TRANSCRIPTS OF EVIDENCE

THURSDAY, 27 AUGUST 1998

LEGISLATIVE COUNCIL CHAMBER, PARLIAMENT HOUSE, SYDNEY

MEMBERS PRESENT:

- The Hon. Jan Burnswoods, MLC (Chair)
- The Hon. Dr. Arthur Chesterfield-Evans, MLC
- The Hon. Doug Moppett, MLC
- The Hon. Peter Primrose, MLC

WITNESSES BEFORE THE COMMITTEE:

HARVEY MILSON, Manager, Adoption Services, Department of Community Services, and

ALISON LINLEY SMITH, Assistant Manager, Adoption Services, Department of Community Services, sworn and examined, and

DEREK GERARD SMITH, Senior Solicitor, Department of Community Services, affirmed and examined:

CHAIRMAN: In what capacity are you appearing before the Committee?

Mr MILSON: As a representative of the Department of Community Services.

Ms SMITH: As a representative of the Department of Community Services.

Mr SMITH: As a representative of the Department of Community Services.

CHAIRMAN: Did you each receive a summons issued under my hand in accordance with the Parliamentary Evidence Act?

Mr MILSON: I did.

Ms SMITH: I did.

Mr SMITH: Yes, I did.

CHAIRMAN: Are you conversant with the terms of reference of this inquiry?

Mr MILSON: I am conversant with the terms of reference.

Ms SMITH: Yes I am.

Mr SMITH: Yes I am.

CHAIRMAN: The department has forwarded a submission to the Committee. Do you wish to have that submission included as part of your evidence?

Mr MILSON: Yes.

CHAIRMAN: Do you wish to briefly elaborate upon that submission or to make a short statement?

Mr MILSON: Not at this stage, only in response to questions from the Committee.

CHAIRMAN: Questions were forwarded to the department following receipt of its submission. Will you please describe briefly the term "adoption" and explain the different types of adoption?

Ms SMITH: Adoption is a legal process by which a child becomes, in the eyes of the law, the child of the adoptive parents as if born to them, and ceases to be the child of the birth parents. Adoption is probably best understood by looking at the consequences for the child, the birth parents and the adoptive parents from the making of that adoption order. The key consequences are as follows. An adoption order is irrevocable except in exceptional circumstances. The parental responsibilities of the birth parents are terminated. This generally includes any orders made under the Family Law Act, and new parental responsibilities are created in favour of the adoptive parents. Legal relationships of kinship with members of the birth family, including siblings, grandparents, et cetera, are also terminated and new legal relationships of kinship with the adoptive family are created.

The child is issued with a new birth certificate to reflect these new relationships with the adoptive parents and their family, and access to the original birth certificate is restricted. Property and inheritance rights are also altered, other than where the child was already entitled to something, for example, a vested or contingent right to property before the adoption took place. Adoption law places an emphasis on being a parent, not just a guardian or person with parental responsibilities. There are three main categories of adoption: the adoption of a child by a step-parent or relative, the adoption of a locally born non-relative child and the adoption of an overseas born child.

CHAIRMAN: What is a private adoption?

Ms SMITH: A private adoption is a term given to applications to the Supreme Court for the adoption of a child where the application is made by someone other than the Minister if the adoption order was made under the Child Welfare Act 1939 or by the director-general of the department or a principal officer of a private adoption agency if the order was made under the Adoption of Children Act 1965. Under the Child Welfare Act 1939 private adoptions or, more correctly, third party adoptions, were adoptive arrangements made by individuals other than the department. These could even include an arrangement made by a friend or neighbour of one of the parties. The department was not involved at any stage with these arrangements, as the adoptive parents were represented at the court by their own solicitor.

The Adoption of Children Act 1965 restricted the arrangement of adoptions to formally constituted organisations. Under section 51 of the Act it became an offence for any person, other than the director-general of the department or a principal officer of a private adoption agency, to conduct negotiations or make arrangements with another person with a view to the adoption of a child by that person, unless the child to be adopted was to be adopted by a relative of the child. This legislative change arose from some concerns for possible improper practices in private adoptions, such as the payment of moneys. The need for change was foreshadowed in the department's annual report in 1961, when the department expressed its concerns in regard to the opportunities under the existing law for persons to resort to "undesirable though legal arrangements to adopt a child quickly". In 1961 private arrangements represented 48 per cent of the total number of orders made by the Supreme Court. Under the Adoption of Children Act 1965 a private adoption now refers to a step-parent or relative adoption application.

CHAIRMAN: Can you give the Committee an indication of the volume of adoption orders that have been made since the 1920s?

Ms SMITH: From 1924 until June 1997, 102,263 adoption orders have been made in New South Wales. These figures have been obtained from the Registry of Births, Deaths and Marriages. Once an adoption order is made by the Supreme Court, a memorandum is sent by the court to the registry for the issue of the amended birth certificate. These figures include all categories of adoption. During the 1920s adoption orders per year steadily increased, from a low of 28 in 1924, when the Act came into effect, to a high of 837 in 1929. During the 1930s adoption orders per year were fairly static at around 800, until the late 1930s, when they were reaching 1,000 a year. During the 1940s adoption orders per year steadily rose to 2,000. During the 1950s adoption orders fell initially to around 1,500 per year, but rose in the late 1950s to 2,200 a year. In the 1960s adoption orders, on average, remained at 2,200. However, by 1966 the number was close to 3,000. In the 1970s adoption orders rose from 3,000 to 4,500 in 1972, but then steadily fell until, in 1979, only 1,000 orders were made. During the 1980s adoption orders fluctuated, but in 1989 they remained at about 840. In the 1990s adoption orders have fallen to between 300 and 400 a year.

CHAIRMAN: What factors were responsible for the decline in adoptions in the mid-1970s?

Mr MILSON: The 1970s saw a more general acceptance of reliable birth control and the establishment of family planning services. Abortions became more accessible in the case of unplanned pregnancies, and this was largely as a result of the Levine judgment in 1971. The first pre-term clinics were established in 1973. The Commonwealth accepted responsibility for financial assistance to single-parent families to assist in the child-care costs and removed some of the restrictions on eligibility for assistance, such as the requirement to take maintenance action against the father and a reduction in the qualifying period for eligibility for financial assistance. The supporting mothers benefit was introduced. Commonwealth funding to child-care centres became available to reduce the cost to a parent of providing child care.

The Family Law Act 1975 removed many of the provisions relating to accountability or apportioning of responsibilities for breakdown of marriage and provided more accessible options for resolving child-care responsibilities through consent agreements and extended family care. The Children (Equality of Status) Act 1976 and the De Facto Relationships Act 1984 removed the stigma associated with birth outside marriage, and the role and responsibilities of single parents and the rights of children to their family of birth were accepted and recognised more generally in the community. Fathers' rights and responsibilities became more clearly defined.

Community, church and social attitudes were influenced by an enlightened opportunity for groups to speak out, and governments became more responsive to social needs. Responsibility for family support services shifted from religious organisations, and funding was picked up by government, which made accessing these services more widespread. Educational institutions provided training in a wider range of human services and child-care fields, which better equipped workers in government and non-government services to address family child-care needs and options. The notion of "family" changed to include single-parent families, blended families and extended families. Generally, the 1970s represented a period of most significant social change.

The Hon. D. F. MOPPETT: Will you describe the legislative framework for the regulation of adoptions in New South Wales in the period under consideration by this inquiry, 1950 to the present day?

Mr SMITH: The present Act that deals with adoption is the Adoption of Children Act 1965, which came into force in February 1967. Prior to that time the adoption legislation dealing with the adoption process was the Child Welfare Act 1939, and in particular part 19 of the Act. There were no particular regulations in relation to adoption, but there were regulations relating to other aspects of the placement of children. In 1967 regulations were made under the Adoption of Children Act, which have since been repealed. Those regulations were repealed on 1 September 1995 and were replaced by the current regulations, that is, the Adoption of Children Regulations 1995. The adoption process was also affected by various Supreme Court Rules: for the period 1940 to 1967, the Child Welfare Rules 1940; for the period 1967 to 1970, the Adoption of Children Rules; and from 1970 onwards the current rules under part 73 of the Supreme Court Rules relating to the adoption of children.

In 1991 the Family Court became involved in the adoption process in relation to step-parent adoptions. It became a requirement under that Act for a step-parent adoption application to be made to the Family Court to seek leave in order to then proceed towards an adoption application. If leave was not sought, the adoption would not be recognised under the Family Law Act, either for the purposes of that Act or for any Act that relied on the Family Law Act to determine the child's legal status. Other adoption legislation is the Adoption Information Act, which was brought in in 1991. Prior to 1991 the Adopted Persons Contact Register was set up under part 5 of the Adoption of Children Regulations 1967. That register was then repealed by the Act. The Adoption Information Regulations 1996 came into force on 1 September 1996. Both the Act and the regulations are current, and govern adoption information.

The department's Ministers have been responsible for the administration of the Child Welfare Act, the Adoption of Children Act and the Adoption Information Act. However, the degree to which the department or its Ministers have had a role in the adoption process has varied significantly during the period in question. For example, up until 1965, private arrangements for adoptions were within the law, including situations in which the child was not related to the applicants for adoption. One of the reasons for the introduction of the 1965 Act was to outlaw private arrangements for adoptions when the child was not related to the adoptive parents.

From then on all such adoptions could be arranged only by either the department or a private adoption agency, which then had responsibilities to the department. Only at that point could it be said that the department had any significant role in the controlling of adoption practices in New South Wales. Up until that time the controlling of checks around adoption, particularly adoption consents, was a matter for the Supreme Court and was dealt with under the Supreme Court Rules. To assist the Committee I will tender copies of various regulations and rules of the Child Welfare Act 1939, the previous adoption regulations under the Adoption of Children Act 1965 and the various parts of the Supreme Court Rules during the period in question.

The Hon. D. F. MOPPETT: In your answer you alluded to the role of the Department of Community Services in the legislative changes. Would any of your other colleagues like to expand on the role of the Department of Community Services, formerly the Department of Child Welfare, in adoption in the period under consideration by the inquiry?

Mr MILSON: During the period under consideration by the inquiry, the responsibility for legislation in relation to adoptions came within various ministerial portfolios and administrative departments. The department, in exercising its legislative responsibility, had responsibility for the taking and witnessing of consents to the adoption of a child; receiving and processing applications for the adoption of a child, including the assessment of the applicant's eligibility and suitability to adopt; providing pre-adoption care arrangements for children surrendered for adoption; allocating and placing children with approved adoptive parents; supervising the placement pending the making of the adoption order; making applications to the Supreme Court; providing reports to the court in conjunction with making the adoption order; reporting to the Supreme Court if it had not been possible to finalise placement of the child within 12 months; seeking the court's concurrence to continuing care arrangements for the child; approving private adoption agencies; and providing hostels for the care of what was then termed "expectant and nursing mothers".

The Hon. D. F. MOPPETT: Will you summarise the social context for adoptions from 1950 to 1998?

Ms SMITH: The following is only a summary of those aspects of society that may have impacted on adoption practices in the period under the inquiry; it is by no means comprehensive. In the period 1950 to 1966, having children outside marriage was not acceptable. Attitudes to children born out of wedlock were generally negative. Adoptions seemed to be the solution for pregnant single women. A single mother relied on the support of her family or partner to keep the baby. Single pregnant women generally hid their pregnancies, many going to other cities to have their children, then returning home as if they had never given birth. Adoption was considered best for the child. The majority of adoptive parents were in skilled or semi-skilled occupations.

Between 1967 and 1987 there was enormous social change. In the late 1960s, attitudes to children born out of wedlock were still negative, and in the early 1970s a single pregnant woman may still have hidden her pregnancy. But in the late 1970s and 1980s the concept of illegitimacy and the stigma attached to it declined. There was increasing acceptance of people living together outside marriage and ex-nuptial births. Family planning services came into existence, with advice services provided by trained counsellors. In the late 1970s and 1980s different family structures developed, including single-parent families, blended families, and families with working mothers, as well as the traditional family structure. Adoption moved from being perceived as the solution for single mothers, infertile married couples and the child, to a service for children.

From 1987 to the present day the number of single women keeping their children has increased. Societal changes in attitude mean that single women can now make a conscious decision to have a child. Family planning and women's health services, including termination of pregnancy services, have been generally available. A wide range of community and family supports at the local level were set up, including child care. Anti-discrimination legislation has made it illegal to discriminate on the basis of marital status. Infertility and placement of the

child have been separated. A stronger emphasis has been placed on adoption as a service to children, although it is now recognised that we need to take account of the needs of both the birth parents and adoptive parents.

The Hon. D. F. MOPPETT: What was the range of non-adoption options available to unmarried mothers in the period under consideration by the inquiry? Please refer to relevant social security or other State-funded entitlements for single mothers during this time.

Mr MILSON: The non-adoptive care options to enable a mother to retain the care of her child have included marriage to the child's father, return to the mother's family with the child, placement of the child with extended family, entry into domestic service where it was possible to retain care of the child, return to employment with private care for the child through either family or other child-care arrangements, or admission of the child to State care to enable foster care to be provided for the child. The Child Welfare Act 1939 provided for allowances in respect of destitute children living with parents. This allowance was provided for the child and did not provide for the parent. The allowance continued for the child until the child reached school leaving age if the parent or spouse was not in employment.

Food orders and clothing orders were provided by the social welfare section of the department up until the late 1960s. A parent was able to receive child endowment from the Commonwealth. In 1964 this was at the rate of £1 per week per child. A parent could also receive the Commonwealth sickness benefit for six weeks before the birth of the child and six weeks after the birth of the child. The Maintenance Act provided the court with the authority to order the payment of maintenance by the father of a child, if he could be identified. In approximately 1973, the deserted wives and widows pension was payable from six months following the birth of the child or separation from the child's father, subject to the mother taking maintenance action. From 1997 this allowance was paid from the date of birth of the child and the requirement to take maintenance action was relaxed.

Since 1972 assistance has been available to child-care centres and, more recently, to low-income families to enable children to be placed in preschool care centres. In 1973 the Commonwealth introduced the supporting mother's benefit, which was payable after a six-month qualifying period and attempts to secure maintenance from the child's father. The allowance was extended to fathers in 1977. Financial assistance, housing, accommodation, parenting support, disability support services, respite care and day-care services are now available to help parents care for and raise their child. Some of these services are also available for other family members, should they offer to care for the child. A foster agency can now arrange the temporary care of a child, usually with a foster family, while arrangements are made for accommodation and financial support. These arrangements are usually time limited to minimise the effects, such as separation, on the parent and child.

Long-term foster care arrangements are usually made through a court, which will make an order for the child's guardianship and custody. Residential care facilities are available to cater for children who have a high level of physical care needs. These facilities often have a waiting list and some require membership of a private medical fund.

The Family Law Act provides for a range of orders to determine with whom the child will live, contact between the child and other people, maintenance of a child, and other aspects of parenting responsibilities. These orders can be made by consent to avoid costly legal expenses. Children's Courts have the power to make orders. However, generally these are only made when there is a breakdown in care arrangements for a child.

CHAIRMAN: Your submission states that when the Adoption of Children Act 1965 came into effect in 1967, a mother could revoke consent to the adoption within 30 days of giving consent or before the day on which the order for adoption was made, whichever was earlier. Would it constitute a breach of the Adoption of Children Act if a child were placed with adoptive parents before the expiration of the revocation period?

Ms SMITH: Once consent to adoption had been given by the required persons a child could be placed with the adoptive parents. Placement within the revocation period was not unlawful. Under section 28 of the Adoption of Children Act 1965 consent to adoption may be revoked either before the day on which an order for the adoption of the child is made or the expiration of 30 days from the date on which the instrument of consent was signed, whichever is earlier. This legislative provision was stated on a form called "A Request to Make Arrangements for the Adoption of a Child", which, under Adoption of Children Regulation 24, had to accompany the parent’s instrument of consent to the adoption.

Perhaps influenced by the theories advanced by John Bowlby of the child's early need to attach to a nurturing parent, children were placed for adoption during that 30-day revocation period, although this appears to have been a decreasing practice by the second half of the 1970s. Such placements were not a breach of the adoption legislation. The prospective adoptive parents would have been advised at the time of the placement that the relinquishing parent had the right to reverse his or her consent within the time period. Departmental officers at the time can recall occasions on which a parent revoked his or her consent and the child was removed from the prospective adopters' care to be returned to that parent.

Not all children were placed during the revocation period. The opinion of the witness to the consent was sought as to the likelihood of the parent revoking his or her consent. The practice, although it had ceased by the early 1980s, was not considered unethical. It was based on a belief that the best interests of the child would have been served by placement with the long-term parents as soon as possible. Early placement ceased as a practice as we sought to balance the needs of all the parties. The possible pressure of an early placement on the relinquishing parents' right to revoke their consent was recognised and the possible effects of the uncertainty of their placement on the bonding between the adoptive parent and the child was also taken into account, and the practice ceased.

The Hon P. T. PRIMROSE: You said at the time it was not considered unethical. In your view was it unethical?

Ms SMITH: No.

CHAIRMAN: In this area we have received several submissions from birth mothers in which they make the point that their babies were placed with adoptive families before the expiration of the revocation period. In the department's submission about changes that were made in the 1970s and 1980s you state that the practice of placing a child during the revocation period did cease. Mr Primrose has already asked whether you regarded that as unethical. The other part to that question is whether it would have been much more difficult, once a child had been given to a family, to take the child away again.

Ms SMITH: The right of the relinquishing parent to revoke consent was very clearly stated on the consent documents in the particular forms.

[*Interruption from gallery*]

CHAIRMAN: As I said before, this hearing is being held under formal rules and is being recorded by Hansard. Other people will have the opportunity to contribute later. In this hearing witnesses are questioned and their answers given under oath. We must proceed within that framework and cannot allow toing and froing with the gallery. I also point out that we are aware that there has been considerable debate about the use of the term "birth mother", and other terms have been suggested. The Committee has discussed this matter and has followed the terms used by most of the women in submissions. We have also followed the adoption of the term in use at the time of the changes to the Adoption Act in this State in 1990. We are aware that each term is disliked by some group. On the whole women are free to use their own terms but, for clarity, at times a specific term has to be used.

Ms SMITH: The consent documents consisted of two forms. One was the actual instrument of consent and the other was a document called "The request to make arrangements for a child's adoption". That document contained a paragraph that related to the right of the consenting parent to revoke consent within 30 days. So at the time of signing consent the parents would have been aware of their rights. Whether their choice of revoking consent was influenced by the act that the child was placed or not is very difficult for me to answer in a general sense. However, recognition that in some way it may have affected a decision, because of conscience or the pain that a parent thought might have been inflicted on the adoptive parents, may have come into play with some parents. Nevertheless, I repeat that adoptive parents who had a child placed during the revocation period were clearly aware of the fact that they had no claim to that child during the 30-day period and that the parent had the right to revoke consent.

CHAIRMAN: Because the department makes the comment that the practice ceased, it seems clear that the department was acknowledging that there was a problem with the practice.

Ms SMITH: I think we recognise that a dual issue was involved. The other issue was that if we were placing a child for the purpose of early attachment, the anxiety that rested with the adoptive parents—whether the child was going to remain with them—was also a factor. So I think the two factors were taken into account in our ceasing that practice.

The Hon P. T. PRIMROSE: Were there any formalised departmental procedures that prescribed the steps to be taken to ensure that the parent was aware of her rights in relation to revocation? For example, to ensure that the person had adequate legal information, which

I presume did not happen, or to ensure that the parent was literate and, if not, that the procedure was adequately explained. Was anything written in the departmental guidelines about that?

Ms SMITH: There was certainly something on the documents on consent. The request to make arrangements not only stated that the parent had the right to revoke within 30 days but also how to go about revoking that consent. So the process to revoke consent was provided at the time. The other aspect is the responsibility of the witness to the consent. That responsibility included giving the consenting parent ample opportunity to have read the document. If that person was illiterate, special steps had to be taken to ensure that the person understood the nature of consent.

The Hon P. T. PRIMROSE: The Committee has received several submissions from women who were upset that the name of the birth father was not recorded on the birth certificate despite the father's name being recorded on the form of information. The Committee has been informed that the birth father's name would only appear on the birth certificate if the mother filled out a separate form. Was it routine practice for departmental officers to inform women of the procedure to ensure that the birth father's name appeared on the certificate? If not, why not?

Mr MILSON: The requirements of the registration of a birth are legislative matters for the Registry of Births, Deaths and Marriages. However, the registry has advised us that the registration of birth is subject to legislative provisions that when the parents of a child are not married the birth father's details can only be included on the registration of birth if both parents sign the birth registration form. The registry acknowledges that the birth registration form lodged with the registry by a birth mother provided for the father's details to be recorded, but unless he also signed the forms the details are not transposed to the birth registration. The registry confirmed a requirement to be satisfied that the other parent does not dispute the information.

The procedure followed to register the birth of a child was usually commenced in a hospital and required the staff of a maternity ward to partially complete the birth registration form to include details of the child, date and time of birth, name and location of the hospital and details of the medical staff attending the birth. These details were taken from the hospital record and the information was provided by the mother. There was no verification of the information that was provided by the mother and her identify was not verified. The form was then made available to the mother, or she was assisted, to include details such as the given name of the child, her residential address and her signature, and the signature of the father, if he was available. If all signatories were available before the discharge of the mother from the hospital, the form was usually forwarded to the registry by hospital staff.

If a departmental officer was involved in assisting the mother to complete the information at birth, the officer would have advised the mother of the procedure for the father's name to be recorded on the certificate. The father's details could only be recorded if the parents were married or the father signed the registration form. It is the recollection of officers that mothers were informed of these requirements and were afforded the opportunity to obtain the father's signature on the birth registration form if that was the mother's or father's wish. In adoption matters the practice varied. In some cases the completed birth registration forms were provided to the department together with other medical forms, to be included with the adoption papers, or the unsigned form was provided to the departmental officer to be completed during

the taking of the consent. That process was to aid the department's officer taking the consent to the adoption of the child to ensure that the details of the child recorded on the consent were consistent with the details recorded on the registration of birth.

The Hon P. T. PRIMROSE: Is the department confident that these matters were explained to women in all cases, most cases or a minority of cases?

Mr MILSON: It would have been only in cases when the department's officer was responsible for assisting the mother to add those details to the application for the registration of birth of the child. It would have been clearly said: "Yes, you can include the father's details on the form but they will not be included on the registration of birth unless he also signs the application, or he could complete a subsequent application."

The Hon P. T. PRIMROSE: That is from the recollections of departmental officers?

Mr MILSON: It is.

The Hon P. T. PRIMROSE: What measures might assist people who are experiencing distress as a result of past adoption practices?

Mr MILSON: In 1989 the Standing Committee on Social Issues conducted a significant inquiry into the accessing of adoption information. The personal stories of many people affected by adoption formed the recommendations of the inquiry, which led to the landmark legislation, the Adoption Information Act 1990. That Act, which opened adoption records to all parties, has enabled the provision of a variety of services to people affected by adoption. Within the department the Family Information Service provides a range of services. Firstly, the Family Information Service maintains the reunion and information register. Any party to an adoption can register an interest in having contact with another party. When a match is confirmed trained counsellors approach both parties to discuss arrangements for contact. The counsellors provide a supportive and information-giving role.

Secondly, the Family Information Service does outreach on behalf of a party to an adoption who wishes to have contact with another party but has no entitlement under the Act to identify information. Sometimes a party may have the entitlement but may not feel able to make the contact and needs assistance to do so. Thirdly, the Family Information Service provides adoptees and birth parents with prescribed information. The service is committed to the importance of adoptees having as much information as possible about their origins or for birth parents to know as much as possible about what happened to them at the time of the birth of their child. We are deeply committed to this and release as much information as is possible. The Family Information Service staff attempt to link clients with support groups in the community. We see the importance of birth parents being in contact with other birth parents who have gone through similar life experiences.

We attempt to keep up to date with current community groups that are available, and visit them to ascertain the types of support they can offer. These services include organisations such as Adoption Triangle, Mothers for Contact, Origins, et cetera. The Family Information Service also refers to the Post Adoption Resource Centre those people who need more in-depth support and other services. PARC, the Post Adoption Resource Centre, is a specialised agency that was established following the passage of the Adoption Information Act 1990. It

is funded by the Department of Community Services and its services include information meetings, telephone counselling, individual counselling, intermediary services and group programs.

The Family Information Service provides telephone counselling to birth parents, and written literature about adoption that may be helpful to clients. The department also provides a limited face-to-face counselling service. Underlying all our service is a strong belief in the adherence to the principle that all clients should be treated with respect, and that both adoptees and birth parents have an inherent right to information about each other. We attempt to achieve the best outcomes for all parties if possible. This service has been a part of the healing process for many adopted people and birth parents.

The Hon P. T. PRIMROSE: Does the Department of Community Services consider it appropriate to make a formal apology to persons who have experienced distress as a result of post-adoption practices?

Mr MILSON: Any question of a formal apology would be a matter for government, not for the department, and therefore it is not appropriate for the department to comment, particularly at this very early stage of the inquiry. The question also needs to be considered on the merits of each individual case, unless the inquiry ultimately comes to the view that, at any particular period of time, the practices themselves led generally to persons being treated inappropriately, unfairly or even unlawfully. In the circumstances, the department does not propose to make any further comment at this stage. The department has, however, already indicated that it will fully and constructively respond to recommendations that result from the inquiry, as evidenced by the measures already in place as outlined in the department's response to the previous question.

The Hon P. T. PRIMROSE: In your answer to my earlier question, you said you would consider a formal apology, or making a recommendation to government, if circumstances were such that the department had acted unethically or illegally. Can you say today, under oath, whether there are any systematic instances in which you believe that may have been the case?

Mr MILSON: I do not believe that there are any systematic instances where that has been the case—that is, if you mean by that incidents which arose out of a general practice either dictated by or required of the department.

(The witnesses withdrew)

CHERYL EDITH McNEIL, affirmed and examined:

CHAIRMAN: In what capacity are you appearing before the Committee?

Ms McNEIL: As a mother who has lost her child to adoption.

CHAIRMAN: Did you receive a summons issued under my hand in accordance with the Parliamentary Evidence Act 1900?

Ms McNEIL: I did.

CHAIRMAN: Are you conversant with the terms of reference of this inquiry?

Ms McNEIL: As much as I can remember, yes.

CHAIRMAN: You have provided the Committee with a submission. Do you wish that submission to be included as part of your sworn evidence?

Ms McNEIL: Yes, I do. I ask that the names of the adopting parents and my daughter not be listed, please. I actually wrote them in.

CHAIRMAN: The Committee will certainly do that. Do you wish to briefly elaborate on your submission?

Ms McNEIL: Yes, I do. As I said, I am a mother who has lost her child to adoption and that is how I would really like to be addressed. I find it really difficult now to hear the word "relinquishing", which the department was still using in some of its documents, because relinquishing means abandoning and, for me, I did not abandon my child. I guess the example I could give is if a woman gives birth to a baby, and, say, she dies and the child is looked after by a stepmother, the first woman is still known as "mother". She is the woman who gave birth to the child, whether she was married or not married, and for me I would really like to be known as mother—not as birth mother, not relinquishing mother, not surrendering mother, not natural mother.

I know of a lot of women who feel very strongly about it. You mentioned that in their submissions to the Committee a lot of women used that term. I would imagine they would use the term because that is what they have been given. It is used in the newspapers and it is still being used by different organisations, even the word "relinquishing", which I really feel strongly about. I wanted to draw that to the Committee's notice. The other thing I would like to talk about is that I have done quite a lot of counselling group work with specific groups looking at this issue. I have heard a lot of women's stories about what it was like for them. I see myself as probably representing a minority of women, because my story, I think, is really a little different to that of a lot of the others. I heard that you are going to be talking of other women. I am really pleased about that, because when I get into my story a little bit, you will hear the difference. I just wanted to make it clear up front that I see myself as representing a minority.

CHAIRMAN: Do you want to say anything more or shall we move to the questions?

Ms McNEIL: I think we will go to the questions now, thank you.

CHAIRMAN: In your submission to this inquiry you described the circumstances surrounding the birth and adoption of your baby in 1969. Will you summarise those circumstances for the Committee?

Ms McNEIL: I forgot to introduce my friend, Lynne Hancock, who has come as a support person for me. In 1968 I fell pregnant and I chose not to marry the father of my daughter, because I did not think that that was the way to go; that that was a reason to get married. I finally told my mother at five months pregnant and, at that time, she was advised about Crown Street Women's Hospital. So, off we went to Sydney to Crown Street Women's Hospital, where we were introduced to a social worker. From there on I was given a choice of whether I wanted to spend the rest of my pregnancy in a home, or out in the community. I think I was sort of coming from a very good-girl angle, that I would do anything that everybody told me, because I had done this dreadful thing about getting pregnant and not being married.

I chose to go out into the community and work in the home of a divorcee woman with three children. When I look back, wow, she had a really good deal. For about $10 a week, I think it was, accommodation and food I looked after her children. She was running a small business and I did some office work and cleaned her home. I remember at the time the social worker saying, "Why don't you tell them how good New South Wales girls are, because this woman has only had Queensland girls and they were great." Afterwards I worked out why they were so great—because they never left the home. Who could they visit? When I did leave once a week to go and visit a close friend, it caused a bit of a hassle.

From there I would go into Crown Street Women's Hospital and see the social worker and have a medical examination, right up until the birth of my daughter in January 1969. I went into hospital a few days early because I was experiencing bad varicose veins in the leg. I went into hospital and I started into labour and was taken to the labour ward. Does this carry on to question three? I am not sure whether I should try to keep them separate.

CHAIRMAN: That is entirely up to you. The second question about whether you received any counselling or information regarding alternatives really deals with the period before the birth. Did you receive that information before signing the consent? Do you want to talk about what the social worker advised you?

Ms McNEIL: I visited the social worker on a regular basis. I asked for all that information, like the records, and I received just a one-page statement, which amazed me, considering all the visits. I did walk in the door saying that I thought adoption was the best thing, because my mother was working, I could not see how I could look after my child. It was as if I was picked up and taken along with yes, I want to adopt. For all these years I did not know there were alternatives. I was not given any alternatives. It was as if I walked in the door and said, "I want to commit suicide" and she said, "Very well. Do you want to go into the community and commit it or do you want to go to a home and commit it?" I chose out in the community. Now that I know these laws are in place I wonder why someone did not stand up and protect me from me. I have suffered the dire consequences of letting go of my child. I guess I feel really betrayed, because I work in a field that is dealing with these sorts of things, with

social workers, and it was recognised how terrible this was. Not only was I not warned how terrible it was, I was told the opposite, that I was doing the best thing for my child and I would make an adoptive couple very happy.

I will move on to actually giving birth. I went into labour and was taken upstairs to the labour ward. I do not remember having any instructions about what was going to happen. I went in there very naive, with no relatives around, because they were in Newcastle. Mum and dad would visit me occasionally, but I went into all this on my own. I was very scared in this room on my own. They gave me the gas mask to help with the labour pains, and I took too much. Nobody was there to tell me to take only a little bit. I remember getting into trouble and being scolded. I actually had a reaction to it and my hands were crippling up and I had pins and needles. It was like I was this naughty girl in this situation and here I was taking too much gas—how dare I!

Another thing I would like to mention about the treatment in hospital is that I always felt like I was on show. Crown Street was a teaching hospital, therefore I always had these doctors around discussing me and my body like I was an object. The same thing happened in the labour ward. I have some recollection that I was just about to give birth and there was a yell at the door and, next thing, the room was full of these male doctors witnessing me giving birth. One of the major things I remember is some nurse holding my hand, and I do not know how I would have coped without her holding my hand. It was like I had some connection with the human race, that I was not just this thing on a bed shooting out this baby they were going to take.

They put a pillow over my head or up here so I could not see her. She was taken away. I was drugged. One doctor told me I was drugged so much that he thought I would have been comatose. I thought she was being born about 7.30 at night, and I was astounded to read in my medical records that it was 3.41 in the afternoon. I lay in a corridor all that time. I must have been practically unconscious, because it was 7.30 when I started to recognise a clock on the wall. I was eventually taken to the maternity wing at 8.30. I now have my medical records which confirm all these times. I was put in with other women, who must have been married because they had their babies with them, and I could hear babies crying and I did not know if it was my daughter. In the morning I was taken out to Lady Wakehurst, a home—upstairs for pregnant women and downstairs for all the women who did not have babies.

In my submission I have listed that at 3.41 my daughter was born and I was administered 200 milligrams of Pentobarb. I remember when I was taken to Lady Wakehurst being put into this huge ward with beds around it. I was astounded when I got my medical records to find that every night I was administered 100 milligrams of Pentobarb before sleeping. Then, the night before I was to sign the papers—all the dates are in the submission—interestingly enough, at 9 o'clock I was given 100 milligrams of Pentobarb and then at 11 o'clock I was given another 100 milligrams of Pentobarb. I wonder how off my face I was to be able to take in all the information about the consent forms.

I remember sitting out in the garden with one person only. If I understand the law, there was supposed to be a justice of the peace with us to witness that I was informed correctly of the dire consequences of what I was doing. I do not remember a second person; I just remember one, and there is only one name on the paperwork I have. From memory, the paperwork says things like "I am giving up all rights to my child forever, irrevocably." To be

told all that information, that I would never see her again, and then to be told also that I have a 30-day revocation period, I wonder how much I could have taken in. The first message was so strong, and I was so doped.

Did they give these drugs to women who were married and were having babies? I did not have them with my second birth. I cannot find anywhere in the paperwork where I gave permission for this. I do not know whether one is supposed to. On 9 January I was socially cleared and I could leave hospital. I would also like to place on the record that the social worker's one sheet stated at the bottom that I saw my daughter and we had a lovely little chat about her. When did I see her? I was taken from the hospital that morning out to Lady Wakehurst. I do not believe that I have seen her and had a little chat about her. This is where I see myself as a bit different from a lot of the other stories I have heard. Some of the women actually got to see their children. Some of them were in homes and had a different story from mine.

The Hon. Dr A. CHESTERFIELD-EVANS: Were you advised how you could ensure that the name of the baby's father would be included on the baby's birth certificate?

Ms McNEIL: I have no recollection of being advised of that at all. One of the things that they told me was to go home and just forget about it all. I did a really good job of that. At least I remembered that I had a baby. Some women did such a good job that they even forgot that. One of the things I buried was his surname. We had a relationship for six months or more and I lost his surname. So, I was really counting on this information being on the birth certificate. I was coming up to a reunion with my daughter and I hoped I would have some recollection. I was not told, because I am sure he would have come down from Newcastle and signed it. But I was not told that is what I had to do.

The Hon. Dr A. CHESTERFIELD-EVANS: Do you consider that any of the practices you experienced in relation to the adoption of your baby to be unlawful or unethical? Give examples if you feel you have not covered them. You may feel you have.

Ms McNEIL: For me the drugs were unethical. I do not feel like I gave informed consent when signing the papers. I wish I had been told. It is either illegal or unethical—I think illegal—that I was not given all these different choices. Some finance was available. I do not know what I would have done but I am angry that I was not given a choice. Maybe there was a way. To think that they knew what a terrible thing I was going to do for me and my baby, and they still encouraged it to happen.

The Hon. Dr A. CHESTERFIELD-EVANS: How has this experience affected you?

Ms McNEIL: Very much. I spent a lot of years of my life completely cut off from my emotions. I think I was so judgmental of myself: how dare I give away my baby; that I had no rights to happiness after that. I have done a lot of work in different counselling session groups where I just felt so divorced from myself. I could tell the story of Cheryl, whose baby was adopted, without a tear. I would be quite coherent and just knew this story and there would be no emotion. At least now when I start to fill up I know I am more connected with myself. There was the shame and the stigma. I kept it a secret for so long and I found that really hard.

There was also my memory. People tell me that I have post-traumatic stress disorder because when they told me to go away and forget it I just forgot my teenage years and my childhood. I keep photographs because it is the only way I know I have memories of my life, and it was a way of recalling things because I cannot trust my memory. Chunks get taken away. Sometimes I wonder if I am going to learn more about what happened to me later on because of the way I have shut my memories down. And, of course, there is the loss of my relationship with my daughter, the years that I have not had, and the loss my second daughter has suffered.

The Hon. Dr A. CHESTERFIELD-EVANS: What measures do you believe can be put in place now that might help people experiencing distress as a result of past adoption practices?

Ms McNEIL: I had quite a long list in my submission. There are a number of things that I think are really important. First off, a lot of cost has been involved in regaining knowledge about myself. The other thing I feel really frustrated and angry about is that when you get in touch with the department, which was my place of contact, I did not get all the information from the different places there are. Yes, I got my file, then someone said, "But you are entitled to your medical records." So then I spent more money and I went off into a different place. Even now I have ideas that I might be entitled to other paperwork.

Is there not somewhere that knows all the different paperwork that was drawn in all the different circumstances that can give me a list and say, "You are entitled to all of that. Here you go," and not charge us? You have had our babies. What else have we got to pay out? There are many women out there that are on low incomes and cannot afford even a reduced rate. So, they do not do anything. Funds should be available for women and adopted children who want reunions. If I wanted to make contact with my daughter, she lives a long way away and STD phone calls are involved in trying to establish some sort of relationship. Darwin to Sydney is so costly.

Is there any way of accessing funds to assist in physically getting together and maybe carrying on some sort of relationship? Maybe there should be centres where people trained in post-traumatic stress disorders can give counselling, but they should not be connected. I have great concerns about counsellors who may have been consent takers years ago giving support to mothers. How on earth can those people hear the distress against a consent taker? Ethically I do not believe they should be in the room. I have a real issue with that. Therefore, these centres should be staffed with trained people, but not from backgrounds of adoption.

These places should not be the centres that these women went to and lost their babies. Some of them are having to go back to the same building that took their babies. How on earth can you go to a place like that for help? But they are there. Another thing I would like is that the public, especially adopted children, know the truth. Often the stories about us were horrendous: prostitutes, drug addicts, not worth a cent, we could not wait to get rid of our babies. That is not the truth. The truth is that we loved you so much that we believed that we were doing the right thing by letting you go. Now I find out that that is not so. How many children out there think they were not cared for? We were told that was the best thing for you. To do that they drugged me and kept my daughter from me.

The last thing is that I would like adoption to be illegal. There must be other ways to keep mothers and children from being permanently separated. I appreciate that there are situations that need respite for the mothers because of a whole heap of issues. I do not know whether it is Sweden or another country where adoption is illegal. Can we find out what they do over there? More funds should be given to the Department of Community Services and organisations like Family Support, where I work, because part of my job is to help families, try to keep children staying with the parents. We need more funds. The department and Family Support need more funds.

CHAIRMAN: In your submission you make other suggestions and also state that the inquiry by this Committee into parent education and support programs is a good idea.

Ms McNEIL: I do very much agree with it.

CHAIRMAN: Do you have anything else to add?

Ms McNEIL: No. I think that is it. I appreciate the opportunity to speak to this inquiry. I am pleased the Government is looking at this issue.

(The witness withdrew)

JILL ELIZABETH DAVIDSON, Social Worker, Australian Association of Social Workers, affirmed and examined, and

JILL TALTY, Social Worker, Australian Association of Social Workers, sworn and examined:

CHAIRMAN: In what capacity are you appearing before the Committee?

Ms DAVIDSON: As President of the New South Wales branch of the Australian Association of Social Workers.

Ms TALTY: As a member of the Australian Association of Social Workers. I am a former president of the association and a social worker at Crown Street Women's Hospital from 1973 to 1983 and at the Royal Hospital for Women, Paddington from 1983 to 1990.

CHAIRMAN: Did you each receive a summons issued under by hand in accordance with the Parliamentary Evidence Act?

Ms DAVIDSON: I did.

Ms TALTY: I have.

CHAIRMAN: Are you conversant with the terms of reference of this inquiry?

Ms DAVIDSON: I am.

Ms TALTY: I am conversant with the terms of reference.

CHAIRMAN: Do you wish your submission to be included as part of your evidence?

Ms DAVIDSON: Yes.

CHAIRMAN: Do you wish to briefly elaborate on that submission?

Ms DAVIDSON: No, I will answer questions to the submission.

Ms TALTY: I am here as a support person for Jill.

The Hon P. T. PRIMROSE: What is the role of the Australian Association of Social Workers?

Ms DAVIDSON: The role is in keeping with its objectives, which is to provide as an organisation a venue for developing professional identity, and that involves journals, bulletins, newsletters, et cetera. It is also to establish, monitor and improve practice standards, and that is by looking at the approval of the schools of social work in Australia and in providing education for social workers. We have a continuing professional education policy and an ethics committee in the New South Wales branch that looks at standards of practice and is a venue for complaints by people. That committee investigates complaints and can take disciplinary action against members of the AASW. We contribute to the

development of social work knowledge through education and research, provide a forum and structure to advocate, and we actively support social structures and policies in the promotion of social justice in responding with submissions and being active in a range of other activities.

The Hon P. T. PRIMROSE: Can you explain the social work principle of client autonomy or self-determination?

Ms DAVIDSON: I refer the Committee to pages 6, 8 and 9 of the submission. Client self-determination is a major tenet of social work practice and has been for many years. That is about not telling a client what to do; it is about helping clients to work out what is in their best interests and what will work for them. As such that is about exploring with them what options might be available both internally in their environment, family, extended family, et cetera, and externally in financial assistance and other options like that. It is very much about helping clients and working with them to work out what is feasible and reasonable for them. It may not be ideal, but it is what is feasible for them.

The Hon P. T. PRIMROSE: Can you describe the role of social workers and adoption services in New South Wales from 1950 to 1998? Can you refer to the role of social workers in taking consents?

Ms DAVIDSON: In regard to adoption, by and large social workers are employed in two main areas—in hospitals and in the Department of Community Services and adoption agencies. Hospital social workers have never taken consents. When we are talking about consents and the role of social workers, we are talking about social workers who are working in the Department of Community Services or adoption agencies. There have not been a huge number of social workers working in the Department of Community Services, or the Department of Child Welfare as it was previously, mainly because social workers felt some dissatisfaction working with the department as they felt it lacked a level of professionalism.

In regard to social workers being involved in consent taking, that was as workers employed by those agencies. They would be called in to visit the mother—perhaps before the birth in relation to private adoption agencies, and usually after the birth in relation to the Department of Community Services—to talk with her, to get some background information, and to double check that this was what she wanted to do. Usually they would call back on a separate occasion to take the consent. That is my understanding, as I have been told by my members who have worked in those agencies.

Ms TALTY: This is subsequent to 1965.

Ms DAVIDSON: Prior to 1965, often solicitors for private agencies were the ones who took consents, so social workers may not have been involved at all at that point.

The Hon P. T. PRIMROSE: The Committee has received several submissions from women who are upset that the name of the birth father was not recorded on the birth certificate, despite the name having been recorded on the form of information. The Committee has been informed that the birth father's name would appear on the birth certificate only if the mother filled out a separate form. Was it routine practice for social workers to inform women of the procedure, to ensure that the birth father's name appeared on the certificate? If not, why not?

Ms DAVIDSON: Again I have to make the distinction between hospital social workers and those working in adoption agencies. Social workers working in hospitals would be involved in talking with a mother about the father's name being on the birth certificate only in the case of those who were keeping their babies and not having them placed for adoption. In circumstances where a mother was having her baby put up for adoption, it would be the worker from the adoption agency who would be involved in that discussion. Certainly, in the case of a social worker working in a hospital, it would be expected that he or she would discuss fully with the mother what needed to be done, what the implications were, the name for the baby that she wanted to go on the certificate, and that if she wanted the father's name it would be necessary for the father to sign, I think, a statutory declaration in front of a JP to give his permission for his name to be given. It would be expected that that would be part of the social worker's role and service.

The Hon P. T. PRIMROSE: The Committee has heard that until the 1970s it was common practice for women considering adoption to be separated from their babies at birth and directly afterwards. This practice was thought to assist the mother to cope with adoption. It has been suggested to the Committee that denying the mother access to her baby before an adoption consent had been signed may have been illegal. Did hospital social workers explain this practice to women before the birth and/or give them an opportunity to object? Would failure to allow a mother that choice contravene the principle of client self-determination?

Ms DAVIDSON: With something distressing, like having your baby put up for adoption or having your baby die, the common view at the time was to get over it as quickly as you possibly could. Women who had stillbirths were told to put it behind them and to have another child shortly. Women who had babies adopted were encouraged in a similar way. Through the 1970s that view changed, as more research and literature came out about loss and grief. As that came through, so changes occurred in practice. Rather than not encouraging a mother to see her baby, you would be encouraging her to see her baby. However, if a mother at any time voiced the view that she wanted to see her baby—even if she did not ask it clearly, but if she voiced it in terms of, "What does my baby look like?", "What is my baby's hair colour?" and things like that—it would be expected of a social worker to talk with her about whether she did want to see her baby. If that were the case, arrangements were then made for mothers to see their babies.

CHAIRMAN: The Committee has been told that this practice continued certainly until the late 1970s. Is it possible for you to specify a date?

Ms DAVIDSON: If you are looking at the literature that came from overseas on loss and grief and those implications, that was beginning to be published in America and Britain in the early 1970s, so I would say it would have been filtering through towards the late 1970s, in terms of time for a change in practice. I should add that I know from speaking to people like my colleague on my left, as well as many social workers, that they also were giving education classes to midwives and other staff in hospitals to explain that the mother had a right to see her baby if that was what she wished.

The Hon P. T. PRIMROSE: Before material such as that of Elizabeth Kubler-Ross became available, was it based on prejudice, or was there a theoretical basis for saying, "Let us hide it"?

Ms DAVIDSON: I am not sure what you mean by "based on prejudice".

The Hon P. T. PRIMROSE: If the policy was changed by the work of people like Kubler-Ross, what was the basis for the earlier practice?

Ms DAVIDSON: I do not know; I cannot answer that. I would have to research it.

CHAIRMAN: The Committee has heard from a previous witness about the administration of drugs, large quantities of gas, and so on. Are you able to comment on how that affected either the explanation to the women or their capacity to take in what was said to them?

Ms DAVIDSON: I think that if they were drugged in any way, that would have to be obvious. If any of us are under a high dose of medication, we are not capable of hearing properly and taking it in. I would expect that if a social worker thought that the mother was in a drugged state and not taking it in, he or she would return at a later date to talk with the mother about it. It depends how drugged the person was. Obviously, if a person is very drugged it is obvious; if the person is not so drugged, I do not know.

The Hon. Dr A. CHESTERFIELD-EVANS: You drew a distinction between social workers who worked for the hospital and those who worked for the Department of Child Welfare, which became the Department of Community Services. You suggested—I am not sure how definitive you were about this—that it was a low-status job, that working for the department was regarded as—

Ms DAVIDSON: I did not say "low status". I said it was not as satisfying because there was not a high degree of professionalism there, in terms of things like professional development and supervision, for example, whereas in hospital settings there has been a long history of the provision of supervision and professional development.

The Hon. Dr A. CHESTERFIELD-EVANS: Would that have meant that those who had those jobs would have preferred to be in alternative jobs; that it was not the pick of the social work jobs and that those people were, at an institutional level, leaned on by the department in a way that other social workers may not have believed made for optimal practice?

Ms DAVIDSON: Firstly, I make the distinction that often when we refer to social workers in the department they are not always qualified social workers. It is a common term; we do not have registration of title. Therefore, a lot of people who may have no social work training whatsoever can be called social workers. Secondly, I know that when I was training, cadetships were offered to the welfare department and people then served out their terms after training. Most of them served out their terms and then left.

The Hon. Dr A. CHESTERFIELD-EVANS: In that sense, they were almost apprenticed and fairly dependent on—

Ms DAVIDSON: They were not apprenticed, because they were qualified by that stage,

but they had to serve out the term.

The Hon. Dr A. CHESTERFIELD-EVANS: They were going from university into that environment without a background of experience with other social workers. Therefore, they were isolated in a practising sense?

Ms DAVIDSON: They could well be isolated, not receiving regular supervision. That would be one of the concerns that you would have in that situation.

The Hon. Dr A. CHESTERFIELD-EVANS: Some of them were unqualified, and others were relatively new to the profession; they had not had other jobs, and were obviously inexperienced and isolated professionally?

Ms DAVIDSON: They could well be. I cannot say totally.

The Hon. Dr A. CHESTERFIELD-EVANS: So what you have referred to as optimal practice may not have been what was actually happening in that situation?

Ms DAVIDSON: Yes. I could not guarantee that optimal practice occurred across the board at all times. We are dealing with human beings.

The Hon P. T. PRIMROSE: While the availability of non-adoption alternatives was very limited before the mid-1970s, was it usual practice for social workers to explore non-adoption alternatives with a mother considering adoption?

Ms DAVIDSON: Yes, certainly, that would be expected. It is part of the self-determination aspect. It is about exploring with the mother. Even if a mother says, "I just want my baby adopted", your starting point should be, "Let us go back to when you found out you were pregnant. What did you do then? Who knows about this?" You should try to find out what supports might or might not be there. You should ask, "Have you talked to your parents about this? What are they doing? If you cannot talk to your parents, is there any other extended family member who may be able to assist in this?" That would be part of working out what options might be there, and that is what would be expected.

Ms TALTY: We are talking about the mid-1970s. I would say that what Jill has outlined would be very much standard practice.

The Hon P. T. PRIMROSE: As well as being what was expected, that is what you believe generally happened?

Ms TALTY: I believe that, yes.

The Hon P. T. PRIMROSE: Would failure to explore such options constitute a breach of social work principles, in addition to the Adoption of Children Act 1965? The Committee has received several submissions in which it is claimed that social workers did not provide information to unmarried mothers about the alternatives to adoption.

Ms DAVIDSON: I have heard that people are saying that. Obviously I am concerned because if that is the case it should not be occurring or should not have occurred. In talking

to members of the AASW who worked through some of this period, it was not their practice. At the end of the day people are saying they did not always get full information. It is very

disappointing and it is not what one would expect of a qualified social worker in terms of self-determination.

The Hon P. T. PRIMROSE: The Committee has received several submissions in which it is claimed that babies were placed in an adoptive family before the expiration of the revocation period of 30 days, that is after the passing of the Adoption of Children Act 1965. Can you comment on this claim?

Ms DAVIDSON: I have heard from members and I heard earlier today that babies have been placed with an adoptive family prior to the end of the revocation period. My understanding is that it was a dilemma. People did not want babies to become institutionalised, so they tried to place them with a family. There was a lack of foster families in the early days after the 1965 Act. There was pressure from hospitals not to keep babies for any length of time. There is always pressure on hospital beds, as we know. In many ways that is part of the reason babies were placed with adoptive parents. I received these questions only two days ago. I have had only a brief chance to ask about that because it was not something I had looked into. I have spoken to a couple of people who say they are aware of it, but only rarely, and that adoptive parents were very clear that there was a danger that babies could be removed from them. It is not a good way of doing things because it is brutal on the adoptive parents as well. It is brutal on everyone.

The Hon P. T. PRIMROSE: What measures might assist people experiencing distress as a result of past adoption practices?

Ms DAVIDSON: We outlined a couple of things in our submission. I would like to reinforce that the post-adoption resource centre is a very good service. We would support further funding for it. It tries to provide outreach to rural and remote communities, and more is needed to provide that service. The point made by Cheryl, who spoke earlier, about people not wanting to come back to the place where their baby was adopted is clearly the case, and to expect people to return is appalling. We have to be able to provide services for women where they feel comfortable with them, not where it is convenient for us to place the service. As Cheryl outlined, that involves a cost, and I would endorse it. I would also endorse supporting self-help groups and the partnership that needs to develop between the Department of Community Services, PARC and self-help groups so that we can further progress it. Our submission referred to helping women to tell their stories and publicise them so that the message is that it was not something these women did at all easily, but that it was incredibly painful. They did it, as Cheryl said, for love. They did it because they thought it was the only or best option under the circumstances. Their stories need to be told.

The Hon P. T. PRIMROSE: In 1997 the association issued a statement about adoption expressing, "extreme regret at the life-long pain experienced by many women who have relinquished their children for adoption". The Committee has been informed that some post-adoption support groups are dissatisfied with the contents of the statement. Will you describe the background to the development of the statement? Is the association considering taking the statement further by making a formal apology to those experiencing stress as a result of past adoption practices?

Ms DAVIDSON: The statement came about because we were approached by a couple of social workers who were due to attend a conference in about June last year. We were approached shortly before the conference—a couple of weeks or so—about one of us attending. We could not attend on such short notice. We then considered whether we would provide a statement that could be read to the conference, which is how we came up with the statement. I am aware that some people have asked us to issue an apology. At the moment we are considering that, but we need to be clear what we would be apologising for.

I am concerned that social workers, as I outlined in my submission on page two, are often seen as the public face of an organisation. In this instance I am concerned that we are seen as the public face of society. It was not only social workers who were involved, but also doctors, nurses and midwives. Politicians played a role, as did the media, the churches and men generally. Where were the fathers of the children and the fathers of the women? In some ways we are being asked to take on responsibility for the way in which the whole of society viewed women and children, particularly unmarried women who were pregnant in that time. I would like to see it in an overall context. If that is what we are looking at, we would certainly consider an apology.

CHAIRMAN: I assume the association would be happy to deal with questions that come to the Committee as the inquiry progresses?

Ms DAVIDSON: Yes, of course.

(The witnesses withdrew)

TIMOTHY JOHN SMYTH, Deputy Director General, Policy, NSW Department of Health, sworn and examined:

CHAIRMAN: In what capacity are you appearing before the Committee?

Dr SMYTH: Representing the New South Wales Department of Health..

CHAIRMAN: Did you receive a summons issued under my hand in accordance with the provisions of the Parliamentary Evidence Act?

Dr SMYTH: I did receive a summons.

CHAIRMAN: You are conversant with the terms of reference of this inquiry?

Dr SMYTH: I am.

CHAIRMAN: Do you wish your submission, which you have sent to us, to be included as part of your sworn evidence?

Dr SMYTH: I would be happy for that to occur.

CHAIRMAN: Do you wish to elaborate on your submission and make a short statement, or shall we go straight into questions?

Dr SMYTH: At this stage I would like to reinforce the conclusion to our submission: we welcome the inquiry and look forward to the report and its recommendations.

CHAIRMAN: I understand that the two women with you will not give evidence?

Dr SMYTH: No, they will not.

CHAIRMAN: The Committee wants to get on the record a number of facts, but hopes to go through them reasonably briefly because there is more detail in the submission. Will you describe the formal relationship between the Health Commission and the Department of Health and public hospitals in New South Wales during the period under examination by this inquiry, that is from 1950 to the present?

Dr SMYTH: Two basic developments can be summarised. First, the changing nature of the legal entities of public hospitals during that time and, second, a number of changes to the structure and organisation of the Department of Health. Until the late 1980s public hospitals in New South Wales were separate legal entities under the Public Hospitals Act. They had their own governing boards appointed by the Governor of New South Wales and they received funding from the Government, but they were separate legal entitles. In 1986, as a result of four pilots in New South Wales, area health services were set up in the Sydney metropolitan area, the Hunter and the Illawarra. Some 23 area health services were established, and the public hospitals administered by those area health services were no longer separate legal entities; the entity became the area health services.

However, in rural New South Wales public hospitals continued to be separate legal entities. In rural areas in the 1980s public hospitals were amalgamated into larger entities called district health services. Subsequently those entities were further amalgamated to form rural health services. With the passing of the Health Services Act this year, the majority of public hospitals now come under one of the nine area health services within Sydney, the Hunter and the Illawarra or one of eight area health services in rural areas. A separate group of hospitals, known as third schedule hospitals incorporated under the third schedule of the Public Hospitals Act, continued to operate. Generally such hospitals were linked to or operated by charities or church-related organisations, for example St Vincent's Hospital in Sydney and the Royal Hospital for Women at that time.

Those hospitals retained their separate legal identities until the Royal Hospital for Women was transferred to the South-Eastern Sydney Area Health Service during the 1990s. At a departmental level, up until 1972 the funding organisation for public hospitals was the Hospitals Commission of New South Wales. Its basic role was to provide funding and support to public hospitals. Following a review in 1972, the Health Commission of New South Wales was established, which took over the function of the Hospitals Commission. At that time a separate Department of Health also came into the Health Commission. The Health Commission of New South Wales was transformed into a formal department of State—the Department of Health—in 1982.

It was not until the Health Commission of New South Wales was established, and subsequently the Department of Health, that a more formal responsibility for control of what occurred in public hospitals came under the Department of Health, which is an important feature to note. A number of private hospitals were also involved in providing maternity services. They were incorporated under the Private Hospitals Act 1908. There have been some major organisational changes in the hospitals and, similarly, major organisational changes within the Department of Health over that time, which provide an important contextual feature to the Committee's inquiry.

CHAIRMAN: Can you describe the typical maternity hospital practice for women who were considering the adoption of a child during the period under examination by this inquiry?

Dr SMYTH: It is difficult to describe a typical practice because that would vary considerably depending on the nature of the clinical situation of a particular patient. From discussions with individuals and the information that has been provided to me, perhaps I can best indicate some common features. It may be helpful to the Committee if I group those into particular time periods. If we look at some of the practices and features that were generally applied in the period prior to the 1970s—and I am mainly highlighting a number of points here because the actual detail depends on the circumstances of a patient and the clinical condition—there was a general feature that women would have some form of pain relief during and after labour. The most common drugs used for that pain relief were some form of sedative. Epidural anaesthesia only came into practice in the early 1970s.

Following the advent of epidural anaesthesia there was a whole change in attitude towards birthing and greater control by the woman concerned. Up until that time it was common for a woman to have some form of pain relief, generally of a sedative nature. That sedative combination, those types of drugs, would be somewhat stronger when the labour was complicated or difficult, when there had been some form of intervention, such as a forceps

delivery, or when there was some other underlying medical condition or problem.

Typically that would be known as pre-eclampsia—when a woman, particularly young women, had a blood pressure problem and there was concern that the delivery and the birth may create an increase in blood pressure, causing damage. Also, there tended to be a common practice that when the delivery involved a breech delivery—the baby was delivered bottom or feet first rather than head first—a stillbirth or some form of congenital problem, and also in cases of a baby being surrendered for adoption, the baby generally went immediately to the nursery after delivery. It was felt that because of the nature of the birthing experience the woman required rest and sedation. It was common for a sedative to be administered at that time.

As you have heard from previous witnesses this afternoon, it was also routine practice to separate the baby from the mother. The practice of rooming-in, when the baby stays with the mother in the ward after the birth, is a practice that only came into being in the 1970s. Prior to that it was common for the baby to be maintained in the nursery and the mother only to go to the nursery at set times, usually related to feeding. The separation of the baby from the mother, as has been outlined by some witnesses this afternoon, was based on a professional body of knowledge and understanding at that time that it was in the best interests of the mother. We now know that is incorrect. In relation to an earlier question about the body of knowledge, the change in that understanding was particularly due to the work of John Bowlby, which was very informative. Much of his work did not become well known in the profession until the publication in 1969. So again it was the 1970s when attitudes changed.

Certainly for mothers who were intending to have their babies adopted, and in most cases the hospital was advised of that prior to the mother delivering the baby, there was an active attempt to ensure that the baby was separated from the mother at the time of birth. Again, in the 1970s, 1980s and 1990s, we now know that practice was inappropriate. However, the question I am being asked is what was the usual practice during the period under examination by this inquiry. That was based on an understanding, albeit misguided, that it was in the best interests of the mother and would reduce the trauma and sense of loss. Practices such as putting a pillow on the tummy of the mother so that she could not see over the pillow or putting a sheet up in front of the mother so that she could not see the baby was seen as preventing immediate bonding between mother and baby. Although misguided, it was felt to be in the best interests of the mother at the time.

If we move into the 1970s, 1980s and 1990s, there has been a total change in approach. In particular, there has been empowerment of women in the process, an involvement of active discussion with women both before and during the birth as to a birth plan, how they would like the birth managed and, in particular, how they want to approach pain relief. There is now absolute recognition of the right of the mother to have a major say in what is happening and, in particular, the recognition of the rights of mothers and the rights of all patients to be informed about what might happen and their clinical options, and to be involved in decisions about their care. It was not a matter to be left to the doctors or midwives. As I said before, changes occurred in practices, and it is now routine for babies to stay with the mothers. It is now routine for mothers to stay with the babies when they go to the ward from the delivery suite and for women who are considering adoption to be informed about their options.

In particular, there has been a major change from previous practices. It is recognised that the mother remains the guardian of the baby unless and until an adoption consent and adoption process actually occurs. She has the right to choose who she wishes to have with her in the delivery room, for example, who should see or visit her baby. It is acknowledged it is her baby and not the hospital's baby. She has the right to provide a name for the baby. She can be informed and continue to be informed about the health of her baby while the baby is in hospital with her and she has the right to be involved in decisions that might be made by paediatricians or other staff about her baby. A mother who wishes to have her baby adopted has the right to choose how much contact others have with the baby during that process. We would now actively encourage a mother who subsequently decided to have her baby adopted to be able to leave the hospital with tangible memories of her baby, including photographs and other mementos of the birth. Counselling and support would be available not only for the mother but also for other family members and people the mother deals with. No doubt, there has been a major change over that period of time. While I do not think one can nominate a particular year, on the advice I have received generally we would look at before the 1970s and post 1970.

CHAIRMAN: You have talked about the change of philosophy. Our third question asks you to describe the development of the formal policy on adoption which the Commission put out in the late 1970s and early 1980s.

Dr SMYTH: With your permission I would like to answer that question in conjunction with question 4, which asks why it took from the late 1970s to 1982 for a formal policy to be adopted.

CHAIRMAN: I will read that question onto the record and you can answer both questions. Your submission acknowledges growing concern in the Health Commission about hospital practices in the late 1970s and states, "A number of practices have been identified which occur in some public hospitals in relation to adoption matters which are contra-indicated on either mental health or legal grounds." Given the commission's concern about illegal and unethical practices occurring in some public hospitals, why did it take almost four years to produce a formal policy on adoption in 1982?

Dr SMYTH: In 1979 the then Health Commission commenced the development of a formal policy on adoption. That was largely in response to issues and concerns about hospital practice that had been brought to the attention of the Health Commission by the then New South Wales Standing Committee on Adoption. The Standing Committee approached the Commission and with a draft policy statement sought the Commission's endorsement of that policy statement. The process that the Commission felt was appropriate at that time was to distribute that draft statement from the Standing Committee quite widely. From a review of the files it is obvious that it decided to adopt a very wide and consultative approach. It distributed it extensively and sought comments, and many comments were received. Following that consultation the formal policy was then determined and released. However, I would have to agree that the period of time, from 1979 to 1982, was far too long and it was certainly a very protracted process.

In agreeing that it was far too long, I would also emphasise that the actual distribution of that draft policy statement in 1979 led to changes in hospital practice. It was not as though

nothing happened until 1982. Also, as you have heard earlier this afternoon, the body of knowledge amongst the professionals, doctors, nurses, social workers and psychologists, was starting to change and so practices were changing. The very issuing of that draft statement for comment in 1979 was a catalyst for many hospitals to look at whether they had a policy; if they did, to revise it; and if they did not, to develop a policy. Again, while I agree that the period from 1979 to 1982 was too long, the catalyst in 1979 did start to lead to changes.

The Hon. Dr A. CHESTERFIELD-EVANS: To clarify that, I gather from what you are saying that there were not formal policies up until that time, or if there were they were hospital based and would have varied between hospitals. So, firstly, they may not have been written and, secondly, they would have varied between hospitals if they were written. Presumably if they were not written they would have been influenced by the beliefs of personalities within the hospitals at the time. There may have been differences between religious and non-religious hospitals and between schedule 3 and non-schedule-3 hospitals? Are all those things likely to be so?

Dr SMYTH: The first point is, as I outlined in my answer to question 1, the actual operation of the public hospitals were a matter for those public hospitals and their boards. The Hospitals Commission was primarily the funder of the hospital. In terms of the legislation governing the Hospitals Commission, Health Commission and subsequently the Department of Health, the legislative power of those bodies to direct hospitals only came into being in the 1980s. In that sense, they would have been locally determined practices and policies up until the late 1970s in issuing a draft policy. As to whether there was a difference between charitable and religious hospitals as against the formal public hospitals with boards appointed by the Governor, I am unable to provide any particular comment on that. The possibility is that the ethos of those institutions would have influenced their practices. Clearly that is a possibility. There is no doubt that following the release of that draft policy statement in 1979 it did lead to a process of starting to standardise policies.

The Hon. Dr A. CHESTERFIELD-EVANS: If there were differences, they would not be documented. They would be practices and not written policies. Is that correct?

Dr SMYTH: The Department of Health does not have any documentation on those. If they existed they would be held by those particular hospitals. A number of those hospitals no longer exist.

The Hon. Dr A. CHESTERFIELD-EVANS: What was the procedure in public hospitals to secure consent for the administration of drugs to patients during the period under examination by this inquiry, 1950 to 1998?

Dr SMYTH: There is no separate procedure for consent to drugs. The consent process is in relation to the overall treatment. Generally the practice would have been to have some discussion with the woman about what might happen during the confinement and delivery. However, as I indicated earlier, there has been a major change in the approach to that, particularly since the 1970s and particularly since the release of the Shearman report in 1989, which was a major review in New South Wales of maternity services. So we see a transition from the 1980s and the 1990s, where detailed information would be available. There would be antenatal childbirth classes, discussion with women about how they would like their birth

managed. In many cases there would be a written birth plan that the woman determines, and that is the way it will be unless there is a clinical emergency. Also, there is now far greater availability for a woman to know which midwife will be attending the birth and, wherever possible, that midwife sees the woman beforehand. Similarly, the attitudes of the medical profession have changed and the law has changed. There is far more information and discussion involved between a medical practitioner and patient now than there would have been in the 1950s and 1960s. I emphasise there has not been and there is not a separate consent process for drug administration as part of the consent to the admission or treatment itself.

The Hon. Dr A. CHESTERFIELD-EVANS: The Committee has received several submissions in which it is claimed that women who were expected to relinquish their babies to adoption were given higher doses of drugs before, during and after the birth of their babies than women who were not considering adoption. Can you comment on this claim?

Dr SMYTH: It is difficult for the Department of Health to comment on that claim because, as I said before, the practices and operations at that time were determined locally in the public hospitals. However, the comment that I can provide, based on discussions we have had with a number of individuals, is that we are not aware of a specific direction that a women who was surrendering her baby for adoption was to be given a higher dosage of drugs. It was, as I outlined earlier, more in the context that particularly up until epidural anaesthesia was available it was routine that a mother would have some form of pain relief and generally that was of a sedative nature; that when the birth was difficult, physically, clinically or emotionally, they were more likely to receive some form of sedative. If it had been decided or was being considered by the mother that the baby be surrendered for adoption, that would be regarded as one of those situations when it was in the best interests of the mother that she should have some form of sedation after the birth, basically to have a rest. I emphasise that we now know that that is not the case, but at that time that was a genuinely held belief.

The Hon. Dr A. CHESTERFIELD-EVANS: It would, however, be possible to study retrospectively the record of mothers who had and had not given up their babies, and compare the doses that they received.

Dr SMYTH: Provided that the clinical records were available at the time, some form of structured retrospective study would be possible.

The Hon. Dr A. CHESTERFIELD-EVANS: But such a study has not been undertaken?

Dr SMYTH: I will have to take that question on notice. I am not personally aware of a study having been done, but I will find out and report back to the Committee.

The Hon. Dr A. CHESTERFIELD-EVANS: The 1982 policy on adoption states that one of the practices that led to the development of the policy was a concern that undue pressure was being placed on unmarried mothers to surrender their infants for adoption. From which group of professionals did that pressure emanate?

Dr SMYTH: The Department of Health is unable to give a specific answer to that question, in terms of a particular group of professionals. In light of the discussions that I and officers in the department have had, the comment we would make on this issue is that, first, in the

majority of cases—but certainly not all—of women surrendering a baby for adoption, the decision had been made prior to confinement. The women actually arrived at the obstetrics unit with the papers marked that the mother had decided that the baby was to be adopted. In that case the assumption would be that any interaction with health professionals would have occurred prior to arrival at the hospital.

The second comment I would make is again in the social context. At that time there were limited options for women, particularly single women. There was pressure from family, possibly pressure from their partners and others, and the general social attitude, and the expectation from people in the hospital at the time would have been that adoption was the right thing to do. In that sense, while particular pressure from individuals on the mother was unlikely to have been a common event, the general expectation that adoption was going to happen would have coloured people's views and attitudes and the way they dealt with the mother at the time. I think probably the major influence was that the professionals were reflecting the attitude of society at that time. That was reflected in their manner and in the way they dealt with the mother at the time.

The Hon. Dr A. CHESTERFIELD-EVANS: Did the practices of concern that led to the development of the 1982 policy of adoption include refusing women access to their babies before they had signed a consent to adoption, and failing to respect the mother's right to choose the name for her child? Does the department consider that it failed in its duty of care to these women by allowing such practices to occur over a period of several years?

Dr SMYTH: The first comment I would make is to reinforce that even though we now know that those practices were inappropriate and misguided, they were believed to be right at that time, based on the clinical body of knowledge. In regard to the concept of duty of care, that has to refer to the circumstances, standards and reasonable practice at that time. The second issue, as I outlined earlier, is that the department did not directly operate the public hospitals; they were separate legal entities. The issue of duty of care to a patient at that time is more a matter for the particular legal entity involved. As outlined in our submission, the practices were misguided and wrong, but they were based on what people felt was right, professionally and clinically, at that time. In that sense duty of care would have been based on those standards.

CHAIRMAN: Some of those practices go beyond misguided and wrong, do they not? Were they not illegal?

Dr SMYTH: If that were the case—at this stage that would be based on anecdotal information—one would need to look at the circumstances of the particular case and examine the legal issues. That would generally come down to looking at who were the particular practitioners involved in that woman's care and what happened at that time, and what was regarded as reasonable practice then. Each situation would have to be assessed on a case-by-case basis.

CHAIRMAN: Anecdotal it may be, but remember that the Committee has based these questions on extracts from the department's files that you have given us, that provided the history of the adoption of the new policy in 1982. We are not referring to statements that have been made by some of the women here, for instance. We are referring to statements contained in the department's files on this matter.

Dr SMYTH: I understand now. Thank you for clarifying the point of the question. Those circumstances that are listed in the 1982 policy were based on information provided by the former Standing Committee on Adoption to the former Health Commission. That policy statement was repeating what had been provided to the commission by the Standing Committee on Adoption. It was basically listing what they had been told by others.

CHAIRMAN: Yes, but a department does not normally act on something it does not believe to be true. The departmental process shows that a standing committee put forward statements. Obviously the standing committee had investigated those and was not putting forward statements it did not believe could be backed up. The department was moving towards changing its policy in response to the things that were being said. Those are pretty strong grounds for believing that the abuses or illegalities in fact happened.

Dr SMYTH: Again I think we need to draw a distinction between two issues. One is, were the practices occurring? I would agree that the evidence would suggest that the practices were occurring in some instances. How was the Commission advised of that? Principally through the material that came to the Commission from the Standing Committee on Adoption. No, we would not be arguing that those practices did not exist in some instances. That is not an issue. We agree that they did occur.

Secondly, were those practices appropriate? No, they were not. Again there is no issue involved on the part of the Department of Health or former Health Commission about whether they were appropriate. Clearly they would not have come forward to suggesting a policy and then issuing a policy if they did not agree that those practices were inappropriate. Your question goes on to ask about the duty of care. That is a legal term. I draw a distinction between the issue of duty of care by the Department, as distinct from a health care practitioner involved in the care of a particular woman, and also the separate legal status of the public hospitals and third schedule hospitals. That issue has to be determined on the facts of each case.

CHAIRMAN: Are you saying that the breach of duty of care may rest with the hospital rather than with the commission?

Dr SMYTH: I am saying that it is a legal issue and it is very unlikely that the former Health Commission had a legal duty of care to a particular woman who was surrendering her baby for adoption. That is a legal issue that depends on the fact of the particular case. I am drawing that distinction.

CHAIRMAN: The Committee can obviously follow up that issue.

The Hon P. T. PRIMROSE: The reassurances you have given—I think you used the expression "in some instances"—are based upon anecdotal information?

Dr SMYTH: In terms of my being here representing the Department of Health, yes, that has to be based on what is in the departmental files and what we have read in other reports and material. Clearly, in relation to changes to the legislation regarding adoption, there have been a number of inquiries and Law Reform Commission reports that clearly detail that there were practices in the past. Albeit at that time they felt they were doing the right thing, there is no doubt that those practices were inappropriate and misguided.

CHAIRMAN: Those present in the gallery cannot hear your answer. Would you move closer to the microphone.

Dr SMYTH: Based on the information in the departmental files, on discussions with a number of individuals in the New South Wales health system, and also a number of Law Reform Commission reports in relation to adoption legislation, there is no doubt that there were practices. Albeit at the time people involved thought they were doing the right thing, in light of what we have learned in the 1980s and the 1990s, they were inappropriate and they were misguided.

The Hon P. T. PRIMROSE: I do not know whether you are in a position to answer this question, but I will be guided the Chair. You have outlined the development of the history of the Department, the Hospitals Commission and the Health Commission. I presume that there is no suggestion of oversight responsibility when you had a Hospitals Commission, of individual hospitals' probity, actions or policies. You had a Hospitals Commission and if there had been a major incident in a hospital or with implementing government policy on health, I presume the Hospitals Commission would have had a role in that.

Dr SMYTH: I would have to obtain more information for the Committee on that issue, because I was not working in the health system at that time.

The Hon P. T. PRIMROSE: I am interested in obtaining that information. I am interested in tracking back the chain of responsibility and the duty of care. The department says, "We are not responsible for what the Health Commission did" and the Health Commission would say, "We are not responsible for what the Hospitals Commission did, and in any case we have these individual boards of directors. We were not responsible for what happened there." I am interested in the transitional clauses in the legislation that established those. What and who was responsible? Or in fact was no-one responsible?

Dr SMYTH: I will be happy to get more information on that. It clearly relates to the legislation at that time.

CHAIRMAN: I suppose there are two issues. One is obviously that the department may wish to take some legal advice on exactly what the position is. There is also a factual situation relating to the wording of the legislation at that time. There may be other matters which throw light on it: if a major incident occurred at a public hospital, who was ultimately responsible? Who represented the Government?

Dr SMYTH: Yes.

CHAIRMAN: Has the department updated its adoption policy since 1982?

Dr SMYTH: The department's policy of 1982 has been overtaken by significant policy changes in relation to the whole issue of maternity care in New South Wales. I referred to the Shearman report of January 1989. I think in a nutshell that revolutionised the approach to maternity services in New South Wales. A second updating—I used the term "overtaking"—is that the process of releasing that draft statement in 1979 for comment led to hospitals looking to develop their policies; where they had policies, updating them; where they did not have

policies, developing them; and where they may have had policies that were not written down, actually putting them in writing.

I can provide the Committee, if it wishes, with examples of those policies. I was Chief Executive Officer of the Hunter Area Health Service before joining the Department last year and I have brought with me the policy of the John Hunter Hospital maternity unit on adoption. In addition there have been further circulars on related matters. There was a circular about legislation change, for example. The Adoption Information Act circular was issued in 1991 and there have been further circulars relating to the issue of policy in relation to consent to treatment. In that sense the 1982 policy has now been well and truly overtaken through those processes. However, as we have indicated in our submission, we welcome the inquiry and look forward to the report and its recommendations. They will provide the Department of Health with an opportunity to develop a major code of practice for adoption in the New South Wales health system and that is a project we will pursue on the outcome of this inquiry.

CHAIRMAN: Can you say what measures might assist people experiencing distress as a result of past adoption practices?

Dr SMYTH: Again, in the light of developing knowledge, particularly since the 1970s, there has been a recognition that the adoption process does involve grief and a sense of loss and that there is a need for women who have experienced distress, and other family members in that process, to receive support. It would appear on the information that has been provided to me from talking to individuals that there is a set of issues around access to information. Although there is now a legislative framework for that—the Adoption Information Act—clearly part of the process of assisting women experiencing distress as a result of past adoption practices is access to information about what happened to their babies. The New South Wales health system does make that information available and there is a process for that, as outlined in departmental circulars.

Secondly, there is a real need to provide support and services, particularly in the nature of counselling services, and the New South Wales health system provides a network of those services. They are available in a variety of settings. They do not have to be in a hospital and certainly do not have to be in a maternity unit. We have more than 200 community health centres across New South Wales. We continue to develop our mental health services and we now have an extensive network of community-based mental health services and counselling staff. Social work departments in hospitals and in the community health sector are also available and, as has been mentioned before, other services such as the post-adoption resource centre. We would encourage women who are experiencing distress to seek assistance from persons they have confidence in and they have trust in. Another group they could approach is their general practitioners if they believe that the general practitioners could assist them in that process. The primary port of call would be their local community health centres or their general practitioners.

CHAIRMAN: Given that the Department has acknowledged that past adoption practices in some public hospitals were illegal and misguided and that for some women these practices have created ongoing personal and family distress, does the Department consider it would be appropriate to make an apology to the people affected by these practices?

Dr SMYTH: I think every health professional working in the New South Wales health system would be disturbed by the practices that occurred in the 1950s, 1960s and early 1970s, and we would all want to offer every support and assistance possible to women who have experienced stress as a result of those practices.

CHAIRMAN: I think you have avoided answering the question. Does the Department consider that it would be appropriate to make an apology to the people affected by those practices?

Dr SMYTH: I think clearly the issue of an apology by a government department is a matter of government policy. I would have to take that question on notice and take it back to the Government.

CHAIRMAN: I anticipated a different answer. It may be that the issue of legality and responsibility may have something to do with this question as well.

Dr SMYTH: I would be happy to take that on notice.

The Hon P. T. PRIMROSE: I have another question that you may wish to take on notice as well, as you are under oath. Does the department, and in particular its senior officers, believe that there were or may have been any instances of systematic illegal or unethical behaviour in the past practices of the department, its antecedents or its agencies, in relation to adoption and, if so, what are the specific details?

Dr SMYTH: I have no evidence to suggest that there was systematic behaviour of that nature by the Department of Health, the Health Commission or the Hospitals Commission.

The Hon P. T. PRIMROSE: You are quite happy, on behalf of the department and its senior officers, to give us that assurance?

Dr SMYTH: Your question was in relation to the Department of Health and its antecedents—that is the Health Commission and the Hospitals Commission—and my answer is I have no evidence to suggest that that occurred.

CHAIRMAN: Would you be willing to take the question on notice and perhaps provide a more detailed answer?

Dr SMYTH: I would be happy to take the question on notice. Obviously the issues about the Hospitals Commission extend back into the 1950s, and that would make it very difficult as some individuals are no longer alive.

The Hon P. T. PRIMROSE: Are there files?

Dr SMYTH: There is nothing on the files to support that statement.

CHAIRMAN: I thank all those who have attended today. Although there is an official closing date for submissions, the Committee would be happy to accept further submissions. As I said earlier, the Department of Health, like the Department of Community Services, is willing to respond to matters that arise during the inquiry.

(The witness withdrew)

(The Committee adjourned at 5.04 p.m.)