<td>34.0</td>
</tr>
<tr>
<td>Amentia, imbecility, idiocy</td>
<td>15.9</td>
<td>3.1</td>
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<table>
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<th>Causes:</th>
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<th>1905-1908</th>
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</thead>
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<tr>
<td>Alcohol related (%)</td>
<td>21.9</td>
<td>17.4</td>
</tr>
<tr>
<td>General Paresis</td>
<td>2.1</td>
<td>3.8</td>
</tr>
<tr>
<td>Syphilis, not GPI</td>
<td>0.7</td>
<td>5.8</td>
</tr>
<tr>
<td>Attempted suicide</td>
<td>2.5</td>
<td>1.6</td>
</tr>
<tr>
<td>Masturbation</td>
<td>1.4</td>
<td>1.0</td>
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</table>

**Primary diagnosis

<table>
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<th>Age Distribution***:</th>
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<th>1905-1908</th>
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</thead>
<tbody>
<tr>
<td>&lt;20 (%)</td>
<td>3.6</td>
<td>6.1</td>
</tr>
<tr>
<td>20-29</td>
<td>30.9</td>
<td>14.2</td>
</tr>
<tr>
<td>30-39</td>
<td>35.0</td>
<td>22.4</td>
</tr>
<tr>
<td>40-49</td>
<td>16.8</td>
<td>25.6</td>
</tr>
<tr>
<td>50-59</td>
<td>8.3</td>
<td>13.0</td>
</tr>
<tr>
<td>60-69</td>
<td>3.9</td>
<td>9.0</td>
</tr>
<tr>
<td>≥70</td>
<td>1.5</td>
<td>9.6</td>
</tr>
</tbody>
</table>

***Where ages were stated or could be read from the notes

A comparison of these data with those from the Devonshire County Asylum admissions for the periods 1845 to 1880 (period 1), and 1881 to 1914 (period 2) is made in the following table:
<table>
<thead>
<tr>
<th></th>
<th>Period 1</th>
<th>Period 2</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Woogaroo Male</td>
<td>Devon Male</td>
</tr>
<tr>
<td>Melancholia (%)</td>
<td>9.5</td>
<td>18.0</td>
</tr>
<tr>
<td>Mania</td>
<td>28.6</td>
<td>41.5</td>
</tr>
<tr>
<td>Dementia</td>
<td>54.4</td>
<td>14.6</td>
</tr>
<tr>
<td>Idiocy/imbecility</td>
<td>15.9</td>
<td>8.9</td>
</tr>
<tr>
<td>General Paresis</td>
<td>2.1</td>
<td>11.6</td>
</tr>
<tr>
<td>Puerperal</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

It is difficult to make direct comparisons. The incidence of General Paresis appears much higher in the British figures, but the Devon County Asylum was based in Plymouth, a large naval port.

Between 1865 and 1874, three Aboriginal men were incarcerated in Woogaroo. Between 1905 and 1908, a further six men and three women were incarcerated. All twelve patients were diagnosed as manic or demented. In the earlier period, 13 Chinese were admitted, and 20 in the second period.

Of the men admitted to Woogaroo during 1865 to 1874, 57 (20.1%) gave their occupation as shepherd. This apparent susceptibility of shepherds to mental ill health prompted an anonymous correspondent to comment on the apparent increasing prevalence of insanity, while noting that it was a melancholic and lamentable fact that, the further one travels into the bush, shepherds were betraying too evident traces of insanity: the harmless, vacant, wandering gaze of incipient idiocy to the restless, distrustful, undershot glances of the more unfortunate. He attributed this unfortunate state of affairs to the aimless and solitary monotony of their work, and, should the opportunity present itself, to the maddening sensuality for the gratification of pent up passions and desires.\textsuperscript{11} By 1905, the situation had changed. Shepherds were now rare among the male inmates of Woogaroo, thanks presumably to widespread fencing.

\textsuperscript{11} \textit{Brisbane Courier}, 11 March, 1871.
Appendix 3 The origins of Syphilis

The geographical origins of venereal syphilis are the subject of much learned debate, especially pertaining to the question of the origins of the epidemic of a previously unknown disease, soon to be named *morbus gallicus*, the French disease, or, later, syphilis,¹ which swept through Western Europe in the early sixteenth century. The French disease appeared soon after the return of Christopher Columbus from Hispaniola (or Santo Domingo) in March 1493. It was this congruence that would form the basis of the controversy. The disease received its name following the invasion of Naples in 1495 by the French king Charles VIII and the epidemic spread of the new disease from that date. As historian John Arrizabalaga says, it seems important for a culture that diseases are seen to come from somewhere else, another country or another race. The French attempted to avoid the name *morbus gallicus*, and blamed the Neapolitans. The rise of European consciousness in the eighteenth century convinced Europeans that the great pox originated outside Europe. In 1736, the Frenchman Jean Astruc (*De morbus venereis*) placed the origin of the disease firmly in Santo Domingo, while those who opposed the American origin were often of non-European ancestry, and especially Jewish or Arabic.² Early descriptions of the new disease do not fit classical venereal syphilis, but the period 1495 to 1496 was marked by severe weather conditions throughout much of Italy, leading to widespread food shortages and much disease. Perhaps the interaction of these ‘environmental’ conditions with the new disease explained its atypical nature,³ which perhaps also applied to Aboriginal populations exposed for the first time to venereal

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¹ The name syphilis only achieved wide currency from about 1850, according to palaeopathologist Ethne Barnes, *Diseases and Human Evolution*. University of New Mexico Press, Albuquerque, 2005, p. 213.


syphilis. The current consensus amongst historians of the subject is that venereal syphilis is of New World origin. ⁴

Syphilis was recognised as a ‘new’ disease in the European world by the end of the fifteenth century, gonorrhoea was an ancient disease. Despite this, at some point in time, they became connected into a single concept. Historian Richard Davenport-Hines says that, after 1513, gonorrhoea all but vanished from medical literature. ⁵ It came to be believed the principal symptom of gonorrhoea, the purulent discharge, was an early, or premonitory, sign of impending syphilis. The idea was not entirely without foundation. It is well known that double infections of different sexually transmissible agents are common. A person who develops gonorrhoea after a short incubation period may develop a syphilitic chancre three weeks later if the contact was infected with both infections. In 1767 the British surgeon John Hunter reputedly infected himself with pus from a gonorrhoeal discharge. Later he developed a chancre, thus proving, to his satisfaction, the unitary identity of the two diseases. The French venereologist Philippe Ricord showed in a series of experiments in the late 1830s that gonorrhoea was not produced by the virus of syphilis. He also concluded that male gonorrhoea was a ‘simple catarrh’ caused by a variety of irritants, including gonorrhoeal pus, and menstrual and puerperal secretions ⁶—in other words, virtually all women could transmit the disease. The unitary theory of the venereal diseases remained popular until the middle of the nineteenth century, making any understanding of the epidemiology of the sexually transmissible infections before then virtually impossible, since many were classified merely as ‘the venereal’.


⁶ Mary Spongberg. Feminizing Venereal Disease The Body of the Prostitute in 19th Century Discourse. New York University Press, New York, 1997. Pp 38-39. While Ricord was partially correct in his assumptions, the implication of his theory of the cause of gonorrhoea was that virtually all women were capable of transmitting the disease.
Appendix 4 The Early History of Leprosy

India is probably the ancestral home of leprosy, from whence it spread eastwards to China, and westwards to Persia and the Middle East. Greek and Roman medical authorities recognised leprosy as a chronic and incurable disease, caused by an imbalance of the humours, largely brought about by immoderation. If contagion was mentioned, it occurred in the context of the internal and pathological process whereby the body becomes impregnated with venomous humour.¹

Roman and Greek texts saw no sin in leprosy,² but from their early days, Christian authorities found an immediate nexus between sin and leprosy, which appeared to have been spreading through the Middle East in the decades before the birth of Jesus of Nazareth. *Tsaarath* is the word in the Old Testament of the Bible subsequently translated as leprosy.³ *Tsaarath* defined ritual uncleanness, making a person or thing unwelcome in the temple. Leviticus, chapters 13 and 14 define ritual uncleanness, which is not associated with sin. *Tsaarath* was translated into the Greek of the Septuagint as ‘lepros’ or ‘lepra’, meaning scaly; this word had no taint of ritual uncleanness. Other stories from the Bible equate ‘lepra’ with the spiritual sins, pride, envy, anger and avarice.⁵


² Aurelius Cornelius Celsus wrote, early in the first century of the Christian Era of the disease the Greeks called Elephantiasis; his description of lepromatous leprosy is very good. A. Lee *Aurelius Cornelius Celsus on Medicine in Eight Books*, London, E. Cox, 1831, Book 3, Cap XXV. Aretaeus of Cappadocia, wrote in the first century C.E. of Elephantiasis (an alternative Greek name for leprosy), which he sometimes called Satyriasis as a result of the shameless impulse for sex. This however was the effect, not the cause of the disease. Aretaeus makes no mention of sin as a cause of the disease. *The Extant works of Aretaeus of Cappadocia*. Ed: Francis Adams Boston: Milford House Inc. reprinted 1972, pp 366-372.


⁴ The semantic confusion was made worse when leprosy was translated from Greek to Latin as ‘Elephantiasis’. Elephantiasis of the Greeks (leprosy) was distinguished from Elephantiasis of the Arabs (presumably filariasis). See Rod Edmond. Leprosy and Empire 2006, pp 38-39.

Lepers were sinners; Jesus of Nazareth healed lepers, and thereby took away their sin and their deformities. Leprosy therefore came to be seen as a mark of God. The eastern empress Eudoxia, wife of Arcadius (383-408) is said to have founded a leper hospital in Jerusalem in the fourth century.6

During the reigns of the Abbasid Caliphs 7 Harun Al-Rashid (reigned 786-809) and his son al-Ma’mum (reigned 813-833) there arose a major ‘translation movement’ dominated by the Nestorian Christian Hunayn ibn Ishaq who, with his pupils translated 129 works of Galen into Arabic.8 Orientalist Michael Dols believed that Arabic-Islamic texts, which created the nexus between classical and later western scholarship, dealing with leprosy (‘djudham’) lacked any moral censorship of the afflicted,9 but medical theories of the time were complex and often contradictory. Many Arab medical writers believed leprosy to be both hereditary and contagious,10 yet the Prophet himself had denied the possibility of contagion, since all disease came from God.11 Ibn Sina (Avicenna, d.1037) the Persian philosopher, polymath and physician, whose *Canon of Medicine* remained an important text in western universities for several centuries, categorised leprosy as an infectious disease but says nothing about isolation.12 Historian Robert Moore suggests that isolation

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7 Islamic caliphate, based in Baghdad, the capital city of the Caliphate.


was practised in some, if not all parts of the Islamic world, but without the social opprobrium that came to characterize the western response to the disease.

The earliest example of a leprous skeleton in Britain is from a Romano-British burial from Dorsetshire, dating to the fourth century CE. The provenance of this skeleton is unknown. The first English leper house in England, the Blythe at Nottingham, was established in the seventh century. After the First Crusade, the number of leper houses increased dramatically in both continental Europe and Britain. Leper-houses were constructed as part of a widespread eleemosynary impulse. Strict ecclesiastical rules, designed to not only heal the soul of the pauper or leper, but also to provide an opportunity for the inmates to pray for the souls of their benefactors, were enforced. In some houses, the inmates wore monkish habits, and some the tonsure. As historian Carole Rawcliffe has argued, the poor and sick were already certain of celestial rewards, it was ‘the rich man’s soul that hung precariously in the balance.’

The mediaevalist F-O. Touati detected indications of changing perceptions towards leprosy in France from the decade 1220 to 1230, attributing this in part to an idea leprosy
might be contagious, in the modern sense, through the medium of corrupted air.\textsuperscript{20} At the same time, the pendulum of benevolence swung the other way, and leprosy came to be seen, not as the mark of God, but as the signs of sin, of God’s punishment.\textsuperscript{21} Roy Porter states leprosy was no less a religious than a medical diagnosis because of its association with sin, especially lust.\textsuperscript{22} Sheldon Watts refers to what he called ‘the Great Leprosy hunt’, suggesting, palaeopathological evidence notwithstanding,\textsuperscript{23} most medieval ‘lepers’ were troublemakers and social deviants whom the priests (and others in positions of authority), who made the diagnosis of leprosy, wanted out of the way, in other words, they suffered from moral leprosy, not Hansen’s Disease.\textsuperscript{24} He further suggests that, once doctors became involved in the diagnosis of leprosy, the incidence of the disease diminished, since the doctors concerned themselves with physical, not moral, signs. Brody mentions the ambivalence of the Church towards those suffering from leprosy—punished by God, but also given special grace. Yet in the Middle Ages, he says, few of the burdens the leper carried were as heavy as his reputation for immorality,\textsuperscript{25} though historian B. L. Grigsby has suggested the connection between leprosy and lust developed only after the advent of the apparently new disease of syphilis.\textsuperscript{26} Brody also comments on the development of the concept of the ‘moral leper’, people who had no signs of disease, but whose sins, for example perjury or fraud, placed them on a par with those


\textsuperscript{21} Rawcliffe places this changing of attitudes towards the sick poor in the east of England to the fourteenth century. P 8.

\textsuperscript{22} Porter. \textit{The Greatest Benefit to Mankind} 1997, p 122.

\textsuperscript{23} Vilhelm Møller-Christensen described changes in the skull which are specific to lepromatous leprosy and not found in other diseases. In a study of a supposed leper cemetery, he showed that about 50\% of skeletons showed these changes. \textit{Bulletin of the History of Medicine} vol 27, 1953, pp 112-123. These and subsequent research suggests that most of those buried in such cemeteries did, in fact suffer from the disease.

\textsuperscript{24} Sheldon Watts. \textit{Epidemics and History Disease, Power and Imperialism} Yale University Press, New Haven 1997, pp 48-64.


\textsuperscript{26} Grigsby. \textit{Pestilence in Medieval and Early Renaissance English Literature}, 2004., pp 70-74.
who had actually contracted leprosy.\textsuperscript{27} It appears that by the end of the mediaeval period, leprosy became a stigmatised disease, and the stigma has continued to this day.

The replacement of the Greek god Asklepios with the perfect healer, Jesus of Nazareth, provided an immediate opportunity for the arts of healing to come under the wing of Christian orthodoxy. The Galenic theory of immoderation leading to imbalances in the humours causing disease also fitted in well with Christian beliefs. As learning became restricted in the early mediaeval period to clerics, so healing became increasingly, but not universally, a priestly art.\textsuperscript{28} Many notable mediaeval physicians and surgeons were priests. The ruling of the Fourth Lateran Council (1215)—forbidding the clergy to shed blood, effectively to not perform surgery—deterred some, but not all clerics from the practice of surgery.\textsuperscript{29} (Canon 22 also ordered, since sin sometimes caused bodily infirmity, before prescribing for the sick, physicians, under pain of punishment, should exhort their patients to call in a priest to provide for their spiritual welfare. This suggests that not all physicians were necessarily priests.) With time, an increasing number of secular doctors trained at universities with schools of medicine, though the historian Nancy Siraisi suggests the combination of priestly and medical activities could still be found in seventeenth century England.\textsuperscript{30} The universities, despite being mostly founded by religious authorities, developed with time an increasing level of autonomy, moving away from religious control, and developing increasingly secular curricula.

The Renaissance was characterised not only by a renewed interest in the classical period, which included classical texts, but also by the appearance, in Naples in 1493, of an

\textsuperscript{27} Brody. \textit{The Disease of the Soul} 1974, p 142. Today, the new ‘lepers’ are smokers!

\textsuperscript{28} Nancy G. Siraisi. \textit{Medieval and Early Renaissance Medicine}. The University of Chicago Press, Chicago1990, p 7 passim.

\textsuperscript{29} Guy de Chauliac, (c.1300-1368) is considered by many to be the Father of modern Western surgery. He was a Canon of the Church.

apparently new disease which spread rapidly through Europe. The question of the origins of the epidemic of venereal syphilis has been discussed in the previous chapter. The new disease was given the same causes, spiritual sins, as leprosy, but as people came to appreciate syphilis affected the sexual organs, so the focus changed to carnal sins, and with time, leprosy also became conflated with carnal sins.  

A new chapter in the history of leprosy opened with the discovery of the New World in and after 1492. The first load of African slaves was sent to the Americas in 1503 from Lisbon. By 1515, the Portuguese shipped them directly from Africa, and in ever increasing numbers.  

Writing more than two hundred years later, the physician John A. Peyssonel wrote an account of leprosy in the West Indian island of Guadeloupe. He recorded the presence of the disease in blacks, whites and mulattoes, and noted ‘the disease begins to shew itself in the Negroes by reddish spots, a little raised...the Negroes sometimes bring these spots with them from their own country.’ Unlike many others, he did not suggest the disease was the result of sin, but affirmed ‘it is hereditary, and some families are more apt to be seized with it’ but, confusing the issue, ‘it is infectious, being communicated per coitum, and also by keeping company with those so diseased.’ It is commonly assumed that leprosy in South America came from Africa, though how and when the disease spread from India or the Middle East to Africa remains unknown.

In due course, leprosy died out from Britain. The last autochthonous case in the British Isles is said to have been the Shetland Islander John Berns, diagnosed in Edinburgh in 1798. In Scandinavia, leprosy initially flourished, then died away, as had happened in

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31 Grigsby. *Pestilence in Medieval and Early Renaissance English Literature*, p 157 Carnal sins are sins of the flesh, spiritual sins of the soul.


Europe and Britain, but not entirely. In the eighteenth century, a resurgence of leprosy occurred in Norway resulting in nineteenth century Norwegian interest in the study of leprosy.\footnote{See Rod Edmond. \textit{Leprosy and Empire A Medical and Cultural History} Cambridge University Press, Cambridge, 2006 for a detailed history of the changing perceptions of leprosy in the Nineteenth Century.}

Some of the confusion arising in the history comes from semantic confusion. Robert Liveing, in his book ‘Elephantiasis Graecorum, or True Lperosy’, published in 1873, defined the problem thus:

1. ‘Elephantiasis Graecorum, equivalent to lepra Arabum, or true leprosy
2. Elephantiasis Arabum, or the Barbados leg, unknown to the Greeks*
3. Lepra Graecorum, answering to our psoriasis.’

*Today called filariasis
Appendix 5 Plague Epidemics

Conventional wisdom states there have been three major pandemics of plague in the past two thousand years. (The Greek historian Thucydides described in detail the clinical features of the pestilence that broke out in 430 B.C.E. in Athens soon after the outbreak of the Peloponnesian War, but it is not certain that this pestilence was a manifestation of bubonic plague.) The first of these, generally known as the plague of Justinian, started in the years 541-542 C.E. and persisted intermittently for about two centuries. It affected large parts of the Byzantine Empire, before spreading as far west as Ireland, and as far north as Denmark. The disease affected Ireland and Wales in 544 or 545, but records of the time for England are poor or absent. England was later affected by two outbreaks, between 664 and 666 C.E. and 684 and 687 C.E. According to biologist I. W. Sherman, this catastrophic event marked the end of the Classical period in western history, ushered in the Dark Ages, and had serious social repercussions, including a diminution in trade, the withering of cities, the growth of feudalism and an increasing fatalism associated with organised religion.

The second pandemic started in Central Asia in the 1340s, spread slowly westward, and struck Europe, as the epidemic known as the Black Death, from about 1347 to 1350. About a third of the population of Europe is thought to have died during this acute phase. Although the disease died away in the second half of the fourteenth century, it did not disappear altogether. Fresh outbreaks occurred over the next four hundred years, including the Great Plague of London of 1665-6. The last major outbreak of this pandemic was the epidemic in Marseilles, between 1720 and 1722. After

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this, the disease appears to have receded from Europe, though the reasons for this are obscure.\footnote{4}

There is, according to biographer and historian Philip Ziegler, little evidence of the use of the term ‘the Black Death’ during the epidemic outbreak in the fourteenth century. He believes the term came into general currency in Britain during the seventeenth century, to distinguish the earlier epidemic from the outbreak of 1665.\footnote{5} The term, however, would be used occasionally in the context of the twentieth century epidemic in Australia.\footnote{6}

It will probably never be known whether the plague of Justinian was due to the same organism that causes modern day plague. Biologist Graham Twigg gives reasons for believing bubonic plague played an initial role in this epidemic. According to Twigg the pestilence in Britain in 555 C.E. was called the yellow plague. He believes this was some form of jaundice, while the plague of Cadwallader in 664 C.E. was not bubonic.\footnote{7} By contrast, the medieval historian John Maddicott is convinced bubonic plague caused the seventh century outbreaks. The initial epidemic in Western Britain in 544 he believes was bubonic plague which was followed by a variety of epidemic diseases which probably included smallpox and the yellow plague, the nature of which is uncertain.\footnote{8} There are also some who question whether the Black Death was due to \textit{Yersinia pestis}, citing unusual clinical or epidemiological features. The historian Samuel K. Cohn says, whatever the Black Death was, it was \textit{not} bubonic plague.\footnote{9} The body of the book is a critical review of the clinical and epidemiological descriptions of the Black Death. In his


\footnote{5}See, for example, \textit{The Northern Territory Times} 20 April and 4 May, 1900. The Brisbane papers appear to have been more circumspect.

\footnote{7}Twigg. \textit{The Black Death} 1984, pp 34-37 and 39-41.


conclusions, Cohn states that ‘in place of Yersinia pestis, I offer no alternatives’, while Twigg does not categorically accept or deny the possibility.\textsuperscript{10} Susan Scott and Christopher Duncan provide telling evidence that the Black Death was probably a viral infection, spread directly from person-to-person and state categorically that it is impossible for Yersinia pestis to have been the causative agent of the Black Death.\textsuperscript{11} Others however are convinced that what Europe suffered was true plague.\textsuperscript{12} The latter opinion has received support by the demonstration of plague DNA in extracts of dental pulp taken from skeletal remains of five people believed to have died of plague in France between 1590 and 1722, though not all have been able to replicate these findings.\textsuperscript{13}

\textsuperscript{10}Twigg. \textit{The Black Death}, 1984, 54-60.


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