The Derby (Bungarun) Leprosarium and its Aboriginal Inmates*

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I would like first to acknowledge the traditional custodians of the land on which we stand today - the Gadigal People of the Eora Nation.

And thank-you to the RAHS organisers for making this lecture possible today.

Why is Derby Leprosarium important?
The Derby Leprosarium is very significant for the Indigenous people of the northwest of Western Australia. It was specifically established for Indigenous patients with Hansen’s disease, and only about three white people were patients there. Approximately 1200 people were inmates of this institution in total over the fifty years it was in operation. This makes it the largest of all such institutions in this country in terms of the total numbers detained. And so it is obviously an important part of Australia's history.

Many people spent decades in the leprosarium, and 350 died there. If you have the opportunity of visiting the leprosarium, you will see the cemetery. The graves are mostly unmarked, and just designated with white crosses, and a large wall has the names of the deceased engraved in it. These large numbers mean that many Indigenous people in this region are related to or know someone who was a patient there. So this place and its history are of vital importance to them. Here we have a recent newspaper article, in which a former patient and a friend are appealing for help to preserve the few remaining buildings on the site of the leprosarium.

[Former Derby leprosarium residents want to bring decaying facility back to life, abc.net.au, 26th June 2016]

Finally the Derby Leprosarium is an important part of history for the Sisters of St John of God, the community of Catholic Sisters whose members nursed and educated the patients, and who also lived there and were as much a part of this place as the patients. And I say this with the qualification that there were many differences in the positions and experiences between the Sisters, who had some choice to take this path in life, and the patients, who were compelled to take it.

HD – what is it?

• A mildly infectious disease caused by the microorganism Mycobacterium leprae
• Mainly affects the skin and nerves
• Varies in form and severity
  in some people, it does lead to the kinds of disfigurement and disabilities that are commonly associated with this disease, and others acquire a range of conditions such as blindness and chronic ulcers. In others it manifests differently, and often with more benign symptoms and patients may go on to live long lives with mobility and reasonable health.
• Means of transmission uncertain – probably by droplet.
• Long incubation period – this can be more than 10 years, and this important because it means the disease may go unnoticed for many years and in the meanwhile it can spread to others. So isolating often comes too late.
• No effective treatment until the late 1940s. This is when effective antimicrobials were introduced. And this is important because it played a part in determining the official and public responses to the disease.

**HD in Australia**
There is no evidence that HD occurred in Australia prior to the 1850s, and it did not appear in the Indigenous population until the late 19th century. But by the mid 1920s most cases notified to the authorities were Indigenous, and they were located in the remote north of Australia i.e. the Northern Territory, northwest Western Australia and also in north and central Queensland. Members of other races continued to be identified with the disease around Australia but not in the same numbers.

**Official responses to HD in Australia**
The response of colonial (and later state) authorities in Australia to this disease was to isolate sufferers either on small islands or sites on distant coastal fringes. One example in NSW was at the old Coast Hospital at Little Bay from the late 19th c. These special places set apart were often known officially as lazarets. In part, this practice was based on conventions followed internationally. There was of course great fear of this disease based on its reputation in Western culture but it was also known to be infectious, and as pointed out, of unknown means of transmission and with no cure. So isolation was the main policy and this applied to all races of people identified. And, in fact, states and colonies almost all passed laws from the 1890s making it compulsory to report any suspected cases to health departments and health departments had the legal right to remove these people from their homes and detain them in lazarets.

**HD in the Kimberley, W.A.**
By the early 1930s, rising numbers of Indigenous people with HD began to cause concern in areas such as Broome, Beagle Bay and Derby. Initially the Western Australian government shipped these people to the Northern Territory where the Commonwealth government had established a leprosarium (an institution for people with leprosy) on Channel Island. This policy had severe ramifications for the patients involved. The trip was about 1000 km on rough seas and patients were compelled to remain below deck in cramped unhygienic conditions for the entire trip. Once in the Northern Territory, there seemed little hope they would see their families or homes again. One patient who took one of these trips was a part Aboriginal girl named Teresa Puertollano and she was only thirteen at the time. A sight on the jetty before they departed from Derby horrified her and remained with her for the rest of her life. About forty Indigenous men and women were under escort by the police, naked and chained together by their necks, waiting to board the lugger. She remembered, “And they had to walk from where they had come, and that’s miles and miles away...They were raw on their necks, where they put the chains. Not little chains, you know. I cried and was frightened for them”.¹ According to Puertollano, the Captain was also upset about this and convinced the police to remove the chains.

¹ Teresa Puertollano, ‘These were the girls who left Broome for Beagle Bay’ in Peter Bibby (ed.), *The Telling of Stories: A Spiritual Journey of Kimberley Aboriginal People*, Western Australia: Catholic Education Office, Kimberley Region, 1997, p.45
The use of chains to convey Indigenous people from their homes for incarceration in jails or in lazarets was normal in Western Australia – and it continued until the late 1940s, and was endorsed in state parliament when it was raised. So that is one point of recounting Teresa Puertollano’s memory; the other is that chains were deemed necessary by the authorities because there was no way these people would agree to leave their homes on the grounds of white Australian laws or policies. And health authorities and doctors were fully aware of this at the time: they knew Indigenous people feared being taken away from their home country and their families, particularly if sick or dying. Experience had shown that those removed rarely returned; white people’s medicine could do nothing for them.

At the same time, new cases were accumulating in the Kimberley, made worse by delays in shipping and fewer spaces at the Channel Island leprosarium due to the Northern Territory’s own mounting HD problem. These new cases were being held in two different makeshift lazarets. One was at the Beagle Bay Catholic Mission and the other on the grounds of the Derby Hospital. At the latter, the Sisters of St John of God carried out the nursing and, in addition, medical care was provided by two medical specialists, brought out from Germany by the Catholic bishop, Otto Raible. At the Derby Hospital, care was provided by a nurse and her husband, Mrs and Mr Luyer. The government provided medication for both facilities and also paid subsidy per patient.

The Royal Commission
In 1934 the Western Australian government ordered Royal Commission to “Investigate, Report, and Advise upon matters in relation to the conditions and treatment of Aborigines”. Henry Doyle Moseley was appointed commissioner. On learning of the HD situation, Moseley was quite shocked, declaring it of the greatest importance of all other diseases. “…So keenly did I feel the urgency of this subject that on 3rd July 1934, I submitted to your Excellency, from Derby, an interim report…” First, Moseley noted the increasing numbers of cases coming to light in the West Kimberley. Second, he expressed concern at the lack of secure isolation of the patients at the Derby Hospital lazaret. There was no fence or any barrier to prevent the people going into town and mixing with the general public. Finally, he roundly condemned the policy of sending Western Australian patients to NT: “In spite of the utter discomfort and wretchedness obtaining under the present system, the only request I had from the patients was that they should not be sent to Darwin.” The policy, he maintained, was counter-productive since the fear of being sent so far from country induced many to abscond. In conclusion, Moseley recommended a thorough inspection of the northwest region for Hansen’s disease, abandonment of the Darwin solution, and the erection of a state leprosarium, possibly on Sunday Island. There, he proposed, the residents could reside in huts, go fishing and be locked in at night to prevent their escape.

Moseley’s recommendation took some time to be heeded. The problems he alluded to did not go away and by 1936, doctors began publicly raising the alarm about what they perceived as a crisis in the management of Hansen’s disease in the Kimberley. 147 new cases had been identified and most of these had been detained at the Derby Hospital.

4 Ibid., p.11
5 Ibid., p.11.
Lazaret, compounding the problems outlined by Moseley. The views of Dr Byron, the DMO, who emphasised the potential threat to the white population of the Kimberley, were widely circulated in newspapers around the nation. And it was this kind of pressure that finally prompted the Western Australian government to begin to take notice of Moseley's advice and begin plans for building a leprosarium.


The government was, however, unwilling to finance the entire cost, and appealed to the Commonwealth government for a hefty contribution. The premier of Western Australia argued on the grounds that HD was a problem for all of Australia and there was no reason why his state, the poorest of them all, should bear the whole burden just because it happened to have a substantial Indigenous population. The Commonwealth agreed to provide 5000 pounds which, when the budget was finalised, equated to almost a third of the cost of construction.

By December 1936 the leprosarium was open for business. The decision was taken not to build it on the mainland, rather than an island, due to the required access for doctors. In this way, Derby leprosarium differed from the other two leprosaria for Indigenous people operating in the same period in Queensland and the Northern Territory. The leprosarium was situated on mud flats about 10km from the town of Derby, considered a safe distance away as far as the healthy population was concerned. The leprosarium was described as “the best and most up-to-date in the Commonwealth”.

The first members of staff were the Luyers, the married couple from the hospital lazaret, but they only stayed a few months. The cause for their departure is unknown, but the departmental correspondence shows that the district medical officer was dissatisfied with the way the medical treatment was given to the patients. He felt they were being overdosed with an agent that causes a flare up of symptoms. It was also later found that quite a few of the patients did not have HD at all and were erroneously diagnosed at the old lazaret.

In March 1937, arrangements were hastily made for the temporary appointment of two Catholic Sisters from the Beagle Bay Mission to undertake nursing duties at the leprosarium. At around the same time, the government employed a married couple, Mr and Mrs Wybert and Gladys Powell, to oversee the maintenance and management of the leprosarium. In July of the same year, the arrangement with the Sisters became permanent. So this staffing combination – the SSJG Sisters as nurses and a husband and wife for other duties including superintendence – continued over the next 50 years, except that individuals left and were replaced.

**The nursing Sisters**

The first of these Sisters to work at the Derby leprosarium were Sisters Gertrude and Brigid Greene. They were Sisters of St John of God but, more particularly, members of the Kimberley community, a group that for about 30 years had been involved as

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*Davidson, W.S., *Havens of Refuge: A History of Leprosy in Western Australia*, Western Australia: University of Western Australia Press for the Public Health Department, 1978, p.63.*
missionaries in this locality. The two Sisters were registered nurses and Sister Gertrude held qualifications in midwifery and mothercraft nursing. They were also biological sisters. Another sibling, Sr. Matthew, joined the staff soon afterwards. They were not young women, but they were experienced in the conditions and challenges of working in the extreme climatic conditions of the Kimberley, and they were familiar with some of the patients, as they and their families had been with them at Beagle Bay. For these Sisters, based permanently in the western Kimberley and immersed in the lives of many of the patients and their relatives, leprosarium work preserved and extended local missionary endeavours and relationships that began with their community’s formation.

It should be emphasised that the Sisters’ services did not come for free to the Western Australian government. The government agreed to a remuneration of £390 per annum plus food and lodgings for the two original Sisters. This was a rate higher than many lay nursing Sisters earned in Australia at the time, and it signified recognition of the Sisters’ qualifications and the value of their work. It also ensured the state bureaucracy had some control over their performance. As the government undersecretary said, “our position is safeguarded by the fact that the nurses are paid servants of this department.” The money earned did not go directly to the Sisters, in line with their vows of poverty, but was remitted to their community.

The patients

By early 1937, there were 90 men, women and children in the leprosarium. 16 were from Beagle Bay Mission, while others had originally come from the various cattle stations in the area where they worked as stock hands, domestics and drovers. Over the ensuing years, people were brought in from other mission stations, schools and town camps. Among them were school children and babies. Some of the patients who went to Channel Island were also returned, including Teresa Puertollano who I mentioned before. From the 1940s, the Eastern Kimberley became involved so that people from places like Turkey Creek and Wyndham were brought in.

One feature of the leprosarium populations, both in Western Australia and elsewhere, was that very often patients were related to each other. HD was not hereditary (although this was the belief in earlier times), but more likely some families had a genetic susceptibility to the disease. Regardless of the cause, it meant the toll of the disease was especially hard on some families.

How were patients found? Sometimes the public or doctors notified the authorities. Other times, people were found with what were known as ‘leper patrols’. These involved the police and black trackers searching the districts, sometimes making surprise raids on camps, and then bringing the people in. Sometimes the district medical officer was involved in these trips. The distances were quite vast for some people and getting them there over rough terrain and without roads was also a challenge. We have to remember that these people were identified because they showed signs of the disease, sometimes quite advanced, and they might have been ill and had sores, but they still had to make this onerous journey. In the accompanying picture a man is escorted to the Derby Leprosarium by foot. With him are Aboriginal

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7 Memo of Discussion between the Hon. Minster, CPH and Under Secretary, 20/7/1937 (PHD, 1935/0251; SROWA, Cons 1003).
trackers and either a doctor or policeman on horseback, then a group following behind, possibly with more patients. [State Library of Western Australia, Stuart Gore Collection, 022231PD]

Institutional Life

Conditions in the leprosarium

Originally, housing consisted of small huts, each designed for two-four people, however it was decided these were too cramped, and conducive to the spread of the disease. So long dormitory-style buildings were built, and divided into men’s and women’s quarters. These huts would not have been very comfortable either in the winter or summer, as they were made of galvanized iron. Gender segregation was considered essential, primarily to prevent sexual contact and the birth of children, as these would be at risk of contracting HD. It was not only in housing that we see this segregation; it was in most of the occupations that involved the patients, especially where supervision was minimal. And you will notice this in the images I show you soon of the various activities. Segregation policies did not prevent cohabitation between couples, and many babies were born in the leprosarium. They were then immediately taken from their parents and after a period in the Derby Hospital or in the care of the leprosarium Sisters, they were placed in foster care. Some of those babies were frail and several died after short illnesses.

Treatment

The Sisters were in charge of the treatment of the patients. They were merely handed a short list of duties, which read, “attend to sores, treat other diseases, give injections twice weekly, take temperatures.” This was a vast underestimate of the extent of nursing work undertaken by the Sisters. The injections referred to at this time consisted of an agent obtained from India known as chaulmoogra oil. It was a thick substance, which had to be heated on a flame over a kerosene stove before injecting into patients’ limbs or the edges of their skin lesions. It was a very painful procedure and of questionable use, although some doctors, including international experts of the 1920s and 1930s, did believe it helped considerably. It was all they had at this time.

Each month, the Sisters tested for the Hansen’s bacillus. They extracted serum (known as ‘smears’) from the tissue of the patients’ ear lobes, nose and eyebrows, stained it, and examined it under the microscope for the presence of the bacteria. Results were recorded along with clinical observations and used to chart the course of the disease in each patient. Smear tests detected the infectivity of the patient and, taken in a continued series over months and years, revealed the course of the disease in the individual.

The greater part of the Sisters’ days, and, sometimes, nights, was occupied with managing and trying to ameliorate the multifarious and sometimes serious conditions and complications induced by the disease and the distressing and painful reactions many experienced to Hansen’s disease medication. Twice daily, they spent hours attending to the routine clinical procedures: giving out medication for various purposes, washing and bandaging the patients’ lesions, paring ulcers, and applying caustics. At other times, they were in the dispensary, mixing solutions and compresses,

8 Letter from Mother Margaret to Under Secretary, 3/8/1937 (PHD, 1935/0251; SROWA, Cons 1003).
or performing dental extractions. If amputations or other medical procedures were required, they assisted and then took care of the patient’s recovery. They also provided ante- and postnatal care and delivered and looked after the newborns.

**Work and Exercise**
The leprosarium was planned to be self-sufficient, and this would not be possible without the cooperation of all the able-bodied patients. The women fed poultry, milked goats, and washed and made clothes. Livestock were purchased and some of the men who had worked on cattle stations were put in charge of their slaughter and processing. There was also a carpentry workshop and a blacksmith’s forge and the superintendent trained the men in manufacturing items for the institution. Mr Powell, the superintendent, explained that such works would be both beneficial for the leprosarium and to keep the men occupied. And these two considerations were very important underpinnings for the various activities that the staff encouraged the patients to undertake.

The issue of subsistence is very important here. In some ways the photographs you see here, dated in the late 1940s, and showing happy smiling faces at work, mask the extreme difficulties of the first eight or so years of the leprosarium in terms of material well being for the patients. Attempts at self-sufficiency failed miserably due to drought and the death of crops and animals. Supplies were inadequate due to unreliable ocean transport. I have a copy of a letter from Sr Gertrude to the health commissioner almost pleading for some vegetables for the patients and also some fabric so she could organise some clothes to be made for them. She was told it was not her business to be concerned with such things – that it was the job of the superintendent to organise supplies. Teresa Puertollano remembers women patients knitting clothes from the wool of the dead goats and sewing outfits from flour bags prior in these years before World War II. Conditions did improve after this period, but it’s important to interpret these images with caution and to acknowledge that smiles for the photographer are not certain reflections of the day-to-day experiences of the patients.

To return to the point about efforts to keep the patients occupied: most of each day was accounted for. Every morning the patients had to line up for exercises, which were considered physically therapeutic, as well as good for mental discipline. The patients then had clinic and the adults then went to their jobs. If they were children, they went to school, usually just for a few hours per day. Teresa Puertollano was teacher. She had been educated at a convent school before being taken ill with HD and had taken it upon herself to teach the Indigenous children at the Derby Leprosarium. Some of these children did not speak English, let alone read or write, so we can see the influences here of Western culture, as in the mission stations. Teresa also introduced some children to Christianity by teaching them about the Bible and how to say the Rosary.

In the late 1940s, a new Sister arrived who was both a registered nurse and a trained musician. Her name was Sr Alphonsus Daly and she replaced Sr Gertrude as sister in charge. Sr Alphonsus began teaching the patients music and established a patient orchestra. She realised both adult and young patients could pick up playing instruments without the need to sight-read, and she appealed to the public and the government for donations of musical instruments. The patients played classical music and folk songs, and, in later years, jazz and the Beatles. When official visitors came, they held concerts and dressed up, as you can see in this photo. For Sr Alphonsus, who
became sister in charge, the orchestra performed a number of different therapeutic functions; it was, in her view, a kind of panacea. She told the patients that playing instruments exercised the fingers, no doubt hoping to stave off some of the common deformities that occur with HD, such as claw hand. Playing music was also aimed at keeping the patients distracted from their problems. And patients looking back on this time agreed this was the main reason they were encouraged to play. In their words “music was an escape from confinement” and another claimed, “it was to keep us occupied instead of thinking about our relations”. Another, that “it helped lift spirits up”, In her memoirs, Sister Alphonsus called it the ‘therapy of distraction’. It was an attempt to substitute negative thoughts and, sometimes, negative actions, with activities that she believed were satisfying. It resonates strongly with modern therapies for anxiety disorders used by psychiatrists in more modern times, such as cognitive behavioural therapy which, and I quote a psychiatry textbook, seeks to “maximize engagement in activities …provid[ing] a sense of pleasure and mastery”. The fact that Sr Alphonsus spent a great deal of her time and energy in trying to apply these therapies is evidence of her recognition of the patients’ suffering and her determination to try to address it. Sr Alphonsus eventually passed the baton on to a younger Sister, Sister Camille Poidevin, a conservatorium trained musician, and the orchestra continued into the 1960s until patient numbers dwindled.

Sr Alphonsus was under no illusions about the limitations of her techniques – in her memoirs she discussed ruefully the young male patient whose sadness could not be dispelled, no matter what methods she tried. We can’t assume she was successful with any of the patients, necessarily. But we do gain an understanding of her attempts. The orchestra is significant because it shows the individual approach taken by Sisters in their missionary vocations, and how they use their personal resources and talents in different and sometimes inventive ways to help those under their charge.

If keeping the patients occupied in activities such as work and music was desirable, idleness was highly discouraged from the point of view of the morality and health of the institution. Staff and authorities feared the idle patient was prone to gambling, drinking and sex, all of which were disapproved of, and therefore this became another reason for ensuring the patients always had something respectable with which to fill their time. One Sister looking back on her time at the leprosarium remembered Sr Alphonsus used evening orchestra practice to distract the men from seeking the company of the women. So apart from everything else, the orchestra was a form of discipline - and a much more merciful one than the punishments meted out by the superintendent, including head-shaving and incarceration in the leprosarium lock-up.

There were many other interesting aspects to institutional life that time does not permit to explore. One significant feature, for example, was the cultural exchange that flourished, due to the diverse backgrounds of the patients. This was a place that brought together Indigenous groups that in some cases were traditional adversaries of one another. But inevitably, especially if they arrived as children, they mixed and

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10 Daly, M. Alphonsus, Healing hands: memories and milestones of the Derby Leprosarium. Perth: Health Department of Western Australia, 1986
11 David M. Clark, ‘Cognitive behaviour therapy for anxiety disorders’ in New Oxford Textbook of Psychiatry, (Books@Ovid)
patients learned different languages from each other, they learnt about each other’s cultures and beliefs, and this included varying degrees of Western cultural assimilation. And, although Catholic missionaries were the predominant carers, the practice of other forms of Christianity was also permitted. Protestant, UAM and Catholic missionaries had rights to visit and conduct church services for their own members at the leprosarium.

In the late 1940s, new antibiotics were introduced at this leprosarium as well as others around Australia. These were called the Sulphone drugs and they were hailed as the first effective treatment for HD. This made a radical difference to the patients’ prognoses and health, especially those in the early stages of the disease where permanent damage had not set in. It was by no means the end of the leprosarium, because although the disease resolved for many people and they were subsequently discharged, there was a host of other problems that had to be dealt with. One was the fact that discharged patients had to remain on their medication long term and needed regular health checks. This was difficult, sometimes impossible to ensure in the home areas of the patients. There just weren’t enough remote health services. Consequently patients were held in the leprosarium longer than would seem justifiable. In fact Western Australia was much slower than the Northern Territory to bring in the medical and rehabilitative advances that were needed to support and heal Indigenous HD patients so they could avoid long-term detention in the leprosarium. It was only in 1986 when this could be achieved and when the Derby Leprosarium finally closed its doors.

For the few elderly people remaining, knowing no other home after spending most of their lives there, this was a sad day. It was also a wrench for the St John of God Sisters who were there at the end. They had shared very distinctive experiences, so different and very cut off from the rest of the nation, and for some former patients and staff, this created a bond, what scholar Katharine Massam has called “a family of outsiders”.¹² As the late Sister Camille Poidevin said, “we realised the terrible emotional trauma they went through. We had a tremendous bond.”¹³

