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PARLIAMENT OF NEW SOUTH WALES

LEGISLATIVE COUNCIL

STANDING COMMITTEE ON SOCIAL ISSUES

INTERIM REPORT ON

INQUIRY INTO ADOPTION PRACTICES:

TRANSCRIPTS OF EVIDENCE

FROM 27 AUGUST 1998 TO 19 OCTOBER 1998

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TERMS OF REFERENCE

That the Standing Committee on Social Issues inquire into, and report on:

1. the professional practices in the administration and delivery of adoption and related services, particularly those services relating to the taking of consents, offered to birth parents and children in New South Wales from 1950 to 1998;

2. whether adoption practices referred to in clause one involved unethical and unlawful practices or practices that denied birth parents access to non adoption alternatives for their child; and

3. if so, what measures would assist persons experiencing distress due to such adoption practices.

The Committee will consider adoption practices in New South Wales from 1950 to 1998. However, the primary emphasis of the Inquiry will be on the practices occurring before the introduction of the *Adoption Information Act, 1990*.

These terms of reference were referred to the Committee by:

The Honourable Faye Lo Po', MP
Minister for Community Services. Minster for Ageing.
Minister for Disability Services. Minister for Women.

COMMITTEE FUNCTIONS

The functions of the Standing Committee on Social Issues are to inquire into, consider, and report to the Legislative Council on:

- any proposal, matter or thing concerned with the social development of the people in all areas of New South Wales;
- the equality of access to the services and benefits including health, education, housing and disability services provided by the Government and non-Government sector to the people in all areas of New South Wales;
- recreation, gaming, racing and sporting matters; and
- the role of Government in promoting community services and the welfare of the people in all areas of New South Wales.

Matters for inquiry may be referred to the Committee by resolution of the Legislative Council, a Minister of the Crown, or by way of relevant annual reports and petitions. The Committee has the legislative power to:

- summons witnesses;
- make visits of inspection within Australia;
- call upon the services of Government organisations and their staff, with the consent of the appropriate Minister;
- accept written submissions concerning inquiries from any person or organisation; and
- conduct hearings.

COMMITTEE MEMBERSHIP

THE HON. JAN BURNSWOODS, M.L.C., AUSTRALIAN LABOR PARTY

CHAIR

THE HON. DR. MARLENE GOLDSMITH, M.L.C., LIBERAL PARTY

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THE HON. ARTHUR CHESTERFIELD-EVANS, M.L.C., AUSTRALIAN DEMOCRATS

THE HON. JAMES KALDIS, M.L.C., AUSTRALIAN LABOR PARTY

THE HON. DOUG MOPPETT, M.L.C., NATIONAL PARTY

THE HON. PETER PRIMROSE, M.L.C., AUSTRALIAN LABOR PARTY

THE HON. CARMEL TEBBUTT, M.L.C., AUSTRALIAN LABOR PARTY

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INTRODUCTION

In June 1998 the Minister for Community Services, the Hon Faye Lo Po', MP, asked the Standing Committee on Social Issues to inquire into the professional practices in the administration and delivery of adoption and related services in New South Wales from 1950 to 1998.

Once the Terms of Reference were received, advertisements were placed in a number of newspapers inviting members of the public and relevant agencies to make written submissions to the Inquiry. By mid November 1998 the Committee had received 246 submissions.

Public hearings commenced in August 1998. Four days of hearings have been held. Those appearing before the Committee included mothers (and one father) whose children were adopted, representatives from the Departments of Health and Community Services, the Australian Association of Social Workers, the Post-Adoption Resource Centre and several church-related adoption agencies. This Interim Report is made up of the transcripts of those hearings. You will notice that to maintain the confidentiality of some mothers their real names are not revealed.

Throughout this Inquiry there has been considerable media interest. Articles have been run in a number of newspapers ranging from the *Australian* to smaller regional and suburban papers. The public hearings have featured on nightly television news broadcasts and current affairs programs both in New South Wales and interstate. Over one hundred members of the public have attended each public hearing.

The NSW Parliament will be prorogued before the end of the year in the lead up to the March 1999 state election. Once this occurs, Parliamentary Committees are unable to conduct any official business such as holding hearings to take evidence. The Committee will use the period from December 1998 to April 1999 to conduct background research, undertake a detailed analysis of the submissions received and prepare some of the introductory chapters of the final report.

It is expected that following the election the Committee will recommence hearings around May 1999. The Committee anticipates taking further evidence from parents, children, adoption agencies and government agencies. At that time, we will write to all those on our mailing list informing them of the hearing dates.

The Committee has decided to release the transcripts of the public hearings held to date. The release of the transcripts from public hearings is an unprecedented step for this Committee. The Committee has made this decision for a number of reasons. Members are very conscious that, for many people, involvement in this Inquiry has been difficult and very emotional. Some people find they are overwhelmed at the hearings and, much to their frustration, unable to remember all that is said. Others have requested access to the transcripts so they can use the information provided to make supplementary submissions. There is considerable interest in the Inquiry from people living interstate and overseas who are unable to attend the hearings. Providing the transcripts to these people will, it is hoped, help them feel part of the process.

WRITTEN SUBMISSIONS

The Social Issues Committee will accept written submissions to this Inquiry up until Monday, 31 May 1999.

In preparing your submission please remember that any material presented to the Committee may be made public once the final report is tabled in Parliament. Should your submission contain information you do not wish to be released into the public domain please clearly label the submission "confidential". It would also be helpful if original documents, such as birth certificates or hospital records, were not included. The Committee cannot take responsibility for returning such items. You are, however, more than welcome to include photocopies.

Want to add to your submission?

If you have already made a submission and, upon reading these transcripts, wish to add to the material you originally provided, please feel free to make a supplementary submission. We will ensure the additional material you provide is attached to your original submission.

All submissions, including supplementary submissions, should be sent to:

The Director
Standing Committee on Social Issues
Parliament House
Macquarie Street
SYDNEY NSW 2000

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.)

TRANSCRIPTS OF EVIDENCE

WEDNESDAY, 2 SEPTEMBER 1998

JUBILEE ROOM, PARLIAMENT HOUSE, SYDNEY

MEMBERS PRESENT:

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

WITNESSES BEFORE THE COMMITTEE:

SARAH BERRYMAN, Senior Manager, Benevolent Society of New South Wales, Post Adoption Resource Centre, and

PETRINA SLAYTOR, Social Worker, Benevolent Society of New South Wales, Post Adoption Resource Centre, and

LYNNE PERL, Social Worker, Benevolent Society of New South Wales, Post Adoption Resource Centre, sworn and examined:

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

Ms BERRYMAN: Yes, I did.

Ms SLAYTOR: Yes.

Ms PERL: Yes.

CHAIRMAN: Do you have a written submission?

Ms BERRYMAN: Yes, I do.

CHAIRMAN: Do you wish to add to the submission, to make a statement or just answer questions?

Ms BERRYMAN: I do have a general statement on the submission of the Post Adoption Resource Centre.

CHAIRMAN: Ms Slaytor, will you be commenting on the submission or answering questions?

Ms SLAYTOR: Sarah has been appointed as the spokesperson.

CHAIRMAN: You will answer questions if appropriate?

Ms SLAYTOR: Yes.

CHAIRMAN: And Ms Perl, you will also answer questions if appropriate?

Ms PERL: Yes, certainly.

Ms BERRYMAN: I will be responding to the Committee's questions as Senior Manager of the Post Adoption Resource Centre—PARC—which is a service of the Benevolent Society of New South Wales, and as the representative and spokesperson of that service. PARC's submission was written in consultation with the staff of PARC: myself Sarah Berryman, Thea Ormerod, Lynne Perl, Petrina Slaytor and Claire Storr. PARC was established in 1991. It did not exist as a service during much of the key period being examined by this inquiry. PARC's submission, the comments and questions that we will be responding to are not a first-hand

account, nor do we presume to define the varied experiences of the women whose children were adopted. PARC has, however, spoken to 32,000 people over the past seven years. Approximately 25 per cent of the people using our service are birth parents, most of which are birth mothers.

We estimate that we have perhaps spoken with up to 8,000 birth mothers. We have therefore had the privilege of hearing the accounts of many women and of assisting them through their search and reunion. Most of our submission deals with the experience of women but we do not wish to discount the experience of birth fathers, who have also been deeply affected by adoption. It is the case, however, that the terms of reference of this inquiry largely refer to the experience of the mothers. What PARC feels able to do, therefore, is to reflect on what women have told us of their experiences and to make some statement about the nature and impact of these experiences.

Each woman who has lost a child through adoption has had a unique journey of loss and has experienced that loss in different ways. In the statements that we will be making we do not want to imply that every woman experienced the same thing in the same way. Throughout our submission and in the response to the Committee's questions here today we will be using both the term "birth mother" and the term "mother". We are aware of the different opinions on the title that should be given to women who have lost children through adoption and we mean no disrespect by our use of either term. I add also that the matter on which we will be answering questions will be PARC's practice and existence over the past seven years only and not prior to that period.

CHAIRMAN: Could you briefly describe the role and history of the Post Adoption Resource Centre?

Ms BERRYMAN: As I said, PARC was established in 1991 to coincide with the implementation of the Adoption Information Act. PARC is a service of the Benevolent Society of New South Wales, which is Australia's oldest charity and until 1992 ran the Royal Hospital for Women at Paddington and which also from 1983 ran a post-adoption service at that same hospital. PARC is a statewide service and provides the following services across the State. We provide information on the Act, on searching and on post-adoption issues for anybody affected by adoption. We have a telephone and face-to-face counselling service. We have an intermediary service, groups and information meetings, training for professionals, referrals to support groups and other counselling services, consultation for regional support groups, resource material and library, and a support group for Sydney Network for Adoption Support, known as SNAS, which is open to all parties affected by adoption, as well as conducting research into post-adoption issues.

PARC employs myself as senior manager, four counselling staff, three of which are social workers, one of which is a psychologist, only one of whom is more than full time, and two part-time administrative staff. We have a register of more than 60 volunteers who are current or past clients of the service and who provide a number of services for PARC and for people who use the service. Therefore, people are able to have a choice of whether to have professional counselling or whether to get more informal support from someone who perhaps has had the same experience as themselves.

CHAIRMAN: In your submission you explore the cultural context of adoption services,

particularly prior to the early 1980s. You say that "adoption has, until perhaps the last decade, been seen by society as a means of 'solving' two problems—that of 'unwanted' children and fertility". Can you summarise the social context for adoptions from 1950 to 1998 with particular reference to the period before 1980?

Ms BERRYMAN: Certainly. Throughout our submission we sought to reflect broadly on what women have told us about the cultural context at the time of the adoption of their children and how society's attitude has impacted upon them at that time and in the intervening years. Our use of the term "unwanted" reflects some of the social language which was evident during the period in question. The period being considered for this inquiry, 1950 to 1988, saw many changes in culture and in what was felt by society to be acceptable behaviour. Attitude towards premarital sex and children born outside of marriage have changed substantially throughout those years. There have been many developments in the availability of financial and family support for single parents and in broad attitudes to single-parent families. Developments in family planning, in the availability of legal abortions and in fertility treatment have impacted on the number of children being adopted and on the number of families who needed to seek out alternative ways of becoming parents.

Before the 1980s there was much less understanding of many concepts which informed current thinking on parenthood and on child development. Much less was known about modern concepts such as grief, trauma, the bond between mother and child during pregnancy or even about bonding and attachment. Little was known of the long-term effects we now know were experienced by birth mothers and arguably by the adopted person and the adoptive parents. There was a powerful belief recalled by many of the birth mothers with whom we speak that adoption was "the best thing for all parties". Women were told they would get over it and would go on to have other children. The adoptive family would have the joy of parenthood and the child would not know the difference.

In some cases all or some of these things were true but in many situations the adoption of the child has had a profound impact upon all parties. Birth mothers did not forget. Some adoptees speak of the difficulties they have experienced, the sense of being different and never quite fitting in, their fears of rejection and of love being withdrawn. We now, as practitioners in the late 1990s, know that right or wrong adoption had, and continues to have, a profound impact. Women whose children were adopted as late as the 1970s speak of tremendous pressure from a variety of sources, including their family, the medical profession, the church and society in general. They speak of being judged morally and being made to feel ashamed. Those whose families did not support their keeping the baby or for whom marriage was not an option had little choice but to have the child adopted. That is a difficult concept for us to take on with the benefit of hindsight and the greater freedom to make life choices now available to young women.

The period from 1950 to the early 1970s was a time of intense government conservatism with intolerant attitudes towards not only unmarried mothers but also defacto couples, homosexuals and those wanting to divorce. The women who have spoken to us about their experiences pre-1980 give many examples of the way that widely accepted language and ways of thinking made their decision more difficult. Blaming language such as unwanted children, fallen women, illegitimate, was part of the cultural context that caused pain and distress to those whom it labelled.

The Hon. Dr A. CHESTERFIELD-EVANS: Your submission states:

> Some women entered hospital with no intention of having their baby adopted, but say that the pressure to consent to adoption and their isolated and powerless position left them no space to make another decision.

You say that these women were caught up in the system that pressured them to consent to adoption. What factors contributed to the isolation and powerlessness of these women? Can you explain how this pressure was applied?

Ms BERRYMAN: Women using PARC services have told us that pregnant and single they felt caught up in an almost automatic system that saw adoption as the obvious solution to their problem. Young women who were without the staunch support of their family and could not support themselves and their coming child could perhaps see that they had no choice other than adoption. Because of the social stigma attached to illegitimate pregnancy many young women had to disguise their situation; many of them were sent from their families in the country to the city or interstate, perhaps even to New Zealand—we speak to many mothers who were in that situation; some had to stay with family members; some had to act as domestic help until the baby came; others went to mother and baby homes; many were not visited by their families during the pregnancy and this increased their sense of isolation; other young mothers had to stay within the confines of the family home only being allowed to reappear once the baby had been born.

The common factor linking the experiences of the vast majority of these women was their being told not to speak of what was happening to them. This often meant that they were ignorant of what to expect from pregnancy or from childbirth and also that they were strongly discouraged from talking about their feelings. Many women tell us that they had to go back to their family homes as if nothing had happened. Therefore, their grief was not acknowledged and the general expectation was that from this point they would get on with their lives and put the whole thing behind them. All of these factors contributed to their powerlessness and isolation. Women have reported to us that societal attitudes at the time dictated that a child was better off with two parents. Therefore, the birth mother was placed in an untenable position: by the very act of keeping her own baby she was deemed to be doing it harm.

The fact that there were so few options for single women could certainly have been experienced as pressure to relinquish the child, particularly for those women who had no family support or who were actively discouraged from keeping their babies. Single pregnant women were frequently reminded by society's attitudes to their pregnancy, by their families and by some health and welfare professionals of the benefit of a two-parent family, of their own ability to provide the kind of care a mother might want her child to have, of the benefit for the child of material stability, of the damage that might be done to their child by the stigma of illegitimacy. Pressure could also be said to be applied by religious institutions because the stigma and negative attitudes towards illegitimacy and premarital sex was very harsh in some religious groups. Many young women vulnerable and without support would be unable to present an alternative to this message, particularly if their family reinforced the view that stated adoption to be the best course of action. The isolation, the shame and the secrecy around adoption possibly contributed to the sense of pressure that many mothers felt at that time.

The Hon. Dr A. CHESTERFIELD-EVANS: You spoke about the social forces and the norms. Who actually applied the pressure? How was this pressure applied in practice? My

understanding is that obstetricians had much to do with it. Were they the main people or were there other people? Who actually got the forms signed?

Ms BERRYMAN: The women who speak to us obviously give us a range of experiences and I do not want to say any one case is the only case. However, those women say that they felt the pressure began almost from the time their pregnancy was noted; that family members, if they were not supportive of the mother keeping the child, would look at adoption as the next choice. Obviously that started the pressure. People within the hospital system, to a degree within the medical system about which women have talked, at that time felt these messages, "If you want the best for your child you should have him or her adopted", "Your child needs a two-parent family", "You wouldn't want anything other than the best for your child, would you", "If you keep your child you will not be giving him or her the best chance in life", no matter by whom they were given, built up pressure to consent to that one act.

The Hon. Dr A. CHESTERFIELD-EVANS: Your view is that it was not an individual group. Presumably the social worker was the person who brought the form. Was that the social worker's role or did obstetricians do that as part of their consultations?

Ms BERRYMAN: Do you mean in regard to signing the consent?

The Hon. Dr A. CHESTERFIELD-EVANS: Yes.

Ms BERRYMAN: The consent was taken in various ways. Our submission certainly covers that later. Obviously there were responsibilities from medical staff, from the way the hospital was run, as we heard in evidence from Dr Tim Smyth last week. The person taking the consent may have been a social worker or a member of the hospital professional staff.

The Hon P. T. PRIMROSE: In its submission the Department of Community Services 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 an order for the adoption of the child was made, whichever was earlier. Three questions flow from that comment. First, are you aware of any cases when the baby was placed with an adoptive family before the expiration of the revocation period? Second, in your view was the past practice of placing a child with the adoptive parents before the expiration of the revocation period an example of unethical or unlawful practice? Finally, your submission states that cases of illegal practice must be examined and the facts exposed. Can you suggest how this can be done and by whom?

Ms BERRYMAN: I am not able to site specific cases of when the baby was placed with an adoptive family, but some birth mothers have told PARC that they returned to the hospital or the adoption society within the 30 days and were told that the baby had been placed. Other mothers remember asking for their baby to be placed straight away to avoid the child spending time in a nursery. I do not have specific cases to bring before the Committee. It was not the placing of the child during the revocation period that was unethical or illegal. Rather it was the circumstances where the mother was not clearly informed of the revocation period or where she returned to revoke her consent within the 30 days and was told that she was too late or that the child had been placed.

In situations where the child was placed with the adoptive family during the 30 days, all parties should have been thoroughly briefed on the revocation rights of the birth mother. PARC believes that the inquiry today and on subsequent dates will provide an opportunity to publicly examine cases and to hear accounts of women who went through these experiences—cases where the rights of the birth mother were not honoured. It will be a chance for as many birth mothers as feel able to come forward to tell of their experiences and to have those experiences validated. It also will give a venue for agencies to be open and transparent about their practices and protocols. Perhaps it would be of interest, for example, to discover how many revocations did occur during the period in question. The submissions and all evidence given throughout the inquiry will form a body of evidence that should help to build a picture of adoption practices during the period in question and the recommendations from the inquiry will, we hope, provide guidelines for any future examination of these issues.

The Hon P. T. PRIMROSE: In your view, what is the long-term impact on women who have experienced unresolved grief and loss through adoption?

Ms BERRYMAN: The nature of the losses experienced by birth mothers at the time of and subsequent to the adoption of their children is complex and may vary depending upon a number of factors. However, the experience of grief and loss is the defining experience that links all birth mothers with whom we speak. Evelyn Robinson, a birth mother who spoke at the 1997 Brisbane Adoption Conference, talked about the mourning of children lost through adoption as being a form of disenfranchised grief. When grief is disenfranchised it is not openly acknowledged or socially supported, and without the opportunities to express and resolve feelings of loss, bereavement reactions tend to become complicated.

As we have stated already, historically there has been a pervasive silence around birth mother grief. There were no rituals to honour the birth or loss of the child and quite often friends and family avoided any mention of the pregnancy or child. The communal silence may have been interpreted by birth mothers as disapproval and may have reinforced their sense of shame. There was also disenfranchisement within the women themselves, within the shame and secrecy surrounding the pregnancy, and birth mothers had little choice but to conceal their grief also or to deny it altogether. So, rather than feelings of grief diminishing over time, the result can be depression and a deepening of these feelings.

Many birth mothers have feelings of guilt and self-blame. Even if they are able to retain a clear sense of their lack of choice and their love for the child they carried they still come up against the beliefs of others. They signed the consent and, therefore, they chose to give away their child. That can be the public perception. Many women whose children were adopted during the period under examination did not see their child at the time of the birth or at any time afterwards. Some remember this as their own choice, whilst others were clearly denied their wish to see the child, yet others returned to the hospital at a later date to see the baby. Mothers who did not see their child were denied any concrete focus for mourning and may have experienced a whole series of anxieties about the child's health and appearance which may have impacted upon reunion with their now adult child. After the loss of a child through adoption the child is lost to the mother, but still lives. The loss, the experience of the pregnancy and the reality of the child not named or publicly acknowledged impairs the grieving process. Do you want me to go on to the second part of the question?

The Hon P. T. PRIMROSE: Yes.

Ms BERRYMAN: This looks at the long-term impact of grief and loss for women. Because the adoption loss remains unresolved, birth mothers often have difficulty dealing with subsequent losses. A new loss or a traumatic situation can trigger the old losses associated with adoption, making the current situation unmanageable. Other birth mothers appear to be and find themselves to be deadened to other losses, seeming to have a dulled reaction to new losses or feeling that their emotions are somehow locked away. Women who experience this sense of emotional separateness speak of their difficulty in trusting others or in sharing intimate relationships. Some also speak of their relationship with subsequent children being damaged by their lack of resolution over the loss of their, usually, first child.

They may speak of being overly anxious or undemonstrative. Other women have spoken of their inability to conceive or to carry subsequent children and link this with the unresolved feelings caused by their first pregnancy, resulting in, for them, no baby. As PARC counsellors we listen with sadness to the grief of women, and some men, who are trying to come to terms with their massive grief and its profound impact on their lives. A significant number of birth mothers speak of their battle with mental illness, alcoholism, drug abuse, relationship breakdowns, health and fertility problems. The only factor these women have in common with each other is the adoption.

CHAIRMAN: Given what you have just said about the long-term impact, can you tell us how PARC designs its services and how you feel it addresses those problems?

Ms BERRYMAN: The main thing is that we try to provide a flexible service, and we listen to what women tell us about what they feel about our services, what they feel would best suit their needs. I am talking specifically about birth mothers, but the same applies to our other clients as well. We do not, for example, put restrictions on how long someone can see us for counselling sessions. Quite often people will see us for a few months, then go away for perhaps six months, a year or two years, then, if they have had a reunion or other issues come up they will revisit our service or use it in a different way. They may come back for counselling for a period. Then they may want to be put in touch with another mother or someone who has a different story, to try to find out about another person's experience. They may come for counselling for a period, then later they may want to come to a group. We try to be flexible and listen to what people want. We try to give people time to claim the services they want.

The Hon P. T. PRIMROSE: The Committee has received details of the non-adoption options available to birth mothers between 1950 and 1998. Although the Committee realises the availability of non-adoption options were very limited, in your opinion were the mothers given adequate information about the options?

Ms BERRYMAN: Once again, it is difficult to generalise about what information women were given without the women themselves being directly consulted, but the anecdotal information given to PARC in the past seven years suggests that birth mothers were very aware of the limited choices available to them, and they were generally without detailed knowledge of financial assistance to which they might be entitled. Prior to 1973, when adoptions were at their highest and when the Federal Government introduced a benefit for single parents, it was difficult for single mothers to get any kind of financial benefit.

If the mother was prepared to commence affiliation and maintenance proceedings against the father, if she had knowledge that this was possible, with the assistance of the Department of Community Services she might have been able to qualify for the section 27 allowance, which provided very basic assistance for the child only. She would then have to be on the allowance for six months before she qualified for the widows pension. The accounts of most birth mothers suggest they did not know they could take these steps. It would be very interesting for the inquiry to discover how many single mothers were actually able to access benefits. The other ways by which a women was able to keep the child were generally marriage or the support of the family. For many women these two options were not on offer.

The Hon P. T. PRIMROSE: Who would social workers have regarded as their client in those days?

Ms BERRYMAN: That is not a question I can answer. As I said earlier, the ambit of PARC really does not go back to that time, nor was it represented in that period.

The Hon P. T. PRIMROSE: If social workers had regarded the birth mother as their client, do you believe they were acting unethically?

Ms BERRYMAN: It is a very difficult question. You are talking specifically about the financial benefits?

The Hon P. T. PRIMROSE: Not explaining options sufficiently, as you outlined earlier in your evidence?

Ms BERRYMAN: Women should have been given full information about opportunities available to them at that time. If that information was not given to women—and that applies to revocation rights, financial benefits and other non-adoption options—then certainly it was unethical for women not to be given that information in a way and at a time when they could take it in.

The Hon P. T. PRIMROSE: So the profession essentially breached its key underlying focus of client self-determination?

Ms BERRYMAN: I am not talking about one profession, I am not talking about any particular individual. If women were not given that information when it should have been made available and made clear to them then that was unethical, certainly. However, I am not blaming a specific profession or set of individuals for that.

The Hon P. T. PRIMROSE: So the unethical behaviour was across a range of professions and it appears to have been systemic?

Ms BERRYMAN: It may have been.

CHAIRMAN: 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 recording his name on the form of information. The Committee has been informed that the father's name would appear on the birth certificate only if the mother filled out a separate form. Your submission says that the absence of the father’s name from the birth certificate caused

grief and regret for many fathers, and created additional stigma for the mothers and adoptees. Could you comment on this and the suggestion that this limited information had financial implications?

Ms BERRYMAN: Once again, although I am unable to speak for individual women whose children were adopted, PARC staff have been informed by significant numbers of women that they believed by recording the birth father's name on the form of information that his name would appear on the certificate. When, perhaps at a much later date, those mothers eventually saw the original birth certificate they were, therefore, very surprised and, quite often, distressed to find a blank space where they thought the father's name would be. Many birth fathers have contacted PARC to get information about their child, particularly since 1996 when new regulations were brought in to allow birth fathers greater access to information.

They also expected to find their name recorded on the birth certificate because they knew the birth mother had given their name and, of course, they may have been involved during the pregnancy and at the time of birth. It is distressing for those men to discover that they were not named on the birth certificate or to learn of the sometimes complicated steps they have to go through, including contacting the birth mother after an absence of perhaps 20, 30 or 40 years, to have their name added to the certificate. For many adopted people the absence of the father's name can be troubling. Without adequate information adoptees, when seeing their original birth certificate, might assume the father was unknown and it may make their thinking about their conception and subsequent adoption more difficult. PARC has no evidence about the financial implications of this.

CHAIRMAN: Can you comment on the extent to which women who have negative experiences of past adoption practices use your service?

Ms BERRYMAN: I am assuming by "negative" the Committee means both the beliefs about the unethical or illegal practices and also the negative set of experiences surrounding grief and loss?

CHAIRMAN: Yes.

Ms BERRYMAN: PARC is contacted on a daily basis by women who have been through either one or both of these kinds of negative experiences and who are seeking information or support. An average of 70 birth parents use our telephone counselling service each month. Many others attend our focus groups to explore aspects of their experience with other mothers, or they come to information meetings to listen to other stories of reunion or to gain knowledge on the perspective of adopted people or adoptive parents. Some birth mothers make contact only to be given information about their rights under the Adoption Information Act and require no further services. PARC involves and consults with many birth parents in its planning and in making sure its services are accessible and meaningful for clients approaching the service.

Out of our 61 volunteers, 16 are birth parents. Several birth parents are on the Sydney network for adoption support management Committee. PARC also has an advisory Committee chaired by a mother whose child was adopted. Recently PARC released the video "The Path Ahead" produced by a birth mother. Other women contribute to the running of PARC by being interviewed by the media, speaking at meetings or writing for our newsletter "Branching

Out". All of these birth parents speak openly about their experiences and are not restricted or scripted by PARC. Their involvement continually informs and enriches our practice and ensures that the service we provide is accessible and meaningful.

CHAIRMAN: Would either Ms Slaytor or Ms Perl, from their points of view as counsellors, like to comment on their experience with mothers who have had such negative experiences?

Ms SLAYTOR: I can really only repeat what Sarah has said. We see an enormous range of women with an enormous range of experiences. We present to them a range of services from which they can choose. I do not really have anything to add to what Sarah has said. We were all involved in putting the answers together.

CHAIRMAN: Can you tell us about the sort of contact you have with support groups?

Ms SLAYTOR: Five of us are involved with the support groups. A birth mother's weekend group is the last involvement I had. We find that an immensely sad, but valuable, experience for the mothers and also for us because we learn from every mother who ever comes to one of our groups. My involvement is on that level. A greater number of my clients are birth parents rather than adoptive people, probably because I am more of an age with them or perhaps it has just happened that way.

CHAIRMAN: The Committee is trying to get a feel for how the centre operates. Would Ms Perl like to comment on her role at the centre?

Ms PERL: One thing that strikes me fairly often in my work with birth mothers is the number of women who might have accessed other services. By that I mean community health, private health counselling, psychiatrists, a whole range of services. They have reached a point in their lives where they want to address the issues relating to the adoption, but they have not been heard. I would say that a large proportion of mothers I work with come to the centre saying, "I saw another counsellor. I tried to talk about the loss of my baby. The counsellor was more interested in hearing about other issues." In a way that always saddens me, because it is a continuation of isolation and silencing. I hope our centre would be regarded as a place where women can feel heard and can feel that their experiences are validated by us.

Ms BERRYMAN: Women who use our services are also reassured by the fact that everything they tell us is confidential. They can come to a place where they will not be judged or asked to account for themselves. They can tell us what they like and they can miss out what they like and it will go no further. That is certainly something that gives support and reassurance to many people who come our way. Even if it is through our telephone counselling service and they do not wish to give their name, that is fine. Some people choose to do that for a period and that is okay.

CHAIRMAN: What measures might assist people who experience distress as a result of past adoption practices?

Ms BERRYMAN: As part of our submission we considered what women have told us has been helpful to them and we created a list of those things. The matters are not listed in order

of importance. They were within various groupings within our submission. Anyone who wants to see the submission is welcome. These are the things that women say have been helpful: talking or writing about their experience; being heard and believed and having their grief acknowledged; acceptance by their family, by society and by the adopted child; counselling by a therapist who is experienced is post-adoption issues; breaking secrecy with the family; advocating for other birth mothers and having a public voice; reunion; telling their story to the adopted child; getting information on their child from the adoption file or from medical records; meeting with other birth parents; being part of a support group; taking part in therapeutic groups; choosing which services to access, for example, not having to go back to the agency which arranged the adoption if they do not wish; developing ways of honouring the birth of the child and finding ways of managing the stress created by significant dates, such as the child's birthday or the anniversary of the adoption; and women being able to define their own experiences and, I should add, take part in an inquiry such as this.

Some further things that PARC feels would be helpful are trained and experienced counsellors being available throughout New South Wales and ongoing strategies for making sure that birth parents are informed of their rights to seek information and contact. We would also like to see the findings of this inquiry being made available to other States to inform their own examination of these issues. PARC would also like a publication of a collection of Australian birth mothers' accounts of their own experiences. PARC would also like funding to be provided to support groups.

As women who lost children through adoption give voice to their experiences, and if these experiences can be heard and acknowledged, we will be better informed and will be able to more constructively move forward. Perhaps we might need to find ways of saying sorry to those birth parents and adopted people who have borne the burden of those practices of the past. It is not a sorry that admits direct or personal responsibility but rather, in the words of Sir Ronald Wilson speaking in the context of the stolen generation of indigenous people:

> This sort of apology is about identifying with another's sorrow with the desire to lessen this sorrow by sharing it, by taking it on a little bit oneself. It is an offering to play a part in healing. It relieves suffering to know that others have a desire to share what you are feeling.

In this spirit the staff of the Post Adoption Resource Centre would like to say that they are sorry that people have been damaged and hurt by their experience of adoption.

CHAIRMAN: Do you think a formal apology by the relevant government agencies who in the past have dealt with affected women would assist?

Ms BERRYMAN: It is very difficult for one agency to make a recommendation like that. We have clearly made our statement to women who have used our services who are here at the inquiry today, and it is heartfelt and sincere from the staff at the Post Adoption Resource Centre. I would not like to make recommendations about how other agencies should act. I would hope that some clear recommendations about that perhaps will come out of this inquiry and we would be very happy to have any further involvement as those recommendations come together.

CHAIRMAN: Some mothers have told the Committee that it is distressing for them to seek counselling in venues and with professionals with past association with adoption. What is PARC's position on that matter?

Ms BERRYMAN: PARC's premises at Scarba House at Bondi is in a building owned by the Benevolent Society. We moved there two years ago at the time that I became the manager of PARC. That decision was made because the building was owned by the Benevolent Society, we pay a lower than market rent and it is what we can afford within our budget. PARC is aware and very sensitive to the fact that some birth mothers do not want to come to Scarba House because of its past history. Because of that situation we offer alternative venues for counselling interviews at other Benevolent Society sites across Sydney which have no previous association for those women or if a client wishes they can seek a neutral venue.

Some people who are nervous about accessing our services sometimes want to meet us in a coffee bar or somewhere neutral, in a park perhaps, to talk. Some home visits are also available for clients with mobility difficulties. For those who wish we are very happy and ready to make referrals to alternative counselling or support organisations and groups that are available. The move from Paddington to Bondi, as I have said, occurred in August 1996 and there has been no decrease in our client numbers since that time. PARC employs professional staff with a range of professional and personal experiences, myself, as manager, being an adopted person.

Each staff member is committed to the ethos of PARC which is to provide support and information to any person affected by adoption and to promote each person's right to seek information and, importantly, to be treated with respect. PARC believes in being open and transparent about our practice. We are open to receiving feedback and we have a very clear complaints procedure. A person approaching the service will be given a choice of counsellors, each of whom is open about her qualifications and her experience. Referrals to alternative counsellors or support services is available.

As PARC's manager I conduct regular client confidential surveys of counselling clients to determine whether they are satisfied with the service that they receive. Each person attending one of groups or information meetings is asked to complete an evaluation form which does inform and does change practice.

CHAIRMAN: The Committee is concerned about the availability of appropriate counselling services and support groups across the State, particularly rural and regional New South Wales. Can PARC comment on the counselling needs of both parents and the adequacies of the services that are available?

Ms BERRYMAN: As I have said it is part of PARC's brief to provide services to regional New South Wales. We facilitate that by providing a New South Wales toll-free number, by visiting regional areas and by consultation with regional support groups. In the past few years members of PARC staff have visited many regional locations, a few of which are Lismore, Coffs Harbour, Moruya, Bourke, Wagga Wagga and Dubbo. We have actually got visits to Brewarrina, Broken Hill and Kiama planned for the remainder of this year and we try as much as possible to get out into those regions and give on-the-spot services to people there.

When visiting those areas we always find a huge demand for information and for support. Our information meetings are always very well attended. Part of our brief on those visits is to try to help local people affected by adoption to form themselves into support networks. In preparing the questions I added up how many of those such support groups with which we are

in current contact across the State and that number is 32 groups. That gives an indication of the level of need in those areas.

We also run professional development workshops in those areas based on the requirements of local health and welfare professionals. Birth parents have over the years given us information about what is helpful to them about counselling and what becomes clear is that birth parents want to be able to have a choice of services to access. They want the counsellor to be experienced in post-adoption counselling. They want resources and supports available and affordable locally and they want the counsellor to be non-judgmental and not to push one point of view. There are some counsellors in regional areas who provide those requirements but there are many birth parents in rural and regional New South Wales who have no access to any kind of counselling support in their region and we certainly support a need for counselling support to be increased in regional New South Wales.

CHAIRMAN: Are all the 32 support groups birth parents support groups?

Ms BERRYMAN: They vary. We have a list of contact people to whom we can refer people. If someone rings me from Bourke I can give them a contact name in that area of someone to contact. Some of the groups meet regularly, others meet for coffee on a less regular basis. Some are headed up by birth mothers, others by adopted people. It really varies from area to area but we have a list of those to whom we are happy to refer people if they wish.

CHAIRMAN: What contact do you have with Aboriginal people who have been affected by adoption?

Ms BERRYMAN: Quite considerable. We have a very good relationship with Link Up. PARC staff have, in the past, gone on tour with Link Up, if you like, to visit some of the areas where they are providing outreach and running programs. We offer Aboriginal clients who come forward to use our service the choice of staying with our service or of being referred to Link Up in the Blue Mountains and people can make their choice dependent on preference or on geography. We certainly have regular contact with that service and refer people there regularly.

The Hon. Dr A. CHESTERFIELD-EVANS: I presume the practice of adopting the children out and not informing the mothers is quite different now. If so, when did it change? Is that change completed?

Ms BERRYMAN: That is not an area in which PARC works in terms of current or past adoptions. My understanding, however, is that the practice certainly has changed. I am sure the Department of Community Services and adoption agencies, who will hopefully be coming forward to give evidence to the inquiry, will be able to answer that much better than I can.

The Hon. Dr A. CHESTERFIELD-EVANS: But you would have a consumer's eye view which they may lack.

Ms BERRYMAN: Yes I would. I certainly think that practices have changed. It may be more appropriate to get more detailed information from those other sources. In my role as chairperson for the New South Wales Committee on Adoption and Permanent Care I have put

in another submission which represents people currently practising in the adoption and permanent care which may be able to answer that question more fully.

The Hon. Dr A. CHESTERFIELD-EVANS: Presumably people have recently adopted and have come to you and there must be a change in the stories. Can you comment on that?

Ms BERRYMAN: People who are using our services tend to be talking about adoptions that happened 18 years ago or more. We get relatively few calls from people who have adopted in more recent years, perhaps because they are getting support from other organisations or parenting groups that exist, I do not know. But the issues that people ring us about tend to be for what we are funded, that is, to provide information for adults seeking information under the Adoption Information Act so it is really outside our area.

The Hon. Dr A. CHESTERFIELD-EVANS: Is information now freely available? Can people easily trace their children or their parents?

Ms BERRYMAN: Yes, the Adoption Information Act gives equal rights to birth parents and to adopted people to seek information or to seek contact with the person from whom they have been separated. We get lots of calls from birth parents and from adopted people who want to seek contact and want to find out information about each other.

The Hon. Dr A. CHESTERFIELD-EVANS: Do they always manage to find the people and make contact? Is the information entirely available? Can they get to the relatives?

Ms BERRYMAN: In the vast majority of cases the search is relatively straightforward. It becomes slightly more difficult if people have moved interstate or internationally or if there has been some discrepancy in names given, for example, which makes it slightly more difficult but the vast majority cases are relatively straightforward. The Act allows people to conduct the search themselves by accessing marriage searches through the Registry of Births, Deaths and Marriages and then doing searches on electoral rolls.

The Hon. Dr A. CHESTERFIELD-EVANS: Do you have any clients who are adoptive parents or adopted children?

Ms BERRYMAN: We have many, yes, certainly. The majority of our clients are adopted people, probably about one-third more than birth parents. Adoptive parents are a smaller group of our clients that certainly do come forward. We also have a lot of clients who are siblings, who are grandparents, either birth or adoptive, who are other family members and spouses. A lot of people phone on behalf of their spouse or to talk about how adoption or reunion is affecting their family.

The Hon. Dr A. CHESTERFIELD-EVANS: Do the adoptive parents also have difficulty?

Ms BERRYMAN: Certainly they do, yes. There are many difficulties for all people facing reunion and facing the great impact that adoption has had on all family members.

The Hon. Dr A. CHESTERFIELD-EVANS: The Committee has heard evidence that people think that adoption should be illegal. Do you think there is such a thing as an unwanted child?

Ms BERRYMAN: I do not think there is such a thing as an unwanted child, no. Again, this is something that is outside our ambit. I am not sure that I should be answering this question from the Committee on adoptions point of view. However, I think that if we looked at the numbers of adoptions occurring at this point in time we would see that most of the adoptions now occurring are cases where there have been child protection issues involved. As the Department of Community Services gave evidence, the number of adoptions now occurring is 200 to 400, compared to something like 4,000 in 1973. I think we are seeing very different reasons for adoption now occurring, and the adoptions that do occur now are mainly because of some kind of child protection issue, some kind of step-parent or intra-family adoption, children with disabilities being adopted, or inter-country adoption; those are the main areas.

I would like to add also, as Petrina pointed out to me, that I forgot to say that in terms of offering services to people who are under 18, we are currently offering a group for birth mothers whose children are not yet 18 and may want to do some work in preparing for contact, so we are starting to look at that issue.

(The witnesses withdrew)

GEOFFREY ARNOLD RICKARBY, Consultant Psychiatrist, affirmed and examined:

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

Dr RICKARBY: As a psychiatrist who has seen a great number of people from all aspects of adoptions over 35 years.

CHAIRMAN: Did you receive a summons issued under my hand?

Dr RICKARBY: I did.

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

Dr RICKARBY: I have looked at them carefully.

CHAIRMAN: Have you made a submission to the Committee?

Dr RICKARBY: Yes, I have made a submission in writing and have provided a written answer to the questions.

CHAIRMAN: Do you wish to commence by making a brief statement?

Dr RICKARBY: I do wish to make a brief statement, if I may. When I first heard of the distress and illness in the lives of women who had lost a child to adoption, I thought the problems were unusual. Throughout the decades following, I found that I continually underestimated the severity of their distress and the widespread gravity of their disrupted and blighted lives. There are tens of thousands so damaged, and I consider the cruel and unnatural treatment of these women by their fellows to be of such extent and seriousness that it has only been surpassed by the treatment received by our indigenous people.

I would also say that while practices associated with drugging, threats of police and physical separation catch the attention and imagination, the great bulk of damage was due to the mind-bending techniques by those in power that shaped the mother's view of herself, her entitlements, and ability to fight for her rights and her child's obvious rights.

CHAIRMAN: Would you explain your professional experience with counselling mothers who have experienced distress as a result of past adoption practices?

Dr RICKARBY: Back in the 1960s I was to see a few people in my general practice in Melbourne, particularly one couple who were spending all their money on a private detective to find their first child that they lost to adoption. Then, as a trainee psychiatrist and a community child psychiatrist covering a large area, I was to see quite a lot of women who were very distressed, and I think I missed out on finding out that they may have been original mothers because they did not readily supply that information. However, I found that their loss was basically to do with a lot of their problems; their reaction to worrying about their children. And these mothers had children. Most of them had post-traumatic stress phenomena; that is the way that group of women present.

At that stage I was highly distressed about the failure of procedures for selecting adoptive

parents. I was striking a large number of adopted children coming forward to take up the health department's time and energies where they had been adopted by people with mental illness or very frail families, due to one parent being the adopter and the other one being the one who went along with it, and having trouble staying with very difficult identity problems in children and adolescents. I was working extensively in the other side of adoption. Indeed, my experience in the other side of adoption is still more extensive than my experience with original mothers.

A lot of original mothers then began to know about me, and ARMS—the Association of Relinquishing Mothers—contacted me during the 1970s. I had been writing in the journals, and DOCS secured my help in seeing people that they wanted to knock back as adoptive parents, because, when they had been previously faced with anybody who was going to take them to court or make a noise about them knocking them back, they had not been able to stop them. I was seeing them for DOCS on the understanding that I would go to court to support DOCS in refusing these people as adoptive parents.

I gradually started seeing more and more original mothers, and I was hearing a lot about them because, as a Child Psychiatrist, I was going from Dubbo to the Inner-Western Suburbs of Sydney and to the Hunter Region; I had a very wide area. I would hear about a lot of people in distress, and I would in fact do more supervision of other professionals looking after mothers than I would see myself. But as I have come into private practice in the last ten years, I have seen quite a large number. Over 35 years I have seen some hundreds of original mothers with a wide variety of psychopathology and a wide variety of distress. Where I have known people who were original mothers in social situations, I have also been very interested in hearing about their situations too, which has given me another point of view.

CHAIRMAN: You said earlier that you would have seen more children than mothers; hundreds of mothers and hundreds more children?

Dr RICKARBY: Particularly in the 1970s and the early 1980s we would go into an intake meeting at Child Psychiatry and we would have one adoptive family after another. They were the more healthy ones who would come forward, because the ones who had a fair idea that they wanted help, and, that they were going to get help, were the ones who were turning up to Child Psychiatry. We were more worried about the ones who would not come forward. Mind you, though, there were others in the other direction—the well-functioning, secure adoptive family—who did not need to come to us.

The Hon. Dr A. CHESTERFIELD-EVANS: The Committee has received many submissions from women who experienced a high level of distress at the time of signing the consent for adoption. While the Committee realises that women's experience of adoption is wide and varied, are you able to comment on the psychological state of a women considering the option of adoption, particularly in the period 0-7 days after giving birth?

Dr RICKARBY: Yes, they were pressing them as early as they possibly could, on the fifth day after giving birth. Largely they were drugged in one form or another. A lot of them had a steady heterosexual relationship and the guy was kept right out. He was not their husband: he was kept away. They were marked for adoption; they were given, in particular, the drug pentobarbitone in its soluble, injectable form. They would have been in no state to have any idea or to work out what the possible futures were for themselves while in that state of mind.

At that stage many of them thought that they were keeping the baby.

There was the crisis of birth and the crisis of all the other things going wrong. They were given Stilboestrol by injection, usually in the labour ward before they left it, to dry up their milk. The consent form that they signed for the usual things to do with birth, certainly was not about them being given a drug such as stilboestrol to dry up their milk—or pentobarbitone sodium, which is very much what was used for deep sleep. It is an obsolete drug, a dangerous drug. Only a select group of people in the drug scene would use it in the 1990s.

The Hon. Dr A. CHESTERFIELD-EVANS: Were some of the consents signed before the child was born?

Dr RICKARBY: The consent to adoption is not to be mixed up with the broad consent that you sign when you go into hospital. As you are admitted, if you are to have an operation, you give consent to the operation. The doctor may have to do something different, depending on what he finds. You give consent to the birth and so on, but there is no way that that consent could be construed to cover stilboestrol or pentobarbitone sodium—which is really a knock-out type of heavy sedative that would last for days in the system. I would say that anyone who had it in the 48 hours beforehand would be 'off their heads' at the time of signing the consent.

The pressure was on them to sign the consent: they had been marked to sign the consent. Particularly in some places such as Crown Street hospital between 1965 and the middle- to early-1970s as soon as the women looked like saying "no" there was the threat of bringing on the Child Welfare Act, and being 'an unfit mother' and these things were put to them. That was irrespective of whether they were in the 20-21-year-old age group with a guy out there waiting for them, or in the younger age group. Part of the awful thing was that they were separated, the young women. They were in an incredibly powerless position dealing with a linked series of people who had marked them out in what was, frankly, conspiratorial activity to abduct their babies.

The Hon. Dr A. CHESTERFIELD-EVANS: You have almost answered my next question. Are you aware of any situation where a birth mother was given an inappropriate drug, or inappropriate dose of drug, at any time prior to, during or after the birth of the child? If so, are you able to advise the Committee about the impact of any of those drugs on a person's capacity to make decisions regarding consent?

Dr RICKARBY: Yes, yes, and it would compromise their capacity totally.

The Hon. Dr A. CHESTERFIELD-EVANS: Which group in the hospital was responsible for that? There has been considerable stress on social workers as the people who got the form signed.

Dr RICKARBY: Doctors must write up drugs. Social workers have no connection with the administration of drugs.

The Hon. Dr A. CHESTERFIELD-EVANS: Were the obstetricians also involved in obtaining the consents?

Dr RICKARBY: The actual consent-taking was often by a person who came into the place

merely to take the consent and was often someone from the Department of Community Services.

The Hon. Dr A. CHESTERFIELD-EVANS: The antecedents were done—

Dr RICKARBY: The antecedents were done by the people in the antenatal home; the nursing staff in the labour ward; the doctors in their prescribing of drugs; and the other professionals, in changing their attitude to the brainwashing procedures that went on for months beforehand. That is why I used the word "conspiratorial". I do not use it in a sort of Bulgarian-with-black-beard sense, I use it in the notion of a number of different people working together to one end, to take the baby.

The Hon. Dr A. CHESTERFIELD-EVANS: The Committee asked the next question in almost identical form of representatives of the Department of Health. Did mothers who were going to proceed to adoption have different regimes to those who were normal labours and childbirths and was there any evidence of different drug use. The answer was that there was no evidence of different drug use.

Dr RICKARBY: So? What? They are claiming they gave them all a big shot of Stilboestrol in the labour ward, were they?

The Hon. Dr A. CHESTERFIELD-EVANS: Presumably that was after the consent was signed.

Dr RICKARBY: This was immediately after the birth. This had nothing to do with the consent. They could not take that until the fifth day. This is prima facie evidence of conspiratorial action, surely!

The Hon. Dr A. CHESTERFIELD-EVANS: Are you aware of any documentation a broad level, within the records of the Department of Health or within the published literature, that suggests that is the case?

Dr RICKARBY: From the Crown Street records that I have been supplied with, I have prepared thoroughly three legal issues from the psychiatric damages side, and I have studied those three in very fine detail, I have also studied another eight or nine and I have about five or six of those in my possession at home. For instance, if they had given an ordinary patient pentobarbitone to knock them off their heads, so that they did not remember anything much for days, the ordinary private patient would have complained no end. I would be astounded that they would do that to a mother that they were teaching to manage her first baby. I cannot believe that the drug regime would be the same. I would find it unbelievable and implausible if anyone said that was so.

The Hon. Dr A. CHESTERFIELD-EVANS: You used the word "conspiratorial" in regard to the events surrounding the birth, do you think that the drugs were given and then the person to sign the consent was wheeled in, with the timing of those two things being arranged by people within the system?

Dr RICKARBY: All of the things—the separation from their families, the baby being taken, their face covered, the power difference—was built up over months so that the young woman

was put into a powerless, shamed position and then the drugs were added on top of that. Then they came in asking for consent on the earliest possible day. You will find that nearly all of them are dated on the fifth day. I know of one that is dated on the second day and a few who lasted until the seventh day, but it was all done in a situation where the power difference was built up to an incredible pitch, as was the sort of mind-set of the young women and what she believed she could do. In particular she believed the kinder, powerful people were doing lawful things and that anything she would object to would be unlawful. She thought that they were right.

The Hon. Dr A. CHESTERFIELD-EVANS: With regard to the involvement of the Department of Health—obviously the Department of Community Services and the Department of Health were involved—and the point when the drug was administered, was the social worker timed to come as that drug was acting? In other words, was there a conspiracy—a word you used—between the person who had ordered and then administered the drug, and the person who came to sign the consent form?

Dr RICKARBY: No, I do not think they rang one another up on the phone, but they were coming along on the fifth day where the usual routine—for instance at Crown Street in the late 1960s—was to have the person well and truly drugged with barbiturates. They were coming along to a person who was usually drugged. Other places used valium, particularly on the morning of the signing.

The Hon. Dr A. CHESTERFIELD-EVANS: It was only when the DOCS person would come and the drug regime was arranged accordingly by other people within the system?

Dr RICKARBY: It was just the routine. One did their part of the thing, the other person did their part of the thing. Crown Street at least had the notion that the person had to go through the various steps and be what they called "cleared", which means that they had gone through and signed the form on the fifth day, therefore they did not have to pull in any threats of the Child Welfare Act.

The Hon. Dr A. CHESTERFIELD-EVANS: You do not believe there was communication between them, but you believe there was a regime, is that so?

Dr RICKARBY: There may have been. I do not know and cannot say whether there was communication, but they did not need communication: it was a well-oiled machine.

The Hon. Dr A. CHESTERFIELD-EVANS: Presumably it would be known that the social worker was coming on a certain date.

Dr RICKARBY: Everybody knew that they would try hard on the fifth day.

The Hon. Dr A. CHESTERFIELD-EVANS: Were the drugs written up as a statutory dose for that day only?

Dr RICKARBY: No, with a lot of women they kept the drugs running from birth through until after the fifth day.

The Hon. Dr A. CHESTERFIELD-EVANS: So that the social worker could come at any time during that what you might call drugged period?

Dr RICKARBY: Well, yes. They were not allowed by law to come until the fifth day. The Act required them to. This is at a stage when the adoption Act did not come into play until they had actually signed the consent. All this was done to the guardian of the baby, before the adoption Act could start when the consent was signed.

The Hon. Dr A. CHESTERFIELD-EVANS: The stilboestrol was given long before the woman had signed anything so that she had no milk, which proved she was not a fit mother. It was just another piece of evidence, as it were.

Dr RICKARBY: I do not think they used it that way. It was just that it was part of the routine to stop them from lactating. It did not work sometimes. I know that some people had a reverse reaction and had an incredible amount of milk and were around, crying for help, despite the stilboestrol.

The Hon. CARMEL TEBBUTT: In your submission you state that birth mothers were often given the advice to "start life afresh" and that "they would soon get over" the experience of adoption. What do you understand to be the psychological impact on those women on that advice?

Dr RICKARBY: It was just so patently untrue and some of them thought that it was true, because they were so isolated. What we are dealing with here is a situation where each one went away on her own, with no other original mother, and some of them thought that that is what they ought to do; that that is what they were supposed to do, whereas the opposite was true. They did not get on with their lives. Some of them were refused school. They tried to go back to school and were pushed out of it. Their preoccupation and their grief were so profound that they could not concentrate on any form of study or any personal development for years.

Many of them thought they were different from the others, but in fact my experience is that the grief and the pathological grief goes on for years in fairly extreme cases—and sometimes gets worse in their later life as they come up to some crisis, their child's birthday or some stage of their own or the child's development. So the grief went on in a very bad way. The grief really then decompensates at any time into this psychiatric disorder. The notion that they would get over it was part of the doublespeak that they were given. There were a lot of other issues of doublespeak that they were given that were contrary to the truth. Because they were isolated from each other and had no person to support them, there was no-one to test out. They were so shamed by the process and so humiliated that it was very difficult for them to recover to communicate with anyone about that experience. Many of them after 25 years find it extremely difficult to put any of this into words. They almost have to go for weeks before they can even talk about it in a manner that is comprehensible to themselves, let alone to others.

The Hon. CARMEL TEBBUTT: The Committee is aware that many women experienced post-traumatic stress syndrome after giving up a child for adoption. I have a series of questions which relate to this matter. First, could you explain to the Committee the nature of post-traumatic stress syndrome and the impact it has had on the lives of these women?

Dr RICKARBY: Post-traumatic stress syndrome usually went along with pathological grief.

Pathological grief was much more common than post-traumatic stress syndrome. Post-traumatic stress syndrome is when there is a major trauma which imprints itself on their minds. They are preoccupied with the trauma and, in many ways, the grief occurs when they are preoccupied with the loss. So you have the trauma *and* the loss. Many of them had quite traumatic experiences and crises in their hospitals. This then sets up a super alertness to never have anything like that happen again. For some of them it was a deep-seated fear of pregnancy or sexual relations and for others it was a terrible fear that something would happen to their child; that they would lose another child.

There was a lot of anxiety, sometimes feelings of panic, that would come back on them again when various stimulae came up, for example, listening to the news and hearing about somebody else losing a baby or something happening to a baby, or going to hospital. I have known some who could not go near a hospital, which was a very dangerous situation to be in. The major depression came along in both post-traumatic stress disorder and pathological grief which can break down into major depression very easily. Major depression was often one of the most common reactions, although severe dissociative disorder, where they would block out great blocks of experience or part of their lives, is another serious psychiatric sequel of their experience.

The Hon. CARMEL TEBBUTT: You have probably answered this question, but have you come across any other psychological disorders resulting from past adoption practices?

Dr RICKARBY: Yes, I have listed those carefully and explained each of them in my written submission because it is a long list. The relation of those to the experience of losing a child to adoption is a complex subject. If I answered that question verbally now it could take the rest of our time.

The Hon. CARMEL TEBBUTT: At least it is covered in your submission. You have referred to it now so it will be on the record. How common are post-traumatic stress syndrome and other disorders as a result of past adoption practices?

Dr RICKARBY: I found post-traumatic stress disorder to be most common in the ones who would come to child psychiatry. Those who joined peer group organisations tended to have a lot of pathological grief. Major depression was very common and sometimes dissociative disorder. Those who often reject or become very anxious about reunion have the personality damage that I described under the secrecy, shame and guilt type personality. The other group of people that do not come forward readily are the ones who build heavy defences against their loss; so much so that they tend to lose their real self and become thick-skinned, anxious, but not readily acknowledging the origin of this. Some form of psychopathology is almost universal in my experience. I think that some of the more severe ones do not come forward. It takes quite a lot of emotional strength to go along to your peer group or to a doctor and tell about it. I think there are a lot more people out there who have not done this, who are more severely affected and who cannot make use of peer support. I am hoping that some of those people will get the support of their peers because their peers are the people who really understand what is happening.

The Hon. CARMEL TEBBUTT: You said earlier that women who went through past adoption practices would almost universally suffer some sort of disorder.

Dr RICKARBY: Some sort of damage.

CHAIRMAN: When measuring post-traumatic stress syndrome in a broad sense can you distinguish between the effect of the experience of having a baby adopted—the loss you talked about—and the other traumatic experiences associated with being typically very young, very isolated, being treated with shame and so on? Can you comment on how adoption compared with all the other terrible experiences that vulnerable young women went through?

Dr RICKARBY: The pathological grief goes on and gets worse. There is a lot that the people you were describing can do to grow out of that. When you have a baby somewhere else and you have lost your interaction with the baby that was inside your body, the grief, if anything, grows and comes up in waves in certain situations and arises as a crisis in a person's life. There is no comparison with that long-term loss. I see the same process occur in people who have had a severely handicapped baby. As the baby grows their grief recrudesces. But I do not see the two situations as comparable at all. There is no doubt that the loss of the baby is the pivotal issue.

CHAIRMAN: And that is quite different from, for instance, a stillborn child?

Dr RICKARBY: Yes.

CHAIRMAN: Last week when Dr Smyth was talking to us—this leads to another question that I will come back to—he referred to the issue Dr Chesterfield-Evans was questioning you about, that is, drug regimes. He suggested at one stage that the dosages given to mothers whose babies were to be adopted was comparable to the dosages given to mothers who were expecting stillbirths. I have mixed up the two questions there. My first question relates to the loss of a baby and my second question relates to the issue of drugs.

Dr RICKARBY: I think that is almost in the preposterous range. For instance, one mother was given a series of pentobarbitone doses in a prenatal hospital—the sort of dose of pentobarbitone that would make the foetus subject to hypothermia and gross distress at birth. I cannot see that they would have been doing anything like that to anybody else. Certainly in general medicine to drug people on that level with barbiturates by injection, you can't believe that doctors would do that generally in the 1960s or 1970s. It was known then to be a dangerous practice. We are talking about drugs that are looked on with horror in retrospect. They are obsolete because of their dangerousness.

CHAIRMAN: As a Committee we are trying to achieve the greatest clarity possible when someone like you, for instance, is saying that we are dealing with deliberate, planned, unethical, unlawful practices as a regime for women expecting to have their babies adopted—quite deliberate and quite different in character from the treatment of other women giving birth.

Dr RICKARBY: That is exactly what I am saying. I have seen numerous cases. I have seen only a dozen or so in the records that I have gone through closely, but I know of over 100 people that it has happened to. There is no doubt in my mind at all that there has been a concerted plan to take a woman's baby and that she has gone through the mill in the process to have that baby taken. There has not been any doubt in my mind for a long time. It took me a long time to realise that though.

The Hon. P. T. PRIMROSE: Do you believe that any systematic, illegal or unethical behaviour took place in relation to adoption practices?

Dr RICKARBY: I think that with each of the women, and considering the tens of thousands of them, you would find over a million illegal acts on women in New South Wales.

The Hon. P. T. PRIMROSE: I know that you have touched on this matter, but was adoption always in the best interests of the child? What information is available on the varieties and experiences of children who have been adopted?

Dr RICKARBY: This is a fairly contentious issue. Twenty-five years ago I was the person who was standing up and saying that adoption was not in the best interests of the child for a number of reasons. My reasons were the gross identity disorders and the difficulty experienced by adoptive families in coping with identity disorders, mainly because the poor adoptive family was really not given a lot of help. They were told that it was the same as bringing up a normal child. They were not instructed in all the difficulties, the hard, testing behaviours and the difference in temperament and thinking style. They often got children who were incredibly different to them, just in their way of thinking. We were seeing very few people who kept their babies. One issue was that there tended to be more staying power in the biological family when grandma was involved and had a strong bond with the baby. The children, no matter what fate befell their biological mothers, belonged to that family. They usually knew their father. There was some interest. They were more likely to have problems with their father wanting too much access to them rather than anything else. So I have always had a strong contention that adoption is really a last resort and the best interests of a baby was to stay with his or her biological family.

The Hon. Dr A. CHESTERFIELD-EVANS: You said earlier that you had rejected potential adoptive parents and that DOCS had been reluctant to do that in case it faced legal action from those who were rejected. I have done some work in the screening of people and I know that it becomes very difficult. Did DOCS have great difficulty in screening people and, because of potential litigation, gave children to inappropriate parents?

Dr RICKARBY: Yes. To qualify that statement, the criteria were often largely about their income, the house they had, whether they were married and made religious promises, whether they looked squeaky clean and whether they had a stack of references from Reverend so and so or Father so and so. In the 1970s I wrote a fairly extensive article, with the support of the Social Work Journal, on family psychiatry and the selection of adoptive parents trying to get realistic selection and looking out for the traps. Take, for example, the couple where mum wanted to adopt and dad did not, or a case where there was a fairly severe mental illness in the family, or where there was some obsessive wish to have a child of a certain type and that child had to fulfill certain needs of the adoptive couple. There were quite a few of those criteria. I was trying to teach people to look for those who had grown up in a good family, who had had fairly good relationships within their own family of origin and that type of thing.

This is making a very long subject short, but the adoptions certainly needed a great deal of improving. When they came to send people to me that they thought they might have to refuse through a court case, there were not any marginal cases. There were really gross issues of mental illness or personality disorder. They were not the sort that almost anybody

would have had any difficulty in the vetting thereof. They wanted me to stand up in court for them if they were challenged over this.

Dr CHESTERFIELD-EVANS: So presumably there would have been a lot of marginal ones that would have required your real expertise? I mean you were only getting the really overt ones—?

Dr RICKARBY: I was.

Dr CHESTERFIELD-EVANS: —and not the marginal groups.

Dr RICKARBY: That is correct.

Dr CHESTERFIELD-EVANS: Would you say—I do not know if this relates to the terms of reference of the Committee—that there is a danger, given that adoption is being used for fertility problems, that the vetting system is still in danger?

Dr RICKARBY: I do not know enough to say that, but I hope that their experiences made those people older and wiser. I do know that a lot of the people selecting them have been using my article that I wrote in the 70s, so I must concede that they are at least doing that. It probably needs to be revised a bit now too.

CHAIRMAN: Dr Rickarby, I return to what you said earlier, I think in answer to Miss Tebbutt's question about women being given advice that they would soon get over it, start life afresh and so on. You used the phrase "doublespeak".

Dr RICKARBY: That is a bit Orwellian. Yes, that is the origin of it.

CHAIRMAN: Could you give us your view on whether you mean that the professionals involved were really saying what they did not mean—in other words, that they were deliberately, systematically saying to women what they did not mean—or that, as other witnesses have suggested, they were following the psychological pattern of the time?

Dr RICKARBY: Well, it is pretty awful if that was so. I think there was a group of people in the antenatal homes, in the agencies, who had a belief that the married couples who were infertile for various reasons—the high dose pills, the chlamydia, and various other things that were causing quite a large amount of sterility at the time—deserved the babies. I think there was a belief system that these married couples deserved the babies. They believed, wrongly, that this was in the babies' interests and I think that their rationalisations, some maybe conscious, some maybe unconscious, went towards keeping the supply of babies up to the people who were demanding them. Of course, in-vitro fertilisation—Australia leads the world in this—has changed this. The Health Department, I think it was in 1982, gave a very clear message about what was legal and what was not. That was a bit late. Evidently, that stopped things, but they were already down to below 10 percent of their adoptions, the level they were at around about 1970.

Some of it was the universities who trained people in offering, you know, the younger social workers trained in offering the options and really offered the options, which you will find very little evidence I think from the mothers who come before, of options of any sort being offered

to them, and, the 30 days rescinding being treated with contempt. And the presence of the allowance that women could get whose husbands were in gaol; their being eligible for that was not canvassed to them at all.

CHAIRMAN: So when you say that for some it was unconscious, for others it was conscious, you are saying that at least some people involved in telling young women they would soon get over it, et cetera, were deliberately, systematically giving advice they knew to be wrong?

Dr RICKARBY: One of the things that struck me with some of the professionals—I know that people with a social work degree are not trained in psychopathology at all—was that their knowledge of grief was so thin that they not only did not understand grief, but they did not understand the relationship between grief and breakdown and psychiatric illness. I can accept that there is that sort of ignorance because that sort of thing was not in their course, but for them to be that abysmally blind to what the general public knew about—that a person losing her baby is in a stressful situation—and to be that blind to the degree of grief that that person would suffer, I find totally implausible. I cannot think that anybody of that intelligence to get themselves a social work degree or another comparable degree could be that blind.

CHAIRMAN: What measures can you suggest might assist people experiencing distress as a result of past adoption practices?

Dr RICKARBY: I think the detailed findings of this Committee will help very much. The answers coming out and being published I think will have a very therapeutic effect generally. I think it is still very important to identify some of the people who were in a leadership position who would have known better, and I think there are a few. It would appear, although I do not know of any instances, that certainly the mothers believe that there are some people who took a leadership role in illegal actions to take babies who finished up with some of the babies themselves. I think that if there is that belief, the Committee might well determine if that is in fact true.

CHAIRMAN: Do you think that an apology made by the relevant government agencies would assist the women?

Dr RICKARBY: I think it would be seen as tokenism. I would think that many of the mothers might be even insulted by it. I think some of the large religious organisations who ran their antenatal homes and who had practices that were very harsh; I think an apology that is sincere and comprehensive from them might do a great deal of help towards the mothers, but I think today's government agencies putting out an apology for what was not done back then is not helpful.

CHAIRMAN: Thank you very much, Dr Rickarby, for your evidence.

(The witness withdrew)

MARGARET McDONALD, Retired social worker, and

AUDREY MARSHALL, Retired social worker, sworn and examined:

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

Ms McDONALD: I am appearing before the Committee as a former practitioner, as the director of an adoption service, a former director of an adoption service and as someone who is currently researching a book on adoption history.

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

Ms McDONALD: I did.

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

Ms McDONALD: Yes, I am.

CHAIRMAN: And you have made a submission?

Ms McDONALD: I have made a submission.

CHAIRMAN: And you wish it to be included as part of your sworn evidence?

Ms McDONALD: Yes, I do.

CHAIRMAN: Do you want to make a brief statement on your submission or do you want to just do our questions?

Ms McDONALD: I would like to make a brief statement to start with.

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

Ms MARSHALL: I am here as I worked in an adoption agency, a private agency between 1972 and 1975. In 1984 I was appointed by the Minister of Community Services to do an independent review of adoption policy and practice in New South Wales, and currently with Margaret I am researching a book on the history of adoption in Australia.

CHAIRMAN: You received a summons issued under my hand?

Ms MARSHALL: I did.

CHAIRMAN: You are conversant with the terms of reference?

Ms MARSHALL: Yes

CHAIRMAN: Did you make a submission?

Ms MARSHALL: We made a joint submission.

CHAIRMAN: You are going to make a statement and then the two of you will then address our questions?

Ms McDONALD: Yes. Because of the length of time that I have worked in adoption, which is almost thirty years or more than thirty years, and the fact that I have lived through the changes that have occurred, the radical changes that have occurred in the knowledge and understanding of adoption and its current reputation and standing, because of this experience I am acutely aware of the difficulty facing a Committee in 1998 of understanding and setting in its social context practice which took place in circumstances so different from the circumstances and social attitudes of today that it might easily be another world that you are being asked to think about.

This struck me very strongly in the evidence given last week by the birth mother, when she said, "To think they knew what a terrible thing I was going to do". The assumptions underlying that statement appear to be that the knowledge available today about the possible long-term effects of relinquishment was known then, that to give up a baby for adoption was then recognised as a terrible thing and that they or, in effect, we had the power to prevent it happening. I think these are all assumptions that need to be carefully examined.

While in the light of my present knowledge I am only too well aware of what I did not know and could not do in the 1960s and early 70s, I have no doubt that over all this period my own conduct and to my knowledge that of my colleagues was based on these four pillars: our respect for the law, that is, our understanding of the Adoption of Children Act and our obligations under that Act; our commitment to the interests and welfare of the child as a paramount consideration as directed by the Act; our respect for the right of the birth mother to make a decision which she saw as being in her child's and her own interests; and our commitment to dealing fairly and professionally with the applicants for adoption.

In some cases this meant standing by a recommendation that an application should be refused. While the focus of this inquiry is on the treatment of birth parents, the Committee must be aware that, both in law and in practice, in adoption the challenge has always been the balancing of these competing interests. In the balancing of these interests the question of resources was certainly a central issue. It is hard now to realise the mere volume of work that was dealt with by very small numbers of people in those days. For example, the Catholic Adoption Agency had one full-time and some part-time staff, adding up to a total staff of three professional workers and some support staff.

We were counselling mothers, taking consents, assessing families and placing 200 or more babies in a year. When I took over as the principal officer in 1973 there were 400 outstanding adoption applications that I had to get to court. A social worker working at Crown Street in 1970 who had been a social worker student there in the previous year told me that in joining the staff in 1970 as a new graduate, her caseload was 400 single mothers. So the quality of the work and availability of services was greatly affected by those sorts of resource issues.

I should at this stage respond to the conspiracy idea that Dr Rickarby has put forward. To me the whole idea is totally foreign and bizarre. I cannot see that there was any way in those

circumstances that people could have been conspiring together to remove children from their mothers. I cannot see how this Committee can reach a balanced view of the events that have been unfolded to us, the tragic stories that we are hearing—which I do not in any way dispute—without taking into account that larger picture, including the social circumstances that were so well outlined by Sarah Berryman in her submission. All of that is totally familiar to me and they were the circumstances in which we were operating. Within that framework we are very happy to be here to answer your questions and to provide information if we can.

CHAIRMAN: Ms Marshall, do you wish to make an opening statement?

Ms MARSHALL: No.

CHAIRMAN: Can you explain the role of social workers before and after the introduction of the Adoption of Children Act 1965 and, in particular, could you comment on the role of social workers in taking consent?

Ms McDONALD: The role of a social worker depended to a large extent on the setting in which she was working. I say "she" because it was almost exclusively women who were the social workers in adoption. The hospital social workers in most cases provided initial counselling and assistance to single pregnant women, sometimes arranging accommodation and employment during her pregnancy, helping her to consider her options and to work out these plans for herself and her baby. Social workers in hospital were seeing women who presented uncertain of their plans, women who presented stating that their plan was to have the baby adopted and great numbers of women went to Crown Street for the very reason that that was known as a place from which adoptions were arranged. She would also be seeing women who were planning to keep their babies and then the various options available would be explored.

On the whole social workers in hospitals did not take consents either before the 1965 Act or afterwards, although in some cases in country areas a hospital social worker would take a consent on behalf of an agency by arrangement. The situation was different prior to the 1965 Act in that private adoptions could be arranged by individuals and at one stage up to one-half of the consents would have been taken by solicitors, possibly social workers, doctors, ministers, the people qualified under the Supreme Court rules to take consents. The rest of the consents would be taken by departmental officers, most of whom were not social workers.

I do not want to make a distinction in terms of the social worker did this and departmental officers did that. I am not trying to excuse social workers, but overall a majority of consents were not taken by social workers either before the 1965 Act or afterwards because it just happened that the bulk of adoptions were arranged by the department and not many of those district officers were social workers. It might be helpful for me to outline the experience of one social worker to give the distinction between the two periods. We have written something about this for our book and I would be happy to make that text available to the Committee. However, since we are seeking publication of the book we would ask that it be made available at this stage only for the information of the Committee and that it not go on the official record. Is that okay?

CHAIRMAN: Yes.

Ms McDONALD: This social worker worked as a departmental allotment officer. In the department consents were taken by district officers—and they were specifically designated women officers in the city who took consents—but for large hospitals such as Crown Street, the Royal Hospital for Women and probably other large city hospitals like King George and St Margaret's, the departmental person would be an allotment officer. They first existed from the mid-50s. This social worker worked as a departmental allotment officer in 1959. She described her duties as specific and circumscribed, limited to taking consents, looking at the baby in the nursery, seeing that the baby was passed medically fit and choosing the parents for the child. In relation to consent taking, the emphasis was on making certain that the consent was being freely given and that it was properly signed and initialled. If when she went to the hospital she found that the mother was not ready to sign the consent, she simply went away.

[*Interruption from the gallery*]

CHAIRMAN: Ms McDonald has come to give her evidence. The Committee eventually has to take a balanced approach and make an evaluation. We need to give her the courtesy of listening to what she is saying. She is quoting what someone has told her.

Ms McDONALD: If when she went to the hospital she found the mother was not ready to sign the consent, she simply went away, leaving it to the hospital social worker to canvass with the mother her options, which were to take the baby home or to some sort of live-in job or some days later to sign the consent. I refer to the reported judgment on the famous *Mace v Murray* case in which a mother withdrew consent after the child had been placed. This then led to a very long court case in which the different sides were funded by newspapers. The case was first heard in the Supreme Court, was appealed to the Full Bench of the Supreme Court and eventually it went to the High Court. This happened between 1952 and 1955 and the reported judgment is available and I can give you that reference.

The reported judgment in the *Mace v Murray* case confirms this description, clearly describing a process where the departmental officer took the consent, went the first time and the mother said, "No, I do not think I am going to sign." On her second visit she took the consent and then she went back a week or some days later to confirm the decision of the mother. Prior to the 1965 Act there was no period for revocation of consent, although the mother had the right to withdraw the consent right up until the time of the making of the order of adoption. However, because there was no process and because the application could have been taken immediately to court, it seemed as if the assumption was that the consent once given was irrevocable so the practice was to say, "If you are not certain, do not sign." The judgment is well worth reading because it so clearly outlines what happened.

After 1965 there were more social workers involved since it was required that private agencies employ social workers. The common process was that a mother would be referred to the agency by the hospital social worker when she indicated that she planned to have her baby adopted. In the early years of the Catholic Adoption Agency it was likely that there would be only one contact with the mother prior to the birth of her child. The focus in this interview would be on hearing the mother's story, discussing her reasons for the adoption decision, outlining the adoption process—including the taking of the consent and the right of revocation—and her hopes and wishes about the family to be chosen for her baby.

The other important task in this interview was to record the social and medical history so that on this one occasion prior to the birth of the child the agency would have contact with the mother, there was a great deal to be done in that interview. After the birth of the baby the hospital would inform us and then, mostly on the fifth day, the social workers would go to the hospital with the prepared documents to take the consent.

I thought that I would describe for you my own process in taking consents. I think I did not take any consents until probably 1970. The actual taking of a consent would be to read the documents with the mother, starting with form 9, which is the request to make arrangements about the document, and then go through that form explaining the terms. For example, it said the child could be placed with parents approved as fit and proper and selected as suitable for this particular child, so you would discuss that distinction. I would then talk about the section about the religious wish and how it may not be possible to place the child with parents of that religion but if that were to happen, permission had to be given for that wish not to be honoured. I would then talk about the clause relating to the process of revocation and calculate the 30-day period.

My practice was mostly to read that document aloud with the mother, but if I did not read the whole document I would read the last three clauses. I do not ever remember taking a consent in which I did not feel the impact of making those statements and what they must mean to the mother to hear me speak those words, which were, "Upon the adoption of my child I have lost all rights as a parent in respect of the child, I have no right to see or get in touch with the child. I have no legal redress under any Act of Parliament." They were terrible words to have to speak. In that sense, one realised the enormity of the decision that was being made. But it was important that the person taking the consent was aware that the mother had heard those words because following the taking of the consent the person taking the consent would have to sign a certificate saying that the mother had been given the chance to read the instrument of consent and that the consequences of it had been explained to her.

Following the reading of form 9 the consent would be signed and the various alterations initialled. The alterations would mostly relate to the mother's wish about the religious upbringing of the child. In the early 1970s up until 1973 when many mothers were cared for in mother and baby homes sometimes the consent taking would be the first and perhaps the only time at which the agency social worker would see the mother, but at that time it was important to have the mother explain her reasons for signing the consent. The common reasons were, "I'm too young", "I haven't the funds", "I do not have the capacity to provide for this child", "I want the child to have two parents", "I want my child to have things that I know I can't give it."

I certainly accept that so soon after the birth that if the mother was affected by the sort of medication that Dr Rickarby describes, her ability to take in that information could have been limited, no matter how clearly it was presented. But I never would, nor would any member of my staff or any colleague with whom I associated, take a consent where there was any suggestion that the mother was affected by drugs or not able to understand what she was doing. On some occasions the mother would be very distressed and you would have to say, "Do you want to sign the consent or should I come back on another occasion?" One would never take consent when the mother was in such a state that you did not feel that she could in her right mind sign the consent.

It was my common practice also and that of other workers on my staff and other people to whom I have talked to use a similar form of words, that you would recognise that for the mother this was an extremely painful decision and probably the most difficult decision she would ever make in her life; that there would be times when it was going to be a cause of sorrow for her and times when she would regret and question that decision. One would say, "When those times come, you can only feel that this was the decision you made regarding it as the best decision for your child in your circumstances at the time."

[*Interruption from public gallery*]

CHAIRMAN: It is very difficult for Ms McDonald to present her evidence when so many women present at this hearing do not agree with it. She has been summonsed to appear before the Committee to give her evidence and she must be given respect when giving that evidence.

Ms McDONALD: That is probably sufficient on the consent aspect, unless the Committee has questions about that.

CHAIRMAN: Questions about revocation and other issues will come later.

The Hon P. T. PRIMROSE: Your submission states, "It is important that inadequacies of practice resulting from the limitations of knowledge be acknowledged." What were those inadequacies of practice and could they be considered to be unlawful or unethical?

Ms MARSHALL: The meaning of the terms "unethical" and "unlawful" imply moral turpitude, that is, knowing that what you were doing was wrong and doing it anyway either acting contrary to the law or in defiance of professional ethics. I cannot speak for the whole field, but in the context of a private agency in which I worked and in the social context in which we worked at that time I do not believe there were any illegal or unethical practices. Inadequacies of practice which affected all parties to adoption arose from the underdeveloped state of knowledge, not from any ill will or power play. From what we now understand, it is the lack of support services for women who surrendered children for adoption that may be the most serious lack.

The traditional role of adoption agencies historically was to focus on the placement of children surrendered for adoption. That was our principal purpose. A secondary focus was on developing assessment methods so that the best adoptive parents could be selected. Private adoption agencies had much more flexibility than did State departments. Resources were stretched to the limit and little was done for the mothers once the consent was signed. We worked within the widely held presumption of the time that for an unmarried mother who did not have family support or partner support a decision to have the child adopted was almost inevitable. Social censure for mothers of illegitimate children was strong and there were few avenues of support.

In the agency where I worked the follow-up interview was routinely offered but it was seldom availed of. Many young women had to return to country centres or interstate and in many cases did not want a letter from the agency because the whole affair had been conducted in secrecy and they did not want it generally known. So, the sad consequences, and they have been clearly revealed to us at this stage, were that the women suffered

dreadfully and were offered no help. That must be acknowledged. While acknowledging all the different services and systems involved—medical, welfare and adoption agencies—with the lack of services for mothers and the lack of understanding about the long-term emotional consequences of surrendering a child and thinking back to actually working in that time and the limitations of what was available, it is hard to know what we could have done.

Thinking back, if we had known what we know now, what could we have done? There were no places to refer women who wanted help, unless they had resources. What could we have done? I am still not sure about that question. I have asked myself that a lot since I have learned about the suffering of relinquishing mothers. Around the early 1970s some relinquishing mothers took the initiative of asking the agency to get some information about what had happened to their child. So, the agency made tentative moves approaching adoptive parents and asking for some information and early photographs. Sometimes the adoptive parents responded sensitively and generously, and others less so, but it was the beginning of our recognition that something could be done to help and comfort women who, it was later shown, had suffered one of the most terrible consequences of adoption: not knowing anything about what happened to the child.

I remember a submission I received when I was preparing the 1984 review of adoption policy and practice. One relinquishing mother wrote, "My God, aren't I even to know whether he's alive or dead?" That really brought up sharply the injustice of them not knowing. Of course, the Adoption Information Act to a large extent has redressed that problem. However, as I said, thinking back I really do not know what we could have done, but it is quite clear that services failed those women. But I reject in the context of the time and in the agency in which I worked that there was anything illegal or unethical.

The Hon P. T. PRIMROSE: You have mentioned that under no circumstances would a practitioner with whom you were associated seek to take a consent if they believed a mother was under the adverse influence of medication. How was that assessed?

Ms MARSHALL: It would be obvious, would it not? If a woman was half asleep or dopey or crying, it would be obvious. Despite what the perception might be, we took this consent taking very seriously. If a woman was obviously or apparently not capable, we did as Margaret said and arranged to come back. But many women did not feel they had an alternative and pressed ahead regardless as it were.

Ms McDONALD: Often the taking of the consent on the fifth day was really a response to the mother's wish to be able to leave the hospital and return to her family.

Ms MARSHALL: If the women were in hospital, some regional hospitals were different but large hospitals offered no choice. The women either had to take their babies or surrender them for adoption. There were no intermediary services of any great significance on which they could call.

The Hon P. T. PRIMROSE: I appreciate that you have answered the elements of this next question, but I formally ask you, do you believe there were or may have been any instances of systematic illegal or unethical behaviour with past adoption practices? If so, could you provide details?

Ms McDONALD: I can only speak from my personal experience, and that is that I am not aware of systematic illegal or unethical behaviour, although clearly in the nature of things there were, and certainly the evidence presented to this Committee demonstrates clearly, individual instances when such behaviour took place. I am certainly aware from my experience at the Post Adoption Resource Centre and from accounts given to me by birth mothers that there were many instances in which women were treated harshly and judgmentally in a way that failed to respond to their needs or to protect their dignity. It would seem to me that such behaviour was unethical; certainly highly undesirable and possibly unethical. If the purpose of that behaviour was to force the mother to consent to adoption, in that sense it was illegal just as it would have been and is under the Act illegal to persuade a woman not to consent to adoption if that is what she wants to do.

Not necessarily professional social workers, but people who were specialised adoption workers, such as the departmental allotment officers, were aware of the importance of ensuring that the mother was acting of her own free will and not under pressure. Another question might be whether the social system was coercive, and clearly it was. That system included community attitudes, including the views of the churches, politicians, media, families and the shame they felt about the pregnant daughter, illegitimacy, social structures, the lack of adequate financial provision for unmarried mothers and some professional practices, and I include practices of social workers. I acknowledge that when one looks at the system overall, workers working at that time were part of a coercive system, but I make the distinction between the fact that these influences were being brought to bear on the mother—and we were part of that system—and the contention that the system was set up to separate women from their children.

CHAIRMAN: To what degree, in taking a consent, would a social worker check with or consult with other professionals as to the state of the mother, for instance, or the impact of drugs? Can either of you shed any light on that?

Ms MARSHALL: My experience is more limited than Ms McDonald's. I can remember not consulting but going away and saying, "I will come back in a couple of days," but I do not remember consulting with medical people. It was obvious it was not the time to do it.

CHAIRMAN: More broadly, was there any consultation between social workers and health professionals, such as team meetings, to discuss the process?

Ms MARSHALL: Not in my experience, but Ms McDonald's experience is broader than mine.

Ms McDONALD: Could you repeat that?

CHAIRMAN: Was there any process of consultation or checking between social workers and health professionals as to the process to be gone through, the timing, whether the mother was in a fit state from the medication or whatever?

Ms McDONALD: The whole question of medication is something we were unaware of, although I have recently had access to my medical record of six confinements between 1958 and 1969. My first child was a full-term stillborn, and I was interested to see that I was given pentobarb. In a number of subsequent pregnancies I was also given pentobarb. No-one asked

me, nor did I give informed consent to be given pentobarb. I was also given stilboestrol on occasions. Informed consent in relation to medical procedures and the administration of drugs, and knowledge about their severity, was very primitive.

It was a surprise to me when the first allegations were made of mothers being systematically drugged because we would have been unaware of it. We would not have raised the question of whether the mother was being given medication. We would consult if a mother wanted to leave hospital prior to the fifth day and wanted to sign a consent. There had to be a medical certificate saying she was in a fit state to sign. We would also consult if there were a question of mental illness, retardation or something of that sort which would call into question the capacity of the mother to give informed consent. In those situations we would seek specialist advice.

CHAIRMAN: What if a mother were undecided?

Ms McDONALD: If the mother were undecided, if she were really undecided and did not want to sign, we would not have taken the consent. But some women would sign a consent in the expectation that they would possibly revoke it.

CHAIRMAN: Would you consult with anyone if a mother was undecided?

Ms McDONALD: Consult with another colleague, or—?

CHAIRMAN: Someone at the hospital?

Ms McDONALD: Not generally.

CHAIRMAN: Social workers had a relationship with the mother?

Ms McDONALD: Yes.

CHAIRMAN: And the people at the hospital had a relationship with the mother?

Ms McDONALD: Yes.

CHAIRMAN: And they basically had no communication?

Ms McDONALD: You have to see it as very much a compartmentalised system. This is also one of the deficiencies of practice. We each did our bit. There would be consultation with the hospital social worker if there were particular concerns about the mother, mostly her health or her state of uncertainty.

CHAIRMAN: But basically it was compartmentalised?

Ms McDONALD: Yes, it was.

The Hon. Dr A. CHESTERFIELD-EVANS: The social worker agency—?

Ms McDONALD: The adoption agency?

The Hon. Dr A. CHESTERFIELD-EVANS: No, in evidence last session the social worker agency basically said the job as a social worker with the department was not sought after because the social workers felt it was a job in which they had little power and that they were very much constrained by departmental guidelines. I gather that social workers were bonded to the department for some time in that they were paid to go through university and they then had to serve out time with the department?

Ms McDONALD: Yes, for a relatively short period. That was mostly in the 50s and early 60s. I do not know. It was really prior to my experience. The allotment officers, who were the specialist adoption officers, had either social worker or psychology qualifications. They were graduates who had perhaps a social work background. At that time the department was regarded as somewhat unsympathetic to professional values, so people tended to move on. But a number of remarkable and talented social workers worked within the department, particularly in the allotment section in the mid-70s when Renata Tankard became the senior allotment officer. There was a great deal of contact between adoption agencies and the department, and advances in practice that came about were largely through that relationship.

The Hon. Dr A. CHESTERFIELD-EVANS: What you are saying does not seem inconsistent with that comment. You are saying they were graduates. If they came straight from university without experience, their first experience was of the department putting pressure on them. By definition the job was the business end of the system and the system was designed to either take your baby home to no income, no job, an unsupportive family and perhaps a boyfriend who could not support or sign the piece of paper. The pressure to sign the piece of paper must have been overwhelming, shall we say. Perhaps the social worker was as depowered as the mother because this thing had to be done one way or another before the mother went home, which was imminent, and taking the baby home within the social support that existed was difficult?

Ms McDONALD: That is a fair statement. It was worse before the 1965 Act. At least the 30-day revocation period gave the mother a period in which she could reconsider her decision if she were able to revoke the consent. Prior to that time the child would have been made a State ward if the mother wanted the baby fostered during that time. The revocation period gave the mother a clearer time to reconsider her decision.

The Hon. Dr A. CHESTERFIELD-EVANS: The allotment officers had up to 400 clients?

Ms McDONALD: No, it was a hospital social worker who may have had 400 clients.

The Hon. Dr A. CHESTERFIELD-EVANS: The allotment officers did not have 400 clients?

Ms McDONALD: No. One of the frustrating things in the department was that the allotment section of the adoption branch was a professional island within a bureaucratic structure, particularly in relation to the assessment of parents and the placement of children. The system was very inflexible. The assessment of adoptive parents was done at district officer level, at local level. Decisions about approval of applications was a clerical function, although the professional assessment section would have been consulted in difficult cases. Those were some of the difficulties of working in that system.

The Hon. Dr A. CHESTERFIELD-EVANS: You said the allotment officer saw that the baby was fit, chose the parents and made sure the consent was properly taken?

Ms McDONALD: Yes, and she placed the baby. But she would have to place the baby not through direct knowledge of the parents with whom she was placing the baby, but often a somewhat limited or uninformative report from a district centre. This changed later, particularly from the mid-70s. That was a problem in the system.

Ms MARSHALL: It was very compartmentalised. It was not one person who saw the mother through the whole system. It was something done here and something done there.

The Hon. Dr A. CHESTERFIELD-EVANS: So that the allotment officer really had very little room to move? In a sense the mother had to sign the paper because she either had to take the baby home or sign the paper. The allotment officer really had nothing to offer, she was guiding the mother through the distress of signing. Would that be too strong a statement?

Ms McDONALD: The department offered other sorts of services to women planning to keep their children. For example, it undertook affiliation proceedings on behalf of the mother. Prior to the supporting parent benefit this very limited amount of money would be available. Those were the available options.

The Hon. CARMEL TEBBUTT: You have probably answered this question, but you may wish to add to it. In your submission you say that prior to the implementation of the supporting mothers benefit in 1973 it was extraordinarily difficult for single unsupported women to take responsibility for a child. Although the availability of non-adoption options were very limited before the 1970s, drawing on your experience, was information about the options given freely and fairly to birth mothers?

Ms MARSHALL: Perhaps I can add a little more. No, in our agency as a matter of routine they were not. The question appears to assume that alternatives were as available then as they are now but that was not the case. The young woman who came to our private agency had been referred, in the great majority of cases, by a hospital or by a mother and baby home where the preliminary discussion about adoption had already taken place. The first step was taken when they came to the adoption agency and we presumed they were going ahead with it. The options were not routinely offered, discussed or brought up. However, when they brought it up it was a different matter and we offered them whatever information we had. When they stopped in track and said that maybe they would not go ahead, what could they do, there was not a great deal they could but we gave them whatever information we had. Of course, the agency records can verify that some women withdrew.

There were some women who went as far as completing the background information and then for some reason they were able to find a solution and they withdrew. The answer is, no we routinely did not do it for those reasons but if they brought it up and asked for help we helped. I do not know whether that fits in there or not. When a consent was signed but the mother revoked her consent within 30 days the agency would willingly give her assistance—I am only referring to the agency in which I worked. These events were stressful for everyone, I remember them well. The workers were torn between joy for the young mother that she had found a solution and sorrow for the adoptive parents. I remember going to a remote country town and reclaiming a baby for a mother who had changed her mind.

In those days if the young mother said she was sure she would not change her mind we told the adoptive parents that it was not legal until the 30 days and they could take that risk on the basis that it might be better for the child and the adoptive parents to start settling down together. We did that only when the mother said she was sure she would not change her mind. Of course, sometimes she found a solution and changed her mind. When that happened we did everything we could to facilitate getting the baby back. That is our experience in that agency and I cannot speak for others.

The Hon. CARMEL TEBBUTT: The Committee has received many submissions from women who claim they were not informed of their right to revoke consent or were obstructed in their attempts to revoke consent. Could you comment on that? In the research for your book on the history of adoption have you come across any statistical data on the number of revocations that occurred?

Ms McDONALD: Yes, speaking from my own experience at the Catholic adoption agency and from the five years when I worked in the adoption branch, I can say without any hesitation that it would have been unthinkable for me, or any worker associated with me, to fail to inform a mother of the right of revocation or to impede in any way her right to revoke, if that was the decision she finally made. However, while I was at the Post Adoption Resource Centre we prepared a submission for the Law Reform Commission on the review of the Child Welfare Act.

We did a small survey of a group of birth mothers about their understanding of the consent process and whether they understood the right of revocation. There were two mothers who said that they had not been informed of their right to revoke and in each of those cases the social worker concerned was known to me and it would have been totally uncharacteristic of that worker not to have informed the birth mother. The other characteristic of the responses that people gave about the right to revocation was that even people who said that they had been told and that they understood it they gave a very garbled account.

In the light of what we now know about the stress surrounding giving a consent to an adoption at that early stage after the birth of the child the conclusion we came to from looking at that evidence was that for many women there was not a recollection of having been told or that their memory of it was flawed because of the stress that they were undergoing and possibly the denial since.

The Hon. CARMEL TEBBUTT: Do you have any statistical data?

Ms McDONALD: Yes I have some statistics but I would also like to say that I had said earlier that after 1973 at the Catholic adoption agency we routinely gave a mother a copy of the documents which she had signed, including the form 9 with the date of revocation worked out on it. I can date that because we had a contested adoption in which a mother who had consented to the adoption revoked her consent, had taken her child home for six weeks and then reconsented and the child was placed. The mother subsequently contested the adoption on the basis that she did not understand the process of revocation.

Although the adoption went through we were alerted at that time to the fact that there needed to be some reinforcement of the decision that had been taken and that the mother needed evidence that that had happened. I was interested in the questions last week about

placement within the 30 days and whether that was unethical. It was common practice, having consulted the mother and assessed the situation, to place within the 30 days. If the mother said, "No, hold the baby" we would hold it for 30 days. It surprised me from reading that case about which there is also available a reported judgment that we would have placed the baby and we placed that baby again within the 30 days even though the mother had revoked her first consent.

Our reason for doing that was that I was the person who took the second consent and she was ringing me and saying, "I can't bear to think the baby is waiting there at St. Anthony's, have you placed it?" What, in fact, triggered her contesting the adoption was the letter that I wrote to her saying the baby had been placed and giving her some information about the parents. When I look at the evidence that came from that small PARC survey, and look back at that case, it seems to me, although I do not remember when we stopped placing during the revocation period but I think it was some time in the early 1970s and the child would go into foster care—

Ms MARSHALL: That was after a run of revocations.

Ms McDONALD: I think it was. We felt it was not in any way wise to do that.

The Hon. CARMEL TEBBUTT: Have you statistical data?

Ms McDONALD: David Handley, professor of law at the Australian National University in a paper he gave at the first adoption conference quoted these figures. In 1973 and 1974 the rate of revocation of the four New South Wales agencies was 10 per cent. This was contrasted with South Australia where the rate was 5 per cent. I am not aware of any time earlier than that, although that information must be available in the files to be collated. Some surveys have been made for the years 1981 and 1991. In 1981 the rate of revocation was 16 per cent and in 1991 it was 21 per cent.

The Hon. CARMEL TEBBUTT: What is the long term effects on women who have experienced unresolved grief as a result of the loss of a child through adoption? You may have covered that in your initial statement and in your evidence but if you wish to add anything now is the time.

Ms MARSHALL: One of the most influential studies which helped us all to understand the extent of the grief was a Western Australian report in 1983 by Winkler and Van Keppel called, "Relinquishing Mothers in Adoption: their long-term adjustment". That report was very influential and has affected practice, of course. I will give a few of the major points from that report.

The Hon. CARMEL TEBBUTT: Perhaps we can get that information from you after the hearing.

Ms MARSHALL: Certainly. To sum it up, the report reaffirms all that has been said and defines two major factors: the inability to discuss feelings and the inadequacy or absence of any support following the consent. They were two very major factors on the psychological and emotional effects long term. The report also notes that it was not the same for everybody so not everybody experienced a negative adjustment.

CHAIRMAN: Can you comment on post adoption support and counselling?

Ms MARSHALL: I addressed that earlier when I said that they were left to their own devices. There were no support services, and that was one of the major inadequacies of the practice.

CHAIRMAN: What measures might assist people experiencing distress as a result of past adoption practices?

Ms McDONALD: I would agree with Dr Rickarby that the report of the Committee is going to be a major way to address the distress mothers have suffered as a result of past adoption practices. The Committee's report could perhaps serve the same purpose for some birth mothers as the English book *Half a Million Women: mothers who lose their children by adoption*. I had a client at PARC who, having read that book, carried it around with her for a time. She said to me, "Now that it is written down I don't have to feel that I have to keep it all in my head".

The recording and acknowledgement of the coercive social circumstances at the time, the deficiencies in knowledge and practice, the recognition that the surrender of a child is a traumatic and life-changing experience from which some women have never recovered and validation of their experience should provide assistance to those women. I would also support all the measures outlined in the PARC submission, particularly the wish of birth mothers that the circumstances of the surrender should be understood by their adult children. It should be recognised by the publication of a book of stories like the book produced by Carmel Bird from the "Bringing them home" report.

The decisions of women who surrendered their children in the sincere belief that it was in the child's best interest and who adhere to that belief should equally be honoured. There should be an extension of post adoptive services which include the funding of self-help groups and, if possible, some provision, where needed for assistance in the waiver of registry or other fees, similar to the fees assistance fund that operated at PARC that enabled people to access certificates when they were in dire financial circumstances.

The Hon. Dr A. CHESTERFIELD-EVANS: Did birth fathers have any rights in terms of the decisions made with regard to adoption, were they taken into account, and how were they informed and involved?

Ms McDONALD: Birth fathers had no legal rights until the 1980 amendment to the Adoption of Children Act, which gave a father who had been identified on the birth certificate, or who had by some other means been identified as the father of the child, the right to be informed of the signing of the consent and to put forward within 14 days an alternative plan for the child. The recommendations of the current Law Reform Commission report are that birth fathers should also have to consent to the adoption.

The Hon. Dr A. CHESTERFIELD-EVANS: That happened after 1980, is that right?

Ms MARSHALL: No, it has not happened yet.

Ms McDONALD: After 1980 the birth fathers had those limited rights. They still do not have the right to consent. There is not the requirement that the birth father consent to the adoption. Although, I understand that many agencies would now involve the birth father if possible. In relation to your question to an earlier witness about when the changes started to occur, I think very marked changes in practice started to occur probably from about the mid-1970s.

(The witnesses withdrew)

CHRISTINE ANNE COLE, sworn and examined, and

DIANE PATRICE WELLFARE, affirmed and examined:

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

Ms COLE: As the chairperson of Origins and as a mother.

Ms WELLFARE: As a mother and as the secretary of Origins.

CHAIRMAN: Did you each receive a summons issued under my hand?

Ms COLE: Yes, I did.

Ms WELLFARE: Yes. I did.

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

Ms COLE: Yes.

Ms WELLFARE: Yes.

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

Ms COLE: Yes.

Ms WELLFARE: Yes.

CHAIRMAN: Do you wish to elaborate on the submission, to make a short statement, or to simply answer Committee member's questions?

Ms COLE: I will defer to Di Wellfare, who has done the main work of the Origins submission.

CHAIRMAN: Would you explain to the Committee the background to the establishment of your support group Origins, including details of the numbers of group members across New South Wales and the nature of the support that you provide?

Ms WELLFARE: Origins was founded in April 1995 by a small group of women who saw the need to provide an alternative support service which focused on two issues that we felt were pertinent to our healing but were not being addressed, in fact, they were being ignored and dismissed. One was our need to address our past adoption experiences and to stop post-adoption counsellors and health professionals from minimising and invalidating the severity of damage created by adoption separation. At the time we recognised that almost all post-adoption workers set up to counsel mothers were the very same social workers who had been involved in taking our babies. We saw that as a continuation of our abuse through professional control. I suppose the bottom line is that we felt it was time in 1998 to bring a bit

of reality and honesty into adoption and to dispel this adoption myth.

As an organisation with a New South Wales membership of 620 mothers already, not including our interstate membership, we have a combination of 28 support groups and phone support services Australia-wide, with 14 service providers in New South Wales. We are affiliated with groups in the United Kingdom and New Zealand. We are entirely self-funded and offer confidential support and assistance through regular and out-of-hours emergency telephone services seven days a week. We hold monthly support group meetings and provide information and support in the search and reunion process, including redirection to alternative search services when the need arises.

We provide mediation where required and offer our members an informative quarterly newsletter, as well as access to a comprehensive reference and research library of historical documents, literature, books, videos and audio cassettes. We also provide information kits to health professionals who seek a wider understanding of adoption trauma to accommodate their patients' needs as required, and have recently sought funding to mass-produce and distribute a booklet on this issue to all health and referral services in New South Wales.

CHAIRMAN: Has the Origins group collected any statistical data on the number of women affected by past adoption practices and the nature of those practices?

Ms WELLFARE: The Registry of Births, Deaths and Marriages asserts that from 1950 to 1997, 76,453 adoptions took place in New South Wales. The registry was unable to provide us with the actual breakdown of step-parent adoptions and of older children placed for adoption. Non-traditional adoption statistics are believed to be relatively small and in the low hundreds per annum as during this period, and especially from the late 1950s, this was where the emphasis changed in adoption from being a service for children in need to providing a service for infertile couples, the emphasis concentrated almost entirely on infant placements, with infertile couples generally refusing to adopt any child other than a newborn, with the promotion of traditional adoption having been based on the premise of alleviating the emotional distress caused by infertility by providing an infant young enough to be "as if born to the adopting couple", rather than to its own mother.

While we have conducted no empirical research data as such, we have provided questionnaires to our members through our newsletters and have tabled those questionnaires pertaining to their adoption experience as part of our submission to the inquiry. We have gathered an enormous amount of literature dating back to the early 1940s—in fact, one going back to 1926—including psychiatric case studies clearly outlining the overrepresentation of adopted children in mental health facilities and the emotional harm and confusion created by adoption separation. I refer to Origins submissions 3, 3a and 3b presented to this inquiry, which were researched by Wendy Jacobs with assistance from Lilly Arthur.

We have observed the high incidence of suicide in adopted males and attempted suicide in mothers. Although no research has yet been conducted into this issue, it has not gone unnoticed that the peak suicide rate in Australian women coincided directly with the peak adoption period. During the last three years I have spoken to more than 2,000 callers—some being one-off calls and others becoming full members—and have observed that, in general, and almost without exception, the mother's interview and confinement process have followed

a routine pattern. The treatment I have referred to was systematic Australia-wide, with only a few slight variables depending on the hospital concerned.

The Hon. Dr A. CHESTERFIELD-EVANS: With regard to past adoption practices, what are your members telling you about the practice of not allowing the mother to view the child after delivery and the use of a pillow or sheet to ensure that the mother did not see the child?

Ms WELLFARE: Probably the best way to begin to answer this question is to quote from Pamela Thorne nee Roberts, who was the head social worker in charge at the Women's Hospital, Crown Street, between 1964 and 1976, policy maker for New South Wales adoption regulations and chairperson of the Standing Committee for Adoption in the early 1970s. As witness for the State in the recent case of *W v The State of New South Wales*, Mrs Thorne explained under oath that the routine adoption practice was to "forbid eye contact between mother and child to prevent bonding". Mrs Thorne went on to explain how the unmarried mother's medical chart would be marked with the codes “UB-”, that is “UB minus”, and “BFA", meaning "baby for adoption". Unbeknown to the mother, this code was used as a routine guide for the labour ward staff. Mrs Thorne explained that this code had three functions.

The first was to ensure that the mother did not see her child. My inclusion there is that policy dictated that eye contact between mother and child was forbidden to prevent bonding. Mrs Thorne went on to say that the second function was regarding the location of mother and child postnatally, where the mother would be separated from her child by being transported by ambulance, heavily sedated, to another hospital without her baby. The third point, according to Mrs Thorne, pertained to the type of medication to be administered to the unmarried mother. According to our medical records, she was inferring that specifically 200 milligrams of sodium pentobarbitone was routinely administered almost immediately upon birth and stilboestrol was administered at the same time to begin suppressing lactation; this is while the mother was still in the labour ward.

Mrs Thorne's explanations coincide directly with the experiences routinely conducted on every unmarried mother in Crown Street and almost every other hospital in this State. We are not aware of any mother who was advised of the medication or treatment that she was to endure and was therefore denied her legal right as a patient to refuse such treatment. It was routine adoption practice to interfere in the birthing process between the mother and child by snatching the newborn from its mother's womb while she was entering the third stage of labour and whisked away and hidden while the mother was still bound by stirrups, heavily sedated, some being shackled by the wrists to the bed, as per the video that we have offered this inquiry, whilst awaiting the expulsion of the placenta.

To prevent the mother from having eye contact with her newborn, measures used to prevent bonding included placing a sheet on the mother's chest or at her face, holding a sheet up to obstruct her view, turning lights down or off, using blind folds, turning the mother's head away, standing in her way of vision, rushing the baby out of the labour room immediately upon birth, using heavy sedation during labour, holding the mother's shoulders down to prevent her from lifting herself up, pushing the mother back down if she sat up, and shackling the mother to the bedhead, as per the 1971 video included in the submission. The baby would then be hidden from its mother within the confines of the hospital. In smaller hospitals, it would be in staff rooms, linen closets, or locked or hidden nurseries, denying mothers free access to their

babies. In Crown Street, for example, the mother would be transported by ambulance to another location, at a time when she was still the sole legal guardian of her child and she could not legally be denied access to the child.

During this post-confinement period methods of keeping the mother at bay varied. Directives came from a collusive agreement between the adoption agency and the hospital to which the unmarried mother's home was affiliated. During the 1960s the mother was usually forbidden to see her baby at all. Some were permitted to see their babies once—but only after they had signed the consent to adopt—although they were not allowed to touch or feed their babies. We have that evidence in the Carramar video that is presented to this inquiry, which is a 1966 video that we uncovered from the Carramar girls experience; that was the Anglican Adoption Agency.

By the 1970s the adoption industry decided that the mother could cuddle her baby once to say goodbye, but only under strict supervision and guarded by hospital staff, in case she got a grand idea to run off with her child. Mothers would be pushed out of the nurseries. In fact, one told me that she was dragged back to her bed by the hair. One young mother managed to grab her own baby, only to have it wrenched from her breast with the nurse running down the corridor while the mother was injected with a sedative; that was the Salvation Army in 1973.

If a mother was found loitering around the nursery window she would be chastised and sent back to bed. Upon obtaining their prescribed information, many mothers have come to realise that they had been shown the wrong baby after signing the consent to prevent bonding. As their records indicate, the baby they saw was not at that location at all. Others were told their baby had died at birth. We believe this was part of the rapid adoption process that was widely accepted by the obstetricians. They preferred that, because the mother of a stillborn child could immediately breastfeed the alien child. These women were told their babies had died at birth only to have the dead baby turn up decades later after being adopted.

Mothers recall being told their dead baby was buried in the rose garden of the hospital grounds. One asked to see her dead baby a day after birth, to be told the baby was too decomposed to view it, and on it goes. These last claims, by the way, come from the Newcastle area. That is where most of those are coming from. Ironically, it is interesting to note that although women were treated as animals without human instincts, at a Sydney staff hospital meeting in the late 1960s a psychiatrist had to remind the staff that unmarried mothers were not a lower order of human beings or animals who lived by our instincts, that we were just human beings like themselves.

The Hon. Dr A. CHESTERFIELD-EVANS: You have touched on the subject of the use of drugs before, during and after birth.

Ms WELLFARE: Yes, I have that coming up. Many women claim they do not recall too much about their hospital confinement period, and it is not until they obtain their medical records that they realise their lack of memory is caused not only by the mind blocking of the trauma and of the separation from their baby, but also by the heavy level of sedation they had received. Mothers were usually heavily sedated during labour with what was known as lytic cocktails, used medically to obliterate feelings. These consisted of a combination of pethedine, codeine and psychotropic hypnotic barbiturates, such as pentobarbitone, sparine, largactyl,

phenobarb, sodium amytil, morphine, heroin, chlorylhydrate and bomadom, which would be administered during the post-confinement period until consent was taken.

The letters "PRN" stamped on the patient's medical drug sheet indicated that the list of drugs had been authorised by the doctor and could be used for sedation as required. Drugging the mother, as it turns out, causes pharmaceutical depression of the mother or baby, or both, causing respiratory depression, and interferes with the bonding and the initiation of breastfeeding. These drugs had a dual purpose, I dare say. Lactation was suppressed directly after birth, by using the synthetic hormone DES stilboestrol—administered usually in three-times the legal dosage and known since 1971 to be carcinogenic—and/or by the method of breast binding. Some women needed both.

The process of suppressing lactation routinely commenced without asking the mother if she was keeping her baby, indicating a pre-conceived presumption and plan to remove her baby from her. All hospital treatment was carried out without written authority or consent from the mother. Most mothers would still not know they had been administered this hormone, nor would they be aware of the now-known and potential life-threatening life risk to themselves or to their subsequent children in having been administered Stilboestrol. I might say here that any woman who has come in contact with Stilboestrol is at this stage in her life not to use hormone replacement therapy because she is now at risk of cancer. This comes from an American drug institution in the recent few years.

The Hon. Dr A. CHESTERFIELD-EVANS: Would you now refer to the process involved in taking consent for adoption?

Ms WELLFARE: In 1952 the World Health Organisation recommended that a mother should be assisted to keep her child in the child's best interests, and the New South Wales Government took on those recommendations and endorsed the provision of financial assistance and other facilities to enable the mother to keep her child. We are talking about 1953. The book *Children in Need*, written by Donald McLean, was endorsed by the then Deputy Premier, Mr Heffron. That book claimed that as part of the regulations in relation to the Child Welfare Act to make sure there was no misunderstanding on the part of the mother, prior to taking consent the mother was to be advised of all facilities to enable her to keep her child.

This included financial assistance under section 27A (aid) of the Child Welfare Act, foster care, various child minding facilities, State wardship until she was better placed to care for her child; and, as a result of the Mace-Murray case, because of the debacle that split the nation, the mother was also to be advised of the risk of dire future regret and the risk of psychological harm if she was to decide upon adoption. I will now go into the actual process that was supposed to happen. According to their own manuals on adoption practices—which I believe nobody has bothered to read for over 40 years—it was and still is the responsibility of both the social worker, who was called the almoner and counsels the mother prior to delivery, and the allotment officer, who takes the consent after delivery, to counsel her wisely on her options and alternatives to adoption.

According to a report presented to the former Attorney General, Mr Frank Walker, by the former Minister for Community Services, Mr Rex Jackson, this included warning the mother of the risk of dire future regret if she was considering adoption. In 1965 *Hansard* reports how

the unmarried mother is to be warned of the psychological consequences inherent in adoption separation. That was back in 1965, yet the adoption industry continues to systematically disregard its duty of care today, in 1998. Possibly the most damning of our discoveries is that the adoption industry has never been ignorant but has been fully aware of this psychological harm that the industry has inflicted upon its clients, with Pamela Roberts declaring in my court case under oath in her written statement that health authorities had been fully aware of the potential for harm in forcing the mother to surrender her child for adoption in 1968.

The child welfare regulations, by the way, clearly emphasise that only if a mother insists upon adoption after all available alternatives and options have been made clear to her, was the adoption procedure to commence. Her consent was not to be taken unless she was firm in her decision. These regulations have never been repealed and yet none of the abovementioned regulations have ever been followed.

The Hon. Dr A. CHESTERFIELD-EVANS: Will you talk about the invasion of the birth mother's privacy before, during and after delivery?

Ms WELLFARE: I have not actually finished my answer. Instead, mothers were systematically denied all knowledge of their legal rights and options, with adoption being promoted as the only course of action available to her, which denied her the right to make any choice at all. Although the baby had already been taken at birth and hidden from its mother, routine consent-taking procedures dictated that some time after the birth, although she had been forbidden by regulations from seeing her child, a mother would be visited by a social worker while she remained conveniently traumatised and sedated. A district officer would then be called upon to take the mother's consent, to make the process look legal, whereas the baby had already been stolen five days earlier than the consent.

Put simply, what occurred as far as the history of practices is concerned is that you cannot deny a mother her legal right to make any choice, forbid her to see her own baby as per hospital practice, hide her baby from her within the confines of the hospital, keep her sedated until the consent is taken and not call it abduction. That is the bottom line with all of this. I would like to go one step further. In the Women's Hospital, Crown Street, the mother's medical chart would be marked with the term "socially cleared" upon having taken the consent, or "awaiting social clearance" prior to taking the consent. The term was an indication that consent had been signed, the mother had been socially cleared and was then free to leave the hospital and resume her place in society. She would be forbidden access to her street clothes until that consent was signed.

If she attempted to discharge herself from hospital prior to being socially cleared she would be threatened with police arrest for abandoning her baby, although by law she could not be charged with abandonment unless she had had no contact with the child for a period of 12 months. We have quite a number of medical records which state "Do not call police. Mother will return" on such and such a date. As far as the men went in this regard, the police would be called to remove a persistent mother who tried to get her baby back from the agency within the legal time. One such example was a 17-year-old mother who in 1967 explained how she had been thrown into the back of a paddy wagon and threatened with gaol if she bothered the adoption agency again. The agency was the Catholic Adoption Agency.

Police were also used to extract a young father from the hospital, although he had the same legal right to see his child as any other father. Many were warned to keep away and others were bashed up by police for good measure. If the mother refused to sign, as many did, unless she had parental support her baby would be taken to an institution such as Scarba House where it would be kept until the mother could be harassed into signing or until the 12 months were up and her consent dispensed with anyway. If the unsupported mother could not be controlled and managed to leave the hospital with her baby, the department's own literature explains that if they provide such a girl with support she will come to see how difficult raising her baby will be and it should then be possible to eventually get the baby off her later. These words are from the department's own literature: they are not my words.

Regarding the invasion of the mother's privacy before, during and after delivery, one way was marking the unmarried mother's records with a code to announce her marital status and that her baby was to be adopted. The second was that although the Secrecy Act in 1967 dictated that no party to an adoption was to have knowledge of other parties to the adoption, the adopting parents have always been entitled to know the mother's name, whereas the mother was not given reciprocal rights. Adopting parents sometimes kept a watchful eye on the mother's progress through life and could have made contact whenever they wished. Mothers were also used as specimens for teaching purposes and could be called up from waiting patients at any time if an intern needed to clock up an induction as part of his training schedule, even if the mother's labour had not begun. Mothers were usually forbidden visitors in hospital and, most importantly, mothers who did manage to see and hold their babies after signing the consent, were never permitted to do so without being heavily guarded by hospital staff.

The Hon. Dr A. CHESTERFIELD-EVANS: Does Origins believe that mothers received adequate counselling or information regarding alternatives to adoption, before signing consent to adoption?

Ms WELLFARE: We have never come across any mother who had any idea that alternatives to adoption had been available prior to 1973 until they heard it from us. Nor have we come across any mother who has been warned of the psychological harm inherent in adoption separation. To the contrary, because quotas had to be filled, all counselling centred around giving the baby up in its best interests. If a mother was audacious enough to ask to keep her baby, she would be swiftly reprimanded for her cruelty and reminded not to be selfish. Although it has been generally assumed that financial assistance for unmarried mothers first became available when Mr Whitlam introduced the sole parent's benefit in 1973, that was not historically true. All Whitlam did was to advertise the already available benefit, give it its own name and bring it into line with the consumer price index.

So contemptuous is the industry of the mother's rights, even the New South Wales President of the AASW, Miss Jill Davidson, disputed one month ago in the *Newcastle Herald* that any benefit was available until the early 1970s. Even with this inquiry they could not be bothered to do their homework! Origins discovered the availability of financial assistance in that group's own literature. The availability of financial assistance, although it varied depending on the circumstances, was always apparently $1 less than the widow's pension.

Not only did we discover our rights to such assistance in the child welfare regulations of 1956—which clearly no-one has bothered to read for more than 40 years—but in the social

work and district officers training manual of 1958, the *Daily Telegraph* of 1965, the social service statistics for 1968, the 1969 social services eleventh national conference presented by Pamela Roberts, but also in their own social work journals. They outline the financial assistance, available day care facilities which gave the unmarried mother priority to enable her to have her child cared for while she worked, temporary accommodation and the right to apply for a Housing Commission accommodation—although there was at that time a three-year waiting list in 1968.

Also outlined are: assistance with obtaining maintenance from a child's father, a layette, special foods and formula where required and State wardship or foster care until the mother was better placed to care for her child. As we managed to discover this in the department's literature, it was obviously known to the department. But none of this information was ever made known to the unsupported mother prior to 1973. Although the apologists will defend themselves by declaring that either 60 per cent or 40 per cent of unmarried mothers kept their babies—depending on who is telling the story—of those who kept their babies, the majority were older mothers in stable de facto relationships, the very young who came from child welfare institutions and possibly knew their way around the child welfare system, and those who were supported by their parents. These provisions were implemented specifically to provide for the unmarried mother and her child who had no family support, yet those were the very mothers who were being denied these options.

The Hon. P. T. PRIMROSE: Clearly, you have already indicated your belief in relation to this matter, but I will ask you directly. Do you believe that any systematic, illegal or unethical behaviour took place in relation to adoption practices? If so, what practices do you consider were, first, unethical and, second, unlawful, and could you give examples?

Ms WELLFARE: I have a whole list here. I would like to start off with what I believe was the first big mistake the adoption industry made. It has entirely misinterpreted its own regulations and the law for all most 50 years. Firstly, under the Child Welfare Act, it was in the child's best interests to remain within its family. Provisions were introduced in the early 1950s to enable the unmarried mother to care for her own child. Therefore, in having promoted adoption over assisting the mother to keep her baby and not warning the mother of the potential harm that such a course of action may cause her, the Department of Child Welfare and its adoption agents have committed an offence which not only breaches their regulations and adoption legislation but also constitutes a breach of duty, unconscionable behaviour and a breach of statutory law.

The next point needs to be fully understood. It is: the reason very little is mentioned about the natural mother in either the Child Welfare Act or the Adoption of Children Act other than the protection clauses which explain how the mother's consent cannot be obtained by coercion, duress or undue influence is because in law, the Adoption of Children Act does not come into play until a mother has signed a consent to adoption. This means that the period prior to signing a consent, that is, the process surrounding a mother's pregnancy, birth experience or post-confinement period, does not come under the jurisdiction of the meaning of any adoption Act. The natural mother, by law, whatever her age or marital status, is the sole legal guardian of her child, has the same legal rights to her child as any other mother giving birth and “could” not be legally separated from or be denied access to her newborn child at any time. Therefore, under administrative law, any hospital which introduced practices that

discriminated against unmarried mothers has gone beyond its powers, constituting not only malpractice but also a breach of ultra vires law.

In relation to unethical practices and the question of what is unethical and unlawful in this instance, it is difficult to differentiate. We understand that, while it is unethical to deprive a mother of her alternatives and options to adoption, it creates an unlawful situation which denies the mother her legal right to make a fully-informed decision based on her legally available options, as regulations and law dictate. With regard to the Department of Community Services, these are a few of the points I have made. To systematically deny mothers all knowledge of their legal rights and options contravenes ultra vires law, breach of duty of care, unconscionable behaviour, breach of statutory law and elements of conspiracy to defraud. Using both overt and covert methods of coercion to obtain consent by acts of misrepresentation, that is, using the term that adoption is in the child's best interest, constitutes undue influence, coercion, duress and unconscionable behaviour and are criminal offences.

Not informing mothers of the 30-day revocation period constitutes unconscionable behaviour, fraud, breach of duty of care and breach of statutory standards. Expecting unskilled mothers, that is, minors, to sign legal documents without an adult advocate present and without the mothers understanding the meaning or interpretation of the documents they are signing constitutes a breach of statutory law. Preventing mothers from their legal right to revoke their consent within the legally permitted time by advising them that the baby had already been placed, constitutes an element of conspiracy to defraud, unconscionable behaviour and is an ultra vires act. Promising that which can never in effect be guaranteed, that is, an ideal life for the child being adopted into a two-parent family, constitutes misrepresentation and unconscionable behaviour.

In regard to hospital practice, introducing the inhumane practice of forbidding eye contact between mother and child to prevent bonding constitutes a violation of human rights, is ultra vires and is a breach of duty of care. Interfering in the primal act of giving birth between a mother and child by removing the child prior to the completion of the birthing process and hiding babies from their mothers even though they were the sole legal guardians of their children constitutes unconscionable behaviour, an ultra vires act, an element of conspiracy to defraud, a violation of human rights, a criminal offence under section 91, taking child with intent to steal, violation of statutory law, violation of natural law, breach of duty and, under section 90A, is kidnapping under the Crimes Act. Forbidding mothers to see or touch their babies until their consent is taken constitutes an ultra vires act, coercion, violation of human rights, violation of statutory rights, duress and an element of conspiracy to defraud.

Sedating mothers during labour and the post-confinement period with mind-altering psychotropic barbiturates constitutes a criminal offence under section 38 of the Crimes Act, unconscionable behaviour and conspiracy to defraud. Preventing lactation by the use of the synthetic hormone stilboestrol or breast-binding without prior consent from the mother constitutes common assault, trespass to the person, violation of natural law and violation of human rights. Transporting mothers by ambulance whilst heavily sedated to different hospitals without their babies and without their permission constitutes false imprisonment under common law and an element of conspiracy to defraud. Informing a mother that her baby had died when it in fact had been adopted constitutes fraudulent misrepresentation, unconscionable behaviour, an element of conspiracy to defraud, section 91 taking child with intent to steal, section 91A kidnapping under the Crimes Act, violation of human rights and

intent to deprive the owner permanently.

A social worker failing to inform a mother of a conflict of interest in her dual role of serving the mother and the prospective adopters simultaneously is a breach of professional ethics where no statute of limitations in the court of equity applies. No statute of limitations applies under the Crimes Act as well. The bottom line is failing to have any proper regard for natural law and prevailing domestic and international principles concerning the advancement and protection of human rights.

CHAIRMAN: We have been told that mothers were not encouraged to speak about the loss of their children through adoption and they were advised to get on with their lives. You heard some talk about that earlier this morning. While it has since been acknowledged that this advice was inappropriate, can you tell us what you understand was the long-term impact of the advice?

Ms WELLFARE: Yes. It is understood that when a person is subjected to an unnatural trauma the sound mind protects itself by manifesting a false self, essentially in order to remain sane. Although it is correct that we were encouraged to get on with our lives and to forget what had been done to us, our silence has not necessarily been a voluntary response, but an involuntary reaction, where it becomes impossible to speak about it because it has become unspeakable and it is an unspeakable act. The loss of a living part of oneself creates in the mother a level of trauma and anxiety so great that the mother must manifest a false self in order to survive. The experience essentially becomes "Something that happened to someone I used to be." The mother blocks the experience. The mother dissociates as soon as the baby is taken at birth. She remains suspended and, therefore, silent unless a trigger event occurs and forces her mind to face her loss.

This is why it is known that, as with every other reaction to trauma, the mother regresses back emotionally to the age she was when she lost her baby. In many instances her hormones and body react in the same way as they were meant to had her birthing experience not been interfered with. The found child connecting to his or her reality does exactly the same upon reunion. It regresses back to a childlike state. We believe that this is because of the interruption of the birthing process. During this period of dissociation the mother is trapped into a pathological way of coping with affects and remains distracted and distant from her emotions. She exists on a level of anxiety created by the loss of her child and out of her unconscious terror and fear of annihilation she will suffer if she is forced to face her loss. Her ability to remain sane relies on her mind's ability to keep the secret of her experience from herself.

Mothers are being diagnosed today with severe dissociative disorders, pathogenic grief, learned helplessness disfunctions, psychogenic amnesia, severe post-traumatic stress disorders, chronic depression and anxiety disorders. Many use alcohol and antidepresssants as a coping mechanism and have done so for decades. Many attempt suicide, as with the response to trauma. A mother loses her fear of death. That is apparently an understanding of anyone who has gone through a post-traumatic experience. People lose their fear of dying. Because mothers were told to go away and forget their experience they do not attribute their emotional problems to the loss of their babies and their condition leads to being continually misdiagnosed by the health profession. The same applies to adopted children.

CHAIRMAN: You would have heard Ms McDonald refer earlier to the statistical data which is available on the percentage of revocations that have occurred. She said that for New South Wales the figure was 10 per cent for 1973-74. She gave some other figures as well. Can either of you comment on that data? What do you think it might mean in relation to the psychological handling of women?

Ms COLE: I have spoken to many women but I have never spoken to a woman who has tried to revoke within the 30-day period who has got her baby back. I can only assume that Margaret McDonald was referring to situations where the mother had strong family support and the parents or grandparents went back with the mother and assisted her in getting the baby back. The women that I have spoken to have all said that they tried to get the baby back within the 30-day period, only to be told, "Sorry, the baby has already been adopted."

Ms WELLFARE: Whereas what they were interpreting as placement ... for instance, the form 9 (request to make arrangements), actually states clearly in legislation, that the mother has to understand that she has 30 days, or before an adoption order is made through the Supreme Court, to revoke her consent. What seems to have been conveniently omitted is the word *Order* (from the document), which gives the document a different meaning that could be misunderstood by hospital staff. An order can only be made through the Supreme Court. By reading that, hospital staff could imply that the placement of a child meant the adoption had occurred, whereas that placement was only an interim foster placement that was not legally binding.

We were advised by Wendy Williamson, who was second in charge at DOCS a few years ago, that if the mother revoked the baby had to be returned to her within 48 hours. We understand that the reasons mothers did not get their babies back upon revoking were: first, that the whole process was designed to bond the baby with the infertile couple to create an "as if born to you" situation. One of the reasons why we believe rapid adoption was so favoured and why there is potential for major illegalities is that the mother could not have been advised of her legal rights if her baby had been placed with a woman whose child was stillborn. They would not dare risk taking the child off a woman whose natural child had recently died.

Ms COLE: When I was 16 I had my baby stolen. I went back to the social worker three months later. I was extremely distressed and I asked about my baby, only to be told that I should have got on with my life as everybody else had. Now, my understanding is that in that period of time I was still a minor until the age of 21, so how legal and binding was my signature? I mean, even though I was drugged and bullied, besides that there was just the fact that I was 16 and I had gone back three months later, to be told there is nothing you can do.

CHAIRMAN: Certainly the Committee will be seeking legal advice on that issue and many others. Still on that revocation issue, does that 10 percent figure strike you as high or low?

Ms WELLFARE: It does not strike me as anything because, I mean, the mothers just were not being given their legal rights, so it means little, that percentage. The vast majority of women I know did not know there was a revocation. I found out there was a revocation period in 1992. The vast majority did not know. Prior to the 1960s and 1970s the vast majority that I have come across did not know there was that period. Even in Chris's case, for instance, when she went back she wouldn't have necessarily known that the revocation period

would have been 30 days because she went back a few months later.

Ms COLE: And not only that, we were not given any instruction, for instance, on how to go about it. Who do you go and see? I mean, a 30-day period—so what! What does that mean? Who do you actually go to revoke your consent?

Ms WELLFARE: That is absolutely right. That just raised another point, that we were supposed to be advised that we could revoke by applying in writing to the Equity Division of the Supreme Court and yet we—not me—women were told to ring the agency up and so they would ring the agency up only to be thwarted in what they actually wanted to do. As soon as they rang the agency the agency would say, “I am sorry dear, you're too late. It's too late, and too bad, the baby has already gone.”

Ms COLE: Yes.

CHAIRMAN: We have heard a lot of evidence to that effect.

Ms WELLFARE: Yes. The interesting fact is even if they placed the baby, that law was put into place as protection for the mother. Essentially, we believe that that revocation period was used as a ploy to get the mother's signature, and that effectively it did not exist.

Ms COLE: Yes.

Ms WELLFARE: Effectively the revocation period did not exist; unless the mother had support from her parents, and then it was easy to get the baby back.

CHAIRMAN: Ms Cole, your initial response was to stress that you thought that where revocations occurred it was where the young woman had support from parents and so on?

Ms COLE: Absolutely.

CHAIRMAN: What about the fathers?

Ms COLE: I believe the fathers were denied their legal rights because--

CHAIRMAN: Would you think that revocations occurred because the father was willing to provide?

Ms COLE: No. The fathers were actively discouraged from visiting the mothers. They were hounded out of the hospitals. Mothers were forbidden to see their partners. Fathers were often threatened with carnal knowledge if they tried to help the mothers. The fathers, even though they would have had the same legal rights as any other father before the consent was signed, were not allowed usually even in the hospital; and, if they were, they certainly were not allowed to see, hold or touch their own baby.

Ms WELLFARE: That is right. And there's been a lot about fathers already in these questions and what seems to be indicated is that if the mother did not put the father's name on the birth certificate it wouldn't remain there. That is not the case. The father had to apparently sign a stat dec claiming paternity before his name could be placed on the birth

certificate, but once his name was placed on it then they had to have his signature as well—and they actively discouraged the boys. In fact, in 1976 in the first National Adoption Conference the Director of the Catholic Welfare Commission, Father Davoren, explained that the father had the same legal right as any other father had to see his child, but the hospitals and the adoption process was making sure the mother had no support because if the father was permitted to come and see the mother and see his baby he would be less likely to allow the separation and he would be more likely to possibly even marry the girl, but they were being forbidden to see the child.

CHAIRMAN: Just to return to our last two formal questions. What measures might assist people experiencing distress as a result of past adoption practices?

Ms WELLFARE: I am afraid I have a list.

CHAIRMAN: Do you want to table your list?

Ms WELLFARE: No. I think people need to hear it.

CHAIRMAN: I want to run through it, but for the sake of Hansard would you table some of your earlier material, names of drugs, and so on?

Ms WELLFARE: All of this is in the Origin's submission, more or less. While we believe that no mother has been provided with her legal and human rights in relation to her adoption experience, we do not profess to speak on behalf of every mother with regard to their requirement for justice and for personal healing. There will be some for whom a sincere apology and acknowledgement of past practices will be sufficient. Others will find some relief to know their children are made aware of the separation practices from their mothers. There will be others for whom that will not suffice and they may wish to take action through the Supreme Court, while others may wish to take up their right to lay charges under the Crimes Act, bypassing the Statute of Limitations; and others may wish to overturn the child's adoption based on improper consent.

This is a very serious legal issue that has potentially very serious consequences for many. So for the sake of the mothers contributing to this inquiry, and their displaced children, for the mothers waiting for the outcome of this inquiry in other States and who seek their own justice, and for future, for those mothers who remain too traumatised yet to speak, it is an issue we cannot and have no intention of taking lightly. We, therefore, request that avenues be made available for discussion with the Origins Committee and other appropriate parties for discussion into implementation of our following requirements:

We require an arrangement for provision to provide regular seminars and workshops accredited by the Department of Community Services and Health Department to educate and inform all mental health workers and other health workers of the nature of emotional implications resulting from the mother's and child's experience; and provision of weekend, week long and monthly deprogramming trauma recovery research and respite centres to be made available for those in need of in-depth recovery, where required, the same as the trauma centres set up for Vietnam vets. Our trauma is similar from a woman's point of view.

We require provision of State-wide financial and material support to enable the development of self-help organisations in city, regional and outlying areas around the State; a review into and improvement of all counselling procedures; a State-wide and national campaign to remove the stigma put on mothers who surrendered children for adoption in the past, including the removal of the stigma inflicted upon our children in having been classified as unwanted children; and a full national judicial inquiry into past adoption practices and/or a State-wide criminal investigation under the New South Wales Crimes Act, 1900; and an overturning of the Statute of Limitations. We require a full and sincere apology to all mothers and children who have been separated by adoption from the Australian Association of Social Workers, charitable organisations, licensed adoption agencies, the medical profession, the Nursing Association, the Department of Community Services and the New South Wales Health Department.

We seek reparation, and the reinstatement of all original birth certificates.There should be full disclosure of the truth regarding the past adoption practices as an Act of Parliament to begin the official rewriting of adoption history. We require to have the separation of mother and child at birth officially recognised as a severe and damaging trauma to both. There should be full research and disclosure into adoption consequences including the suicide rates of adopted children and mothers and also the mental health implications to both mothers and children. We want disclaimer stickers posted on all past historical adoption literature and case work studies found in state libraries which depict improper adoption facts based on the promotion of adoption myth to ensure that such inhumanity is never allowed to be repeated.

We require the deregistration of all adoption agency and agent licences for non-compliance with the terms and conditions of their professional licence issued by the Department of Community Services for their failure to comply with the terms of the Adoption of Children Act, the Child Welfare Act, failing to comply with their own regulations, failing to apply a professional standard of duty of care as a professional adoption service to the community. We want accountability in the failure of the relevant director-generals of the child welfare departments and its alternative and subsequent names to police the goings-on of its own department and licensed private adoption agencies as licensing regulations dictated. We also require accountability on the part of the Health Department and/or other responsible persons in its failure to police negligent and criminal hospital administration regulations and practices carried out by licensed hospital staff. Thank you.

Ms COLE: Yes.

CHAIRMAN: In many ways you have answered the last question. Do you think an apology made by the relevant government agencies would assist these women? You have gone beyond government agencies.

Ms COLE: I would like to add to that because I have some documents to table regarding that as well and I wanted to address some of the issues that were raised last Thursday. May I proceed?

CHAIRMAN: Yes.

Ms COLE: An apology from the government agencies and the religious organisations who participated in the inhumane and barbaric practice of systematically separating mothers

and their babies is a first step in assisting the healing process for the women and children affected. An apology would not only acknowledge and validate the intense feelings of pain and injustice experienced by women who have been victims of past atrocities, it would begin to alleviate the feelings of isolation they have been condemned to for decades.

For a woman to go through the experience of having her baby stolen because she was judged unworthy has a devastating and lifelong impact on every aspect of her being. Reducing the barbaric act of stealing a child from its mother, and giving it to strangers or institutionalising it, to statements like “It was the societal mores of the time” or “It was done out of kindness”only prolongs our anguish and mental torment, invalidates our experience and continues our feelings of isolation. How can we feel part of a society that sanctions such an evil with compassionless cliches and buck-passing? I am sure that future generations will judge this shameful and cruel part of our history as not only criminal, but a form of insanity. I believe it is insane to steal a mother's baby and expect her to go home, get on with her life and forget she ever gave birth.

Those that have condemned us to reside in this living hell have a responsibility to alleviate some of the distress by apologising at least for the role they played. If Germany had won the war the Holocaust may also have been reduced to the statement that it was the societal mores of that time.What happened to us mothers was not done out of any kindness. No mother I have spoken to was treated with even human dignity, let alone kindness. Common sense would dictate there was no kindness in denying us the right to see, hold or touch our babies, then giving them to strangers and denying us knowledge of whether they were dead or alive. This is akin to kidnap.

Common sense would dictate that there was no kindness in drugging or in verbally and physically abusing us. Common sense would dictate that using coercion, duress and brainwashing for the sole purpose of procuring our children when we were absolutely vulnerable could in no way, shape or form be interpreted as kindness. Forbidding even the human dignity of eye contact with our babies whilst we were still the sole legal guardians—because our files were coded "Baby for adoption" while we were pregnant—not only presumed consent and was illegal, but it defied the argument that denying us access to our children was for our benefit.

To understand the malicious intent on which the fledgling social work profession in this country was based one has only to read its literature. Single mothers were seen as less than human, moral deviates or mentally impaired. Those involved in the adoption industry saw themselves above the law and morally above us, the victims, and therefore entitled to steal our babies. Recently I participated in the submission to this inquiry by the Committee on Adoption and Permanent Care. I asked the Committee to support a recommendation for an apology to mothers. The Committee initially was reluctant, but Mr Harvey Milson, Director of Adoptions for the Department of Community Services stated, "How hard is it to say I am sorry."

His support resulted in the requested recommendation being approved. I would like to table the minutes of the Committee's last two meetings. I have been deeply saddened to hear Mr Milson now publicly stating there is no need for an apology. I must ask: why has he changed his position? Last Thursday in this House the President of the Australian Association of Social Workers, Ms Jill Davidson, stated that she did not feel it was appropriate for her to apologise. This view is not shared by all social workers. I would like to table two letters urging

a strong and clear apology to all the women the organisation has irrevocably harmed because of its past practices. Maybe the reasons Davidson has declined the opportunity to apologise is because of this comment:

> I am very aware that much defensiveness and denial still exists within government departments, and among some members of the profession who may fear that legal action could be taken against them if they admit to some of their past practices in adoption.

The letter also reveals that the author was aware that her client was "offered no assistance during that time with information to enable an informed choice about her options and had no knowledge of the pension which was available". Ms Davidson spoke at length about the part social work played assisting young mothers in realising autonomy yet the contents of this letter paint a very different picture. It stated:

> AASW needs to take an ethical position on this issue which clearly accepts and validates the disempowerment and loss of self-determination experienced by natural mothers, and the role which social work has played in helping this to occur.

She also asks that:

> The AASW formally offer an apology to natural mothers for the part social workers have played in causing hurts and injustices which have denied them self-determination . . .

She requests that apologies be written. This second letter written to Ms Jill Davidson also pleads for an apology to be given as follows:

> . . . for the profession that obviously had failed so many women and their children both by acts of commission and omission. For example, by too often failing to tell individual women what their full entitlements were and for too long collecting a salary by participating in and failing to challenge a system that inflicted so much pain.

She goes on to talk about others involved in the systematic abuses of mothers as follows:

> The district officers who seemed not to care if the adoption consent taken was informed or otherwise, the nurses who held pillows over the mother's faces, the matrons who wrote in the medical records "under no circumstances is this woman to see her child" . . . the social worker's contribution to people's misery was significant, even if in the end it did act, after its conscience was pricked or educated by the many brave people who had been the victim of such a system, spoke out—

not as was alluded to last Thursday that it was only after research dictated was change implemented. Last Thursday I sat in this House while the representative for the Department of Health decided its past abusive actions towards mothers did not warrant an apology even though its own circular sent to all hospitals across New South Wales warned medical staff that they were contravening the Adoption of Children Act on both legal and mental health grounds and, additionally, as stated above professionals, such as social workers, were well aware of the abuses taking place in the hospitals.

I would also like to make the comment that one of the main excuses from the representatives of all these departments was they acted out of ignorance. I would dispute this in this strongest possible terms. It has been well known by the professionals since the 1940s of the psychological harm occasioned to a child removed from its mother and from the 1950s of the psychological damage inflicted on mothers. They have always been aware of the intensive pain, grief and loss the mother suffers. To conclude, I agree with a member of the social worker profession who stated:

> . . . an apology as official acknowledgment of what has been done, as for many, without this, healing or reconciliation are still just not possible.

Personally as a mother who was treated like a leper, systematically drugged, used as a guinea pig for trainee doctors, had my baby kidnapped at birth and then hidden, moved miles away from my child where I was kept chemically incarcerated before being bullied into signing a consent and then having "socially cleared" written on my medical records, condemned to live a tormented anguish that only a mother who is left in the hell of never knowing where the baby she birthed has gone followed by the endless grieving of all the years stolen from my daughter and me, I do not believe an apology is asking too much.

It is a cowardly and despicable act that those bodies who appeared before the Committee last week, who were entrenched in a system that advertised our children as unwanted while at the same time denying us our legal rights or any alternatives to adoption, and who are given the opportunity to come clean and participate in a process of reconciliation and healing instead decide to cruelly wash their hands of us, like Herod, and have neither the decency nor compassion to apologise.

We must not forget that Australia is a signatory to the United Nations charter and as such has a legal duty to own up to the barbaric treatment inflicted on young mothers and the babies that were ripped from our wombs. The treatment parallels that of Argentina. Natural and civil laws have been violated. There is an obligation on the relevant bodies not only to apologise for these monstrous acts but to carry out the appropriate investigation to make those responsible accountable.

The Hon P. T. PRIMROSE: In asking this question I make it clear that I am not suggesting this is your responsibility. You have raised a number of matters in relation to criminality. Can you provide any information? Have any attempts been made to have the matters prosecuted and, if so, what has been the outcome? Have attempts been frustrated?

Ms WELLFARE: I took action three times with the Supreme Court to try to overturn the statute of limitations through the Public Interest Advocacy Centre and we did not get an opportunity to present our evidence because the judge, in all three accounts, misrepresented the evidence. He avoided presenting stuff, misinterpreted the days and I pretty well got shafted by the courts.

The Hon P. T. PRIMROSE: As opposed to a private prosecution, if these matters have been raised with statutory officers, what has been the response from officers such as the Director of Public Prosecutions?

Ms WELLFARE: Of people we have got the advice from?

Ms COLE: The big difficulty has been overturning the statute of limitations.

Ms WELLFARE: We have stepped past that because we realised five years ago when I started my case that we were in the civil courts and they could stop me that way. We could take it through the criminal courts, which we do not necessarily want to if we do not have to. We know there is no statute of limitations on the Crimes Act nor in the court of equity, but this is just further advice. We have learned more as we have gone along on where we stand on this. No mother takes too kindly to having her child taken from her and to find out almost 25

years later that it was illegal, that they were not allowed to do it—

Ms COLE: We have spent the last four years researching quite extensively a lot of the stuff we are bringing up. When you are 16, 17 or 18 you go to a public hospital and do not expect the so-called professionals to be acting illegally. When I spoke to a lawyer at the Law Reform Commission and said, "How could this have possibly gone on for decades? I cannot understand why it was not stopped", her response was simply that it had never been challenged in the way that we are challenging it.

The Hon. Dr A. CHESTERFIELD-EVANS: You were very disparaging of adoption agencies in the past. Do you think they are acting ethically now? Have adoption practices now improved both with regard to Australian practices and overseas adoption?

Ms WELLFARE: In relation to Australian adoptions, although back in 1982 they stopped the dreadful hospital practices that we were a party to or involved with, at the same time, and even though they are aware of the serious psychological harm not only caused to the mothers but to the children—very severe psychological problems adopted children have—they are not warning the mothers that the child may suffer this psychological harm.

This is a shocking breach of duty of care. People should be warned of the dire consequences to allow them to make that choice and to take that risk, if it is up to them. Once the consent is signed and the 30 days are over, the mother has no recourse. It is only after you have lost your baby that you realise what it is you have lost. Your baby has gone forever and the grief compounds itself from then on in. It is a total breach of duty of care not to warn the mother of the psychological harm. Look at breast implants.

The Hon. Dr A. CHESTERFIELD-EVANS: You are saying it is not happening now though?

Ms WELLFARE: No, they are still not warning the mothers. There is nothing in their literature to warn the mothers. They sit there and talk about self-determination. That is all very well and fine but the mother must be warned of the damage that this may cause not only to herself but to her child, not to mention the fact that the success of an adoption placement is based on having the child learn to hate its mother. The child must learn to hate its natural mother in order for the adoption placement to be seen as successful.

We hear this all the time. For instance, when one of our members lost her baby and three years later her sister adopted two, the adoptive parents were goading the seven- and nine-year-old children to make disparaging remarks around the dinner table like "I only want to see that woman once so I can spit in her face". He was talking about his own mother. This is common. We see it from our own children, the rage the adopted child has towards their natural mother irrespective of whether she was 12 or 14. They have a complete rage, saying "You gave me up, therefore I am angry with you and I hate you." The children are so full of pain and this just has to be stopped. A bit of reality must come into play and the myth has to go.

Ms COLE: Because adoption has been based on so many lies and myths that society generally has the view that adoption is a service; that there are unwanted children and loving couples save them. That is still the myth adoption is based on and, therefore, adoption is still

seen by general society as being something that is a service. The dark side is not seen; the mother's pain, suffering and the mental health damage has not been exposed and we are hoping from this inquiry that this is going to be exposed. You were also asking about intercountry adoption.

CHAIRMAN: The Committee is bound by the terms and reference and therefore we cannot inquire into that.

Ms COLE: If you are basing a system on myths and lies, as adoption has been based, that system will extend overseas.

(The witnesses withdrew)

(The Committee adjourned at 2.45 p.m.)

TRANSCRIPTS OF EVIDENCE

WEDNESDAY, 30 SEPTEMBER 1998

JUBILEE ROOM, PARLIAMENT HOUSE, SYDNEY

MEMBERS PRESENT:

- The Hon Jan Burnswoods, MLC (Chair)
- The Hon. Dr. Arthur Chesterfield-Evans, MLC
- The Hon. James Kaldis, MLC
- The Hon. Peter Primrose, MLC
- The Hon. Carmel Tebbutt, MLC

WITNESSES BEFORE THE COMMITTEE:

WITNESS B, affirmed and examined:

CHAIRMAN: In what capacity do you appear before the Committee?

WITNESS B: As a mother who lost her child to adoption.

CHAIRMAN: Did you receive a summons issued under my hand in accordance with the Parliamentary Evidence Act 1901?

WITNESS B: Yes.

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

WITNESS B: Yes.

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

WITNESS B: Yes.

CHAIRMAN: Do you want to make an opening comment?

WITNESS B: The main points that I tried to make in my submission—as a result of my experience—were that professionals were totally committed to adoption and failed to offer any alternatives; that professionals acted unlawfully by preventing me from witnessing the birth of my child; that professionals acted unlawfully by denying me access to my child; and that professionals acted unlawfully and unethically by preventing the revocation of the adoption consent.

CHAIRMAN: I have read your submission, which contains the points you have made. The Committee forwarded some questions to you, which I will now go through. Please tell the Committee about the circumstances surrounding the confirmation of your pregnancy in 1971. For instance, how old were you, how did you feel about the pregnancy and with whom did you discuss the situation?

WITNESS B: I was 22 years old. I had been teaching for a couple of years and had been teaching in the country. I was teaching in the Riverina after being moved four times, which was quite excessive at that time, and was still finding my way in that new place. I went back to that country town at the beginning of the term in 1971. I had deep suspicions that I was pregnant but did nothing about it—I just carried on as normal. I went to the school, I prepared for the year, I played squash and netball. I hoped it was going to go away. I think I was in a state of deep denial and shock. Eventually, of course, I had to face it. I talked to a woman with whom I had developed a friendship over the 12 months I had been there. She said that I would have to find out whether I was pregnant.

I went to the doctor and had a test. In those days it took a little while before the pregnancy was confirmed. When it was confirmed I was approximately 2½ months pregnant. I knew I would have to make plans for what I was to do. I visited the local priest, as I was a practising Catholic. He suggested that I go to a home for unmarried mothers in Sydney. From what

friends had told me, I knew that that was not the place I wanted to go. Eventually I visited friends in Wollongong and told them my circumstances. They said, "Come and stay with us. Don't go to one of those homes." Everybody knew that they were horrible places, and that has been confirmed through the knowledge that I now have. I made arrangements with them to stay there. Is this too longwinded?

CHAIRMAN: No, the Committee is interested in hearing the steps that women took or were forced to take.

WITNESS B: I did not know what to do about my teaching career. I wondered whether I would be allowed to keep teaching. Of course, in those days that was not acceptable. The inspector of schools, who carried out a welfare role, came to the school and asked to see me. He wanted to know what was wrong with me. He then made the plans as to what I should do. He worked out that I should leave school at the end of the first term, which was May. As I was not eligible for what was then called accouchement leave, I was to just leave. I was not to tell anyone or fill out a leave form. I was told to leave at the end of the term, which I subsequently did. I packed up my belongings and went to live in Wollongong.

CHAIRMAN: In your submission you described an interview with a social worker at Wollongong Hospital early in your pregnancy. Why were you seen by that social worker and how many times did you see her?

WITNESS B: When I arrived in Wollongong I knew I had to make plans, step by step. Step one was to book into the hospital, because I knew this event was going to occur and that is what I had to do. I went into the office at the hospital and told them my expected date and said I wanted to book in. They asked for my details and when they discovered that I was unmarried they sent me to the social worker. I dutifully went to see her then and there. I had only one interview with her and, as I said in my submission, she was very unhelpful.

As a teacher I had private health insurance. She was really quite insistent that I go into a public ward, where girls like me go—she used those terms—because that is where I would feel comfortable. I asked her about antenatal classes and she advised me not to go because they were for married woman. She was quite insistent that I not use my private health insurance. That was the only time that I stuck to my guns and I said, "Well, I am. I've got it, I've got my own doctor." I had arranged that already and I said I was going to use my private health insurance and go into an intermediate ward. She was not very happy with me.

CHAIRMAN: Did she explain her objection?

WITNESS B: She said that girls like me go into the public ward, where I would feel comfortable with other girls like me. She said for me to go away and think about it, and so I did. Subsequently I rang her and told her that I had thought about it and wanted to use my private health insurance. She was very cross with me. She did not offer any advice about anything, she did not ask me what I was going to do, she did not advise me about anywhere to go except to the Department of Child Welfare which, she said, would arrange for the adoption of my child. She sent me to the Department of Child Welfare.

CHAIRMAN: In Wollongong?

WITNESS B: Yes.

CHAIRMAN: Did you ever see her again?

WITNESS B: No.

CHAIRMAN: Do you consider that the hospital's social worker acted unethically or unlawfully at your initial interview, which turned out to be your only interview?

WITNESS B: Yes, I think she did. In 1985, when I was actively searching for my son and going to all the places where information was available, no matter how small, I went back to Wollongong Hospital. I visited with the social worker at the time so that I could view the hospital records of myself and my son. When she got out my records the social worker's report from 1971 was there. She was quite horrified about what the report stated. She said that I should have been advised about alternatives or asked what I was going to do, what were my plans, had I considered foster care and what I was going to do when the baby was born. There was an assumption on the part of the social worker that I was going to have my child adopted.

I was directed to the next step, which was the Department of Child Welfare. She certainly acted unethically in that she, like any other social worker, had a duty of care, a responsibility to tell me about the alternatives that were available to me. I think it was quite unethical of her to try to get me to not have the best possible health care that I could—to go to ante-natal classes, to use my private health insurance and to have my own doctor. The only difference between me and anybody else was that I was not married. She treated me differently because I was not married. Because of the statement "girls like you go here" it seemed that this is the way it went. If you were unmarried that is where you went: to the public ward. I think she acted unethically and unlawfully in that it was her duty of care to tell me about alternatives.

CHAIRMAN: Was any comment made about where you were living and whether you should have been in a home? You were living with your friends.

WITNESS B: No.

CHAIRMAN: That never came up?

WITNESS B: Not in my memory, no.

CHAIRMAN: Why were you referred to the Department of Child Welfare? You said a little bit about that. Please describe your first interview with an officer from the Department of Child Welfare, and, again, do you consider this officer acted unethically or unlawfully during the interview?

WITNESS B: I went to the Department of Child Welfare acting on the advice of the hospital social worker and I met with the social worker there. From the beginning the interview was a taking-down of my details for the proposed adoption. Right from the start I was giving details about who I was, who my parents were, my health, and details about the father. We were filling in a big form. In the course of that, quite clearly from the language she used, from what she was saying to me, she was saying that adoption was in the best interests of the child

and that only selfish girls keep their babies. She went on to tell me how my baby would be carefully matched to the prospective parents and they would be very carefully screened. She emphasised that it was the right thing to do, and the thing that really stuck in my memory was how she made a strong point about the revoking of the adoption consent.

She said that was a very bad thing for girls to do, to come back during the revocation period and to revoke consent, because the baby would be settled with its new parents and that would be very disruptive to the family. She really strongly emphasised that point. When she told me that adoption was for life, that I would never see my child again, I asked her why this was so. She said that in some instances it was to protect the family from mothers coming back and demanding money. She clearly used language which showed she really had a low opinion of unmarried mothers. She conveyed an attitude that there was something wrong with you if you wanted to keep your child. I think she was quite blatant in her promotion of adoption.

So, with that—which I think is the next question—I believe she certainly acted unethically in that I was not the client, I was not somebody that she was demonstrating any concern for. She was channelling me into adoption and was not looking out for my interests. I also think it was unlawful in that her role was to describe all the alternatives to adoption. We touched on that when she directed me to the Department of Social Services and said that I would be able to get $10 a week unemployment benefits. I asked her at that stage was there any allowance for mothers who kept their children and she said I would be entitled to $34 a fortnight. Clearly it was all done within the context that adoption was the thing to do, and we did not really traverse any other options or discuss it at all. That was the one and only interview that I had with her—no, that is not correct: I had one interview with her prior to the birth of my baby.

The Hon. CARMEL TEBBUTT: Just to clarify, you are saying with both the hospital social worker and the Department of Child Welfare social worker only provided you with information on adoption, even though at that stage you had not made a decision about your future actions; is that right?

WITNESS B: Yes.

The Hon. CARMEL TEBBUTT: So, you were going there in a position of still not having made any decision, yet they assumed that the decision was for adoption and acted in that way?

WITNESS B: And certainly the conventional wisdom was that that was what you did.

The Hon. CARMEL TEBBUTT: But they did not discuss with you whether there were other options?

WITNESS B: No. Certainly no-one ever discussed it. I was in a very good position, as a teacher, but nobody ever suggested that that was a possibility. It was always like the child was already not yours. It was going to go to these wonderful people.

The Hon. CARMEL TEBBUTT: But you were still considering it was a possibility that you might not go down the path of adoption? You had not made up your mind?

WITNESS B: It is difficult to say that. But I should not have had to make any decision prior to the birth of my child, and everybody should have been giving me options, but what was assumed and what was pushed was adoption. We were filling out this form, which was the set-up to find the prospective parents, so always we were operating on this assumption.

The Hon. CARMEL TEBBUTT: The whole process was set in train before?

WITNESS B: Yes. Whereas in my mind I was still ambivalent.

CHAIRMAN: The next question is to explain the Committee's keenness to understand the role of a mother's family and the father of the baby in the mother's decision to have the baby adopted. Can you tell us something about the role your family and the father of your baby played in the decision to adopt?

WITNESS B: I will answer this question but I really want to talk about what happened to me and my experience. First of all, the father of the child played no role, and I did not tell him about it. My father was told by that inspector whom I have already referred to, the inspector of schools, and I asked him not to tell my mother because I really did not want her to know, and he abided by that. My mother found out about three weeks before my son, Michael, was born because it was very hard to keep something like that from her. They never offered any advice or said anything one way or the other. They left it up to me.

CHAIRMAN: Did the inspector tell your father with your permission?

WITNESS B: Well, I was sitting there and it was always like two men taking control of my life, but at the time I wanted somebody to do something because I was not coping with doing it myself. Certainly the inspector, in his welfare role, rang my father and told my father while I was in the room, so I guess it was with my permission.

The Hon. CARMEL TEBBUTT: Can you describe your treatment in hospital before, during and after the delivery of your baby, and do you consider any aspect of this treatment to have been unethical or illegal?

WITNESS B: Well, when I was admitted to hospital the nurses who were on at the beginning were very nice to me and I was placed in a room all by myself. I was there all day by myself. I certainly did not know what to expect, either, in childbirth. I tried to do some reading but, as I said, I had not been to any of those classes and I just did what came naturally. It seemed to be working while I was there all by myself. Later there was a change of staff and the sister who came on was not very nice to me and wanted to know why I was bearing down at that particular point. I had no idea what I was doing. I was just doing what I was doing, and she admonished me for doing that at that point. As it turned out, it was the right thing to do.

Everything was all right until the delivery was imminent, and I discovered that Wollongong Hospital was a teaching hospital. When the birth was imminent I was taken into a theatre and this cast of a thousand appeared, there were nurses everywhere. Everybody except me was able to view the birth. A sheet was put up in front of me. I tried to take it down at one stage, but the same head sister was quite nasty to me and said, "You chose to have your baby adopted, not us."

Somehow all of the information from the hospital social worker had translated into the action that was taking place. I had not said anything, I had been too busy, but somehow the sister knew that according to the records of the hospital social worker the baby was to be adopted. I had not said anything to anyone. The sheet was placed in front of me. After my son was born I pulled it down again—as one would expect a mother to do—to have a look at him. I had a good look and I expressed what every mother expresses at that point, and the sister turned around and said, "Get that baby out of here." I said, "No, no, leave him, leave him." She said, "Get him out", and they took him away. I did not see my baby again until after I had signed the adoption consent.

It seemed to me that everything just happened. Even though I was saying something opposite, this is what was happening. It seemed to be standard procedure: this is what happened. The hospital had some knowledge that the baby was, according to the records of the social worker, to be adopted. Clearly, following the birth of my child I was not allowed to see him. The hospital said it was against the rules for me to see him. My friends tried to see him, and the hospital went really mad on me about my friends trying to see him. I was denied access to my child, which was unlawful given that I was the sole legal guardian and I had not signed anything. As I have said, it appeared to be standard practice.

CHAIRMAN: We have been told by other women that the drug regime was different for women whose babies were expected to be adopted. Were you aware of any difference in the drug regime for you?

WITNESS B: No, I cannot answer that question. I do not know.

The Hon. CARMEL TEBBUTT: Could you tell the Committee about your attempts to revoke your consent to adoption? Do you consider that the social worker acted illegally or unethically in that situation?

WITNESS B: Might I go back a little, because I have not talked about the taking of the adoption consent in the hospital. I was not allowed to see my baby until I had signed the consent form. Instead of the social worker whom I had previously seen being sent up to the hospital, a young man came who had never taken a consent before—he told me that he had never done that before. He was extremely nervous. All we did was fill out and sign the form. There was no advice given, although I understand that advice should have been given at that stage, particularly given that I was signing a binding legal document. After I had signed the adoption consent the matron at the hospital allowed me to see my son, through the glass—but only after I had signed. I feel it important to make that point.

In terms of the revocation, after I had left the hospital I went home to my mother and father in the country. This is always the worst part for me, because I came that close. I went home and my feelings were quite overwhelming at that stage. I felt that there was no way that I could do this, it was not possible, I could not. So I determined that I would go back down to Wollongong. I convinced my mother and father that they should take me back to Wollongong. I did not say why; I just said, "We've got to get there" and that we had to get there within a particular time frame. During the journey from Lismore to Wollongong I psyched myself up as to what I was going to say.

I was going to say to the social worker whom I had previously seen that, while it is all in

your mind before the child is born, things are very different after your child is born. I wanted him back, I had to have him, and that was all there was about it. I could not do this thing. I went back down to Wollongong. I do not know why but I did not ask mum or dad to go with me—perhaps things would have been different if I had. I went to see the social worker. I believe that she knew what I wanted and what I was doing there and I believe that she deflected my intention by involving me in a long conversation about my return to teaching. During the conversation she phoned the education department to talk about my return to teaching.

When I said to the social worker, "Well, what about my child? Where is he?", she told me a story. "I don't often get to see these things", she told me, "but I was in the hospital the day that he was picked up and he went to these people who cried when they got him, and they had come such a long way to pick him up." I know that story verbatim, I know exactly what she said, "They were so happy." In the end I felt like a terrible wimp—or I do now. That story induced in me some form of guilt. I could not say, "Look, I want him back." I felt that he was no longer mine, that he belonged to somebody else.

At this stage I should point out that the social worker was lying. When I found my son—which was when he was 14—I spent many long nights talking to the adoptive mother about everything that had happened. When I was talking to her about going to the social worker in an attempt to revoke my consent I discovered that Sue had had Michael for only three days. He had been in hospital all that time by himself. I think that was fairly standard, too. What the social worker was saying to me at that time was lies, deliberate lies, so that I would not do what I intended to do.

I recall a previous conversation we had had when I was four months pregnant. During that conversation she made the point that revoking consent was a terrible thing to do to these people, to take the child back from them. Apparently, it was not a terrible thing to do to me. The social worker's clients were clearly the adopting parents. I was not a consideration and my feelings were not considered at all. I believe that the social worker certainly acted unlawfully, because that was my right—I did have a right to revoke the consent. She acted unethically, and I think that what she did was morally reprehensible.

It was a hard thing for me to go there and do that because she had set it up earlier that revocation was a terrible thing. When I went there I was deflected, and I was to get back into my normal life as quickly as possible. The suggestion was made, "Let's get the education department to waive the six-weeks-after rule and get you back to teaching. Let's get you on with your life." I was never going to get back on with that life. My life had changed forever. Certainly I think her actions were unlawful, unethical and dreadful.

The Hon. CARMEL TEBBUTT: In your submission you have stated that adoption professionals were totally committed to adoption and that non-adoption alternatives were never discussed. Did you seek information about the alternatives to adoption from adoption professionals? If not, why not? Why do you think the adoption professionals may have been committed to adoption as the only course of action?

WITNESS B: I have demonstrated why I think they were totally committed to adoption. Did I seek information about the alternatives? I think I did when I asked the question about what allowance was available for me. But, no, I did not know what to ask. I did not know

whether to ask was there foster care or child care. We did not talk about such things in those days. Child care was not an issue. I understand now that those things were available, that social workers would have known those things were available and that it was their role to tell me. In order for me to make an informed decision I had to be given all the choices. If I was seen to be making a choice, I had to be given alternatives to choose from, whereas what I was given was that adoption was in the best interests of the child.

It is my understanding that it was stated in the legislation of the time that it was in the best interests of the child for it to stay with its mother. Certainly I would argue that adoption is not in the best interests of the child. Studies have shown—those studies are not from Australia, and certainly that is one of the measures that I think we should take up; there should be research into the effects of adoption. Adoptees are over-represented in gaols and in cases of child abuse. A 1984 document on child sexual abuse commissioned by the Wran Government showed that adoptees and Aboriginal children were disproportionately represented. Adoption was never in the best interests of the child, it is still not in the best interests of the child—

A MEMBER OF THE AUDIENCE: What rubbish!

CHAIRMAN: I remind the audience that I have the power to clear the gallery. The Committee recognises that this is a very emotional subject but, because the Committee is committed to hearing different points of view from witnesses, witnesses must be treated with courtesy.

The Hon. CARMEL TEBBUTT: You have already outlined one measure that you think might assist people experiencing distress as a result of past adoption practices. Do you have any other suggestions for measures that might assist?

WITNESS B: I do not think that I have clarified all my thinking in this regard. I ask the Committee whether it would be possible if in the future I think of any more suggestions to advise the Committee of them.

CHAIRMAN: Yes, of course.

WITNESS B: It is a big one. No. 1, this inquiry is very good in that it is a validation for me to be able to talk about my experiences. I took my affirmation very seriously and I am telling the truth and nothing but the truth. I think as well as validation that there has to be an understanding generally that this malpractice did occur and that it was quite widespread. My understanding is that, as I tried to demonstrate, it seemed like the procedures that I experienced were common practice. Certainly I have been involved in different groups over the years, such as ARM, Mothers for Contact in Adoption, and Origins, where we have shared our experiences and certainly it would appear that this was fairly standard procedure. I think that there has to be an acknowledgment of the malpractice just like there has been with the Aboriginal stolen generation. I think there has to be an apology. Origins called for a national judiciary inquiry, but I really think—and this is where my thinking is not clarified—that adoption impacts on every single person in the adoption triangle.

Everybody would argue, and we have seen this already, that everybody was powerless within the triangle. I certainly felt quite powerless against this kind of overwhelming wave of

adoption, adoption, adoption. If I knew then what I know now there is no way that would have happened to me, but it did and I felt powerless. I believe adoptees feel powerless because they are still treated like children. I think also that because of their adoption to them their rejection is quite real and tangible. Regardless of how wonderful their adoptive parents were, every time there is a birthday there is a missing parent; that there is, "I'm here with these people because my mother didn't want me" or "My mother gave me away." That is quite tangible to them. Certainly there are social and economic costs that come out of adoption. If it is a lifelong process and it was incurred by the State, then the State has a role to play in this lifelong process, whether that is through ongoing mediation between the adoptive parties to bring about some resolution to it all. I am not totally clear, but I look at things like the veto that exists on some reunions.

It is a terrible thing for adopted people not to be able to find their identity, something that all of us just take for granted. I know with my son it has been so much better for him and he has certainly benefited from knowing who he is and from knowing me, but adoption certainly still stands between us and still looms very large in our lives. Nothing anyone could do would ever change that. Nothing can change the past, but I believe the State has a role to play in an ongoing way, certainly research into what actually happened. I know this is a fact-gathering exercise here, but some academic studies about the impact of adoption in Australia, in New South Wales, would be very good.

CHAIRMAN: The Committee is more than happy to receive a further submission from you, either formally or more informally, if you wish to forward it.

(The witness withdrew)

DOROTHY ALISON CROFT, Social Worker, Anglicare Adoption Services, sworn and examined:

CHAIRMAN: In what capacity do you appear before this Committee?

Ms CROFT: As the Principal Officer of Anglicare Adoption Services.

CHAIRMAN: Did you receive a summons issued under my hand?

Ms CROFT: I did.

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

Ms CROFT: Yes.

CHAIRMAN: The Committee has received a submission from you. Do you wish that submission to be included as part of your sworn evidence?

Ms CROFT: Yes.

CHAIRMAN: Do you wish to make an opening statement elaborating on your submission or shall we proceed straight to questions?

Ms CROFT: I do not want to make an elaboration on the submission, but I had a slight concern about taking the oath in that I was not around at the time and the information I give has been given to me by a third party.

CHAIRMAN: The Committee understands that. Could you please briefly describe the adoption services offered by the Anglican Church in New South Wales from 1960 to the present?

Ms CROFT: In 1960 the Anglican Church opened a home for single parents, for unmarried mothers. It was called Carramar. Until the Adoption of Children Act was implemented in 1967 adoptions were arranged through Carramar with the assistance of a solicitor. When the Act was implemented in 1967 the adoption agency was set up as a separate entity. At that stage it was called the Church of England adoption agency, which remained under that name until the Anglican Church changed its name in 1976. It became the Anglicare Adoption Agency and last year the welfare services of the Anglican Church became known as Anglicare Welfare Services and the name became the Anglican Adoption Services. From 1967 to the present, adoptions were organised for mothers from Carramar, if they requested it. Not all the adoptions organised through the agency were from Carramar—others came from sources outside the Carramar network. In 1985 the agency started a separate program specifically for the placement of children with disabilities, and that has become one of its main focuses in the past 10 years. Do you want more detail than that?

CHAIRMAN: Some of it may come out. For example, our second question is: describe the different ways in which a woman could be referred to Carramar. We will probably get more of the detail about how it operates as we go through.

Ms CROFT: Some of the questions are specifically focused on Carramar and, obviously, the adoption agency was separate. Referrals to Carramar, particularly in the 1960s and 1970s, were made by parents or grandparents. It might have been the minister of the local church they attended, sometimes it was the local doctor, sometimes it was a solicitor. It was rarely through health services or the Department of Community Services at that stage, although in the past 15 years referrals have been more from Community Services and the Health Department. In 1985 Carramar was relocated to the western suburbs. It has been re-established in a small, two-storey house and now accommodates only six mothers. Three units are now associated with Carramar. Mothers can go back to the unit for support and assistance with a child, often while they are awaiting accommodation or sometimes, because of the needs of the child, they need extra help to cope with the child. The nature of the service has changed in the past 15 years.

CHAIRMAN: Can you describe the program for women who resided in Carramar in the 1960s and 1970s?

Ms CROFT: Again, from what I have been told, a lot of the women who were resident at Carramar were still of school age and had been in school, so it was possible for them to continue education by correspondence, and a lot of them did that. It was normal for schools, particularly in the 1960s, to run vocational guidance tests for pupils. Some of the mothers had vocational guidance tests and, following on from that, did some job training, usually secretarial or receptionist work. I am told that the social worker who worked at Carramar part time would run groups for the women who were there. The focus of the groups was to discuss their pregnancies, concerns arising for them from their families, possibilities of keeping, and adoption procedures like revocation, those sorts of issues and things that the women themselves would raise. A general practitioner and a nursing sister would come to give some instruction, particularly around pregnancy and giving birth. For medical care the mothers in residence would go to the Hornsby Hospital Antenatal Clinic at the outpatients department. They would then have the baby at Hornsby Hospital, unless they had already become involved with another doctor.

Some of them went from Carramar to other hospitals to have their children. It was part of Carramar's program to have daily bible readings and prayers. It was not supposed to be compulsory, but most of the residents probably felt there was an expectation that they would attend, and I have heard that from some mothers who have come back and talked with us. Then, of course, there was the expectation that mothers would be rostered on to do the housework and the cooking, and some attempt to make that into a living skills kind of program for them later on. In the present Carramar there is quite a considerable focus on living skills and child care.

CHAIRMAN: Would every woman who was in Carramar have taken part in the discussion groups to which you have referred?

Ms CROFT: I believe they mostly did. A few women took exception to them and would not participate, but I am told that the majority did.

CHAIRMAN: Therefore everyone there should have had access to information that you described about what was involved in adoption?

Ms CROFT: They should have had some access to it, yes.

The Hon P. T. PRIMROSE: In your submission you state that sensitivity and skill was needed to run Carramar, but "inevitably at times of pressure or stress this was not always forthcoming. Recriminations would further distress residents." What have some of the previous residents told you about the way they were treated at Carramar?

Ms CROFT: It is a very variable picture. Some of the women who came to Carramar just felt they did not fit in, they did not make friends, they did not like community living and they were generally very unhappy at Carramar. Some of them found the inevitable structure of an institution difficult, even abhorrent to live with. As I said, some of them did not like attending prayers. There were some, I understand, and I have heard recently of a mother, who wanted a Bible and went seeking it. But some of them did want that kind of thing. Some of them felt the Bible passages that were read were particularly judgmental towards them. That has been disputed by those who kept any record of what was actually read to them. But any record of what was actually read is long since forgotten.

Some of them found it a haven. They felt calm and secure. Some of them had come from very sad and difficult circumstances, and there was some relief in being able to be there. Some mothers made lifelong friendships. In the last 10 years mothers from Carramar have phoned and asked to be linked up again with others they have known. There was even a request for a reunion of a group of them at one stage. But then again for some mothers it was a nightmare experience. They felt it difficult when they went out into the community from Carramar. It was all right living in the house but when they went out because they were in a group they were conspicuous and obvious. They felt people discriminated against them. For instance, when they went to outpatients in the hospitals they felt discriminated against because they were left until last. They felt they were left until last to be served in shops and those kinds of places.

I guess Carramar was like a women's refuge today but probably a bit more structured. No-one was there by choice or was really happy to be there. A lot of women were homesick, lonely and upset about their family's reaction to their pregnancy. Given all those emotions, plus the emotions that were being raised by simply being pregnant and needing to think about what was going to happen to them and the child, it made living pretty difficult. Living in a communal situation with other women in similar circumstances did not make it easy for anybody. For some it was a very difficult experience.

The Hon P. T. PRIMROSE: Were all Carramar residents seen by a social worker while they were at the home?

Ms CROFT: I am told they were. The social worker discussed circumstances with them and, as the previous speaker said, would have been the one who completed the social history form. There is a social worker's report on the file of each person who came in. Recently, a lot of women have come back to us—they have probably written submissions too—and said that they are particularly concerned about the wording of those reports. They thought they were inaccurate or misstated the situation. For example, recently a woman who said that she had been raped was angry that that was not included in the report. That is difficult if it is included or not included but she felt that explained her circumstances, and therefore the report was inaccurate.

In many of the records I am amazed to find details about the fathers of the children who were born through the Carramar program. The fathers were often known and there was usually a lot of information about them. I actually think the fathers were a fairly neglected group. There have been quite a few fathers who have come back and wanted to be identified so that they can apply to have their names on birth certificates and then be entitled to the same rights as a mother on the adoption information. The social worker also said that she always talked about the right to revoke. As the previous speaker said, a mother does not really know what it is going to be like until after the child is born, and having talked about all those things beforehand she can change her mind very dramatically after the child has been born and those things could be very easily forgotten.

The Hon P. T. PRIMROSE: Was it assumed that most women who resided at Carramar actually intended to relinquish their babies?

Ms CROFT: I think it generally was. Most had come from country areas, interstate and overseas—quite a few from New Zealand. They felt they were sent by their families. They experienced a real feeling of rejection by their families. Many of them felt it was going to be a choice between keeping the child and their families continued to reject them, or giving their child up and their family would accept them. Having said that, when I looked at the register and tried to draw statistics from it I found that in fact about 80 per cent of mothers relinquished their child but at least 20 per cent of the children were not placed for adoption.

The Hon P. T. PRIMROSE: Your submission notes that there is considerable evidence that the possibility of keeping the child was discussed with mothers. What is this evidence and why do you believe it to be considerable?

Ms CROFT: I guess I was referring to evidence on the files. It was almost always noted on the files that keeping the child was discussed, and the family circumstances came into that. I suppose because the social worker was not full time but was there regularly there was a lot of opportunity for discussions, which perhaps other women did not have. In a sense there were more ongoing discussions about some of those issues. The social workers to whom I have spoken all claimed that they did talk about it.

The social workers all stressed that the options were not readily available and that they were not as they are today, particularly given the young age of some of the mothers who came into Carramar. There is evidence on files of applications to the Department of Community Services or the Department of Community Welfare, as it was then, for financial assistance from the department. There were affiliation applications in relation to the father as well which was necessary if payment was going to be made. Some of the fathers wanted to be involved at that stage. Having looked at the files I am surprised about how many fathers actually paid the fees for the residents. There was quite a lot of involvement at that time.

The Hon P. T. PRIMROSE: Were professionals at Carramar obliged to explore non-adoption options with a mother during the period under review in this inquiry, that is, from 1950 to 1998? Would failure to do so constitute a breach of ethics or of the law?

Ms CROFT: Social workers have reported to me that they felt a professional responsibility to give a woman information about alternatives, financial support, accommodation, employment possibilities and child care. If one looks at our statistics it becomes obvious that

the biggest number of our adoptions happened in the 1960s. The options open were even more limited at that time than they were in the 1970s and 1980s as time went on. Foster care, for instance, was very difficult to get at that time.

There was still residential care available at places, for example, the infants home at Ashfield where there was accommodation for children, and some of the mothers would go there to work. There was not a lot of foster care. The possibility of keeping a child often hinged more around the family accepting the mother and the child. By the 1980s there were more women in Carramar who were keeping their babies than placing them for adoption. From the 1970s the numbers of mothers in Carramar who placed their children for adoption dropped dramatically, and probably over the last 15 years there have been very few adoptions.

Professional workers certainly considered that they had a professional obligation but I do not know that they considered it was an ethical one. In that it was a professional obligation I would have considered it an ethical one. It was certainly seen as best practice. I have now spoken to about seven of the workers from that time and they were quite adamant that there was an obligation to talk about alternatives. The big problem was that it was not given in writing. Given the trauma and distress experienced by these mothers their options for remembering were few. There was a lot of detail that was not written down for them.

There were brochures such as those from the Department of Social Security in the 1970s that did become available. Recently we have found that even information given verbally needs to be written down and that has been given increasing emphasis. Certainly over the last 10 years mothers have been given information about procedures, alternatives, and the emotional stress that they can expect becomes a consequence further on, but that did not happen in the 1960s. It is understandable that that information was not as clear to people as it might have been.

CHAIRMAN: When you say that those options were explored from the records you have looked at and from the people you have talked to, do you know when during the pregnancy or the residency at Carramar that kind of discussion took place and whether it happened once, in discussion groups or during ongoing discussions with the social worker?

Ms CROFT: It happened in both the discussion groups and individually with the social worker. The length of time that a mother was resident in Carramar varied quite considerably. Some mothers were there for three to four months and some for perhaps six weeks, so the opportunity would have varied from one mother to another.

CHAIRMAN: What are your feelings about at what point in the pregnancy discussion happened about adoption or other options?

Ms CROFT: It was generally later in the pregnancy, because most of them did not come in to Carramar until later in the pregnancy. In terms of the number of times, as I say, that could depend on when the mother had come in. Because there were the regular groups, and there was an expectation, and most of them did in fact attend the groups, there was a chance to talk about that certainly more than once; the groups were weekly groups. In the groups it would have been a discussion all together. Obviously, in the counselling it would have been one on one and the mother's particular circumstances would have been considered.

The Hon P. T. PRIMROSE: You said a few minutes ago that you believed the attitudes of the family were all-important in whether a mother kept her child or not. Could you elaborate on that?

Ms CROFT: Most of the women who came in to Carramar had come from family situations from living within their families. Most of them were 18 or under. Most of them were there because their families had sent them there and there was considerable distress in terms of feeling rejected by their families, together with home sickness. The matron commented on how many times mothers would say they would rather be home with their families rather than in a place like Carramar. There really was a desire to maintain contact with their own family. That varied quite a lot. There is some evidence that there might have been some rejection by the family to begin with, and then as time went on that eased and families became more supportive. There is certainly evidence on file of some of the mothers in those situations then taking the child home.

I think it was the particular group of mothers who would have come to a place like Carramar which made it difficult for them. Most of them had little life experience, were very vulnerable, and found it difficult to consider surviving without their family, so that family support was crucial. I think that in the long term, even after they left Carramar, that support of the family was really crucial. Professionals disappear. They are there for the duration of that, but for a mother the family relationship is all-important in the long term.

I do not know any mother who places her child for adoption because she wants to do it. I do not know any mother who does not love her child. Even if a woman considers it the right decision for her child and herself, in consideration of her own particular circumstances she is still going to experience tremendous grief in relinquishing her child, and that is a long-term, profound grief. The support of the family is all-important in her coping with that. I guess some of the mothers we have seen who have come back to us have not had that support and therefore have been even more distressed and/or grief stricken than they might otherwise have been.

The Hon P. T. PRIMROSE: Do you believe there may have been any instances of systematic illegal or unethical practices in adoptions during the period under review?

Ms CROFT: Can I take questions 11 and 12 together?

The Hon P. T. PRIMROSE: Please do so. Your submission states that while it seems apparent that past adoption practices cannot be described as unlawful in the main, it is likely that in some cases the human rights of some mothers were denied. Can you give examples of instances where this may have occurred?

Ms CROFT: I do not think that there were what could be termed systematic illegal or unethical practices in adoption. There have been allegations, but I think that these have to be dealt with individually and in terms of the practice with which we are concerned in relation to Carramar. In terms of systematic illegal and unethical practices built into the system, I do not think they were built into the system. However, I think that there were probably three particular aspects of the adoption process where there have been particular complaints. One was the inadequate information given about alternatives. As I have mentioned, I think there are indications that information was given. I have heard that from too many sources to feel that

it was not given. How adequate it was in each individual case is impossible to tell. The problem was that it was not written, so it is difficult to know, 30 or 40 years later, just exactly what information was given.

The second area would be a mother not being permitted to see her child at or after the birth. I have certainly heard that from lots of people. Possibly that was not illegal, but it was certainly an insensitive and misguided practice. As I say, it is not illegal because I do not know the law that it actually contravenes, but I certainly think it was an inappropriate practice. It was done because it was believed it would be easier for a mother to get over her child if she did not see him or her. That certainly has been disproved and demonstrated in a lot of research that has subsequently been done.

I am told that at Hornsby Hospital Matron Shirley Jones, who was the first matron at Carramar, pressed the hospital authorities for the right for mothers to see their children, and it became the norm after that. But it was only a one-off thing; in those days there was not a lot of opportunity for mothers to be able to see their children. As time went on, I suppose into the early 1970s and thereafter, mothers have been given opportunities to continue to see the child in foster care even after the consent has been given, up to the point where the child goes to adoptive parents. That has proved to be an incredibly helpful process, to be able to follow through.

The third area is the revocation period. I can only talk about the Carramar experience and the agency experience. Again, part of the problem was that the details were not given in writing. They should have been; the mother should have known that she could go to the Supreme Court to revoke that consent. I am told that at Carramar there was a copy of the consent document. There is a second document that was required to be signed as well, which was the request to make arrangements for the adoption of a child. Those two documents were on the noticeboard for mothers to read, and the revocation is stated on one of those documents. So that information was there for them to be able to see.

There was a requirement with the signings of consent that a social worker witnessing a consent had to be a member of the AASW or a JP. I know that there were periods at Carramar where the social workers would not fit into that. I am unsure as to who actually did the consents; I think probably hospital social workers. But I think there was some confusion—not so much confusion, but the people who saw the mother to take the consent were not necessarily people who knew her, which was certainly not appropriate. In the 1970s it was usually the social worker from the adoption agency who witnessed the consent and who had been involved with the mother prior to that. By the end of the 1970s the details about the revocation procedure were in writing for a mother to have and to be able to go back and revoke her consent.

The other complaint, as we have heard already, was that of a mother coming back and then being discouraged from actually revoking. It seems that there were certainly instances where that happened. As I said, the mother had a right to go directly to the Supreme Court, but I do not know that they were all aware of that or aware of how they would go about that, and they did feel that the agency was an inhibiting factor if they wanted to go ahead with a revocation. Certainly the number of revocations has increased dramatically. The number of mothers who would consider adoption and then keep the child is also very high now. We would see something like 35 mothers a year, of whom half a dozen would actually place the child for adoption. So it has turned right around, and the right to revoke is now stated in a

separate form which a mother is given at the time of the signing of the consent but is sent to her again seven days before the revocation ends.

The Hon. Dr A. CHESTERFIELD-EVANS: There seems to have been a gradual change in practice, with 85 per cent being adopted and now six out of 35 being adopted. Have any scientific, long-term studies been carried out as to the basis of that change and what happened to the parents who adopted and the children?

Ms CROFT: No, I do not think so. I think that there has been more of a change in the resources available. In the 1960s it was very difficult for a pregnant woman to have an abortion. That has turned around dramatically and the number of abortions is now very high. The financial support given by the Federal Government, which came in with the Whitlam Government when it introduced the supporting parents benefit, made a big impact in terms of women being able to keep their children. I think there has also been a change in society's attitudes to sole parents.

The Hon. Dr A. CHESTERFIELD-EVANS: You have spoken about changes in society's attitudes and Federal Government support. You have said that Carramar saw its role as mitigating the situation of women who were between a rock and a hard place; they could not keep their baby because of a lack of support, their family would reject them and they had to give them up, as it were, to get their family back and have a normal life.

Ms CROFT: That would have been in the 1960s. I guess the dates in the questions vary a little. That would have been the situation in the 1960s and early 1970s, but by the late 1970s things had turned around a lot and the numbers of adoptions were dropping right through the 1970s.

The Hon. Dr A. CHESTERFIELD-EVANS: Do you think that Carramar was part of encouraging the change, or do you think Carramar took an active stance on what the mother should do? Was Carramar encouraging the increased adoption rate, was it encouraging the increased keeping of the babies, or would you say Carramar was neutral in the sense of the decisions that were being made?

Ms CROFT: Are you talking about the 1960s or the 1980s?

The Hon. Dr A. CHESTERFIELD-EVANS: Over the process of decision making.

Ms CROFT: In the early 1960s there were few options for parents to follow. They tried to do the right thing by the mother. I am sure there was an integrity in what they were doing and an emphasis on doing the right thing for mothers. In those days that often meant mediating with her family. As time went on the women who came into Carramar changed. To some extent family issues are still involved, but a lot of women who have come to Carramar in the past 15 years have already left home and have nowhere to go so there is not such a strong break with the family.

The Hon. Dr A. CHESTERFIELD-EVANS: When Carramar said that it was doing the "right thing", that "right thing" changed in response to the mores of the time and the external financial circumstances of the mother.

Ms CROFT: I think that was probably the case. The mores at the time had a big impact and professionals cannot be to be apart from that, to some extent.

CHAIRMAN: You mentioned that Matron Shirley Jones changed the practice at Hornsby Hospital.

Ms CROFT: She was at Carramar.

CHAIRMAN: She persuaded them to change the practice?

Ms CROFT: Yes.

CHAIRMAN: When was that?

Ms CROFT: In the early 1960s.

CHAIRMAN: So Hornsby Hospital had a different practice from the others?

Ms CROFT: I think things gradually changed across the hospitals. Hornsby would have been one of the earlier ones to change.

CHAIRMAN: What measures might assist people experiencing distress as a result of past adoption practices?

Ms CROFT: The majority of people who relinquished children in the early years did not receive any counselling. Our experience shows that grief counselling after the event is all important to a mother in helping her to cope with her life. It takes a couple of years for a mother to get back to her former level and start to pick up the pieces again. The implications are lifelong.

CHAIRMAN: Are you talking about the present?

Ms CROFT: I am saying that mothers did not receive any counselling at all, and there are still women who have never had any support, counselling or follow up; and that should be made available to them. It is particularly difficult when one party to an adoption has put a veto on contact under the Adoption Information Act. People who are subject to that veto find it incredibly difficult to cope with the effects of adoption. Certainly groups like Origins experienced that and it is important that we all work together to provide these resources. There is not enough money for each group to do it on their own. I think that counselling support is crucial.

(The witnesses withdrew)

WITNESS A, affirmed and examined:

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

WITNESS A: As a mother who gave up children for adoption.

CHAIRMAN: Did you receive a summons issued under my hand to appear before the Committee?

WITNESS A: Yes.

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

WITNESS A: Yes.

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

WITNESS A: Yes, I do.

CHAIRMAN: Do you want to make an opening statement or go straight to the questions?

WITNESS A: Go straight to the questions.

CHAIRMAN: Could you tell the Committee about the circumstances surrounding the confirmation of your pregnancy in 1971? For instance, how old were you, how did you feel about the pregnancy, and with whom did you discuss your situation?

WITNESS A: I was 19 when I found out I was pregnant. I was really distressed about it. I knew I was pregnant, I had a feeling I was, even before I was tested. I had a pregnancy test with my local GP, and then my mother and the GP talked to me about it. At that initial meeting the local doctor said the only thing to do was to send me to a home for unmarried mothers and to have my baby adopted. I do not know whether my mother had thought about what would have to be done, because this was fairly early in the piece. From that time on I went along that track, and it did not change. Everyone I came into contact with said that that was the only thing I should do.

CHAIRMAN: You say "everyone"—with whom did you discuss the situation?

WITNESS A: No-one much at that stage, it was kept very secret. My mother and the doctor knew, probably no-one else much. I probably told a friend, but I did not tell the father. That was about all at that stage. Later, more people became involved. The doctor suggested I go to St Anthony's, which was a home for unmarried mothers.

CHAIRMAN: Your local doctor referred you to St Anthony's?

WITNESS A: Yes.

CHAIRMAN: Could you describe your experience as a resident of St Anthony's?

WITNESS A: Yes. I found the whole thing fairly traumatic. It was just like a business, and people could come and go but the business kept on. It was an institution and it did not matter whether it was me, some other mother, or dozens of us, we were all "processed" I suppose. When I went there I was told I would not be able to use my surname as everyone was known by her christian name. As there was already someone there named Helen I had to use another name. They allowed only one person to use a first name at a time. It was impossible to know who people were, because some people had to change their name and last names were never used. I am sure that that added to the feeling of disorientation. My mother and my doctor saw it as a haven, a refuge for me, and also a way of getting me out of the way. Coming from a Catholic background my situation was seen as shameful. An aunt, a nun, also knew. My mother and my aunt used to say that being pregnant was the one sin that showed and they would look at each other and smile.

I was constantly reminded that I was a walking sin. My experience at St Anthony's bore that out. To a certain extent I felt that their treatment was about punishing me because I had done something wrong. When I was at St Anthony's all the girls had duties, jobs, every day. For five mornings a week I helped out in the kindergarten. At the end of the shift I had to scrub all the floors in the huge playing area and the bathroom, clean the toilets, basins and toys. I did not help out in the afternoon shift, but came back at the end of the afternoon and did the same: scrubbed the floors, cleaned the toilets, et cetera. As my pregnancy advanced, and because I was having twins, it became increasingly difficult for me to fill buckets, carry them and scrub. But there was never any conversation about whether I would keep on with my duties.

Certainly a lot of people had heavier duties than I had. Basically the unmarried mothers ran the place, they did all the labour. They would cook all the meals, do all the washing and cleaning not only for us but also for the nuns. Also it was a training place for mothercraft nurses, so the unmarried mothers did their work too. Any illusion I had that it was going to be any kind of haven or that there would be any signs of Christian charity went out the window when I realised that the nuns did not even like to say "Hello" to us: they would divert their eyes when they saw us coming, because they saw us as shameful.

I was only there a couple of months. I was going to be there longer but I went into premature labour, and I am sure all the work I did there did not help my pregnancy go longer. I never really left the place except to go into St Margaret's Hospital a couple of times for check-ups. For a couple of months it was my whole world. I was lucky: I occasionally had visitors. You would have to see them in a special room and only for a very short time, but a lot of people never had visitors. My memory is it was a fairly unhappy place. We did not have any counselling, there were no discussion groups and there was nothing diverting. There must have been a television there but by the end of the day I was so tired and so uncomfortable all I could do was go to bed because of the strain of what I was doing and the heaviness of the pregnancy. All I remember is one time a woman came along and talked about beauty tips. That was fairly odd. She said how she put on four stone during her pregnancy but lost it all afterwards, so we were not to worry about regaining our figures. That was not really our main concern at the time. Those are my memories of St Anthony's.

CHAIRMAN: You have touched on the next question by saying there was no counselling or discussion groups that you remember. You did mention in your submission having regular meetings with the social worker. Did the social worker provide any counselling or information

regarding alternatives to adoption at these meetings, and did you seek information about alternatives to adoption? If not, why not?

WITNESS A: Yes, I did see a social worker on a number of occasions. I cannot remember exactly how many but it was the same as the woman mentioned previously. It was mainly a form-filling exercise. She had a whole range of forms that had to be filled in. I had to go away and get information, like the heights and weights of my brothers and sisters. I remember I had to go away and get that kind of information and come back. I also had to give her information about the father—what they call the putative father. That was the main focus of our discussions although she also seemed to have a personal quest.

I said at the beginning that I did not want the father's name on the papers. That was just something I decided at the time. She kept pretending I had already told her the father's name and it seemed to be some kind of game, trying to get me to say the father's name. I do not know for what purpose. I do not think it was needed for the paperwork but, as I had said I was not going to give it to her, she was somehow going to get it. There was no counselling and no talk about alternatives to adoption, although I think at one time she asked was there any way I could get the father to marry me, and that was seen as my only hope, if I could somehow do that.

CHAIRMAN: Do you remember whether you sought information about alternatives?

WITNESS A: No, I did not. I did not know there were any alternatives. It was not until comparatively recently, about a year ago, when I saw an article in the newspaper—I think it was an interview with some people from Origins talking about some aspects of the Act and that they were supposed to be given certain information. They were supposed to tell you about alternatives, about help, and about any kind of financial or other assistance, but I never heard of that. As far as I knew there was no help at all and my only option for keeping my twin sons, as it turned out, was if my family supported me. But my family made it very clear that that was not acceptable because the stigma of illegitimacy was seen as a very big thing and a good Catholic family would not have illegitimate children in the home.

The Hon. Dr A. CHESTERFIELD-EVANS: Could you describe your treatment before, during and after the delivery of your babies in the hospital? Do you consider any aspect of this treatment to be illegal or unethical?

WITNESS A: I think it probably was unethical in that they did not treat me as a human being. I am sure that according to their code of ethics doctors are supposed to have paramount concern for the patient. But I think, because I was having twins, I was seen as a kind of twin-carrying specimen. That seemed to attract a lot of attention when I went along for check-ups. I went into labour but it did not go ahead, so I was in hospital for about three days before I finally went into labour. I think it was a teaching hospital, so I had a constant stream of doctors with students coming along and feeling my stomach, and I am sure a certain number of internals were done too.

By this stage I was just cutting off from what was happening. I felt very powerless and did not feel that I could say to somebody, "Do these people have a right to talk over my body and say here we have this young woman and we are going to try to find out what she is in here for." There were various jokes about that because obviously they could see I was pregnant.

They would be chuckling about that. A couple of times I did try to engage people in conversation to try to remind them there was a human being here, but doctors can be pretty dismissive and usually they would just make some kind of put down. Everybody knew I was from St Anthony's, I was single, I was going to adopt, and I was obviously very young so I did not really have many rights.

When I did go into labour or when the delivery was about to happen they rang a bell, which I think was a fairly standard thing to do so as many people as possible could come along, and some of the nurses had said to me before that they were all looking forward to it because they wanted so many twin births and everybody was totting up the number of births. That was a weird experience. Because it was a premature labour I had a forceps delivery and I was in stirrups so I could not really see the babies being born. They grabbed them and put them into humidicribs and took them out straight away. The room was totally packed with people and I was just there by myself. Then everybody went out and I guess I was there for a while afterwards, because I had to have stitches and everything.

That is when I asked were they all right and were they boys or girls, but beyond that no-one would give me any information. I wanted to know whether they were identical twins or whatever. No-one would ever tell me and I only found that out in the past year or so. I suppose once I gave birth I ceased to be of interest, in a way. I did not see my babies when they were born, and afterwards I was told they would not forbid me from seeing them but they strongly recommended against it as it would only make me unhappier than I already was. I did not and that was something I felt bad about because I thought, "If only I had", but I did not. I think I was really discouraged, and also all my energy was going into trying to hold on and keep myself together. I really felt on the edge a lot of the time. I think it was very hard.

The Hon. Dr A. CHESTERFIELD-EVANS: Some people have given evidence to us that the hospital treatment for people who were adopting was different from the treatment for people who were not. Do you have any knowledge of that at all?

WITNESS A: Because I was coming from St Anthony's I was in a whole ward full of people who were adopting. It is probably hard for me to compare from that experience. But certainly from later experience of having children, it was a totally huge difference, yes. I think the attitude was systemic in that it was just accepted that you were treated in a certain way. Everybody knew if you were in that ward you were going to adopt, so they did not have to treat you in the same way that they would treat other mothers. Your babies were not seen as your own and as soon as you gave birth you were supposed to forget them from the first minute. That is over: now you have to get on with your lives. That was also a very weird experience. It was really hard.

The Hon. Dr A. CHESTERFIELD-EVANS: Was the your drug treatment with the adopted babies different from your drug treatment with the other babies? If so, do you think it related to the fact that you were adopting?

WITNESS A: No. I know other people had that experience, but I was not drugged.

The Hon. Dr A. CHESTERFIELD-EVANS: The Committee is keen to understand the role of the mother's family and the babies' father in the decision to adopt. What role did your family and/or the father of your babies play in the decision to adopt?

WITNESS A: I think my family played a huge role. I did not tell the father, so my family was really my one hope. Either they were going to offer me some support to keep my babies or, as far as I knew, there was nothing else I could do, because no-one had mentioned it and I just accepted there was no other option. The fact that my family felt really strongly that adoption was the only thing to do and it would be a very cruel and negligent thing to keep my babies and expose them to the stigma of illegitimacy and heaven only knows what future with no income, as it was put to me—as I would have no income and no support—it made a huge difference to me that I did not have that support.

Also, I suppose, the fact that through the entire pregnancy nobody spoke to me about any options but my family kept saying, "You have to adopt. How could you do it to your children to keep them, it would be a terrible thing. What kind of dreadful person are you who could even consider it when they could go to a wonderful adopting family of people who could give them all the advantages and you cannot give them anything?" That was said repeatedly and it had a strong effect on me at the time.

The Hon. Dr A. CHESTERFIELD-EVANS: You did not feel that telling the father was an option, in the sense that you did not think you wanted him to help you make the decision or he would not be capable?

WITNESS A: I had a fairly clear feeling that he would not be supportive. I think I made the right decision that way. I think he would not have been supportive of me. I think he was in a fairly confused state at the time and he was fairly young. So, no, I do not think it would have helped.

The Hon. Dr A. CHESTERFIELD-EVANS: Again, you have almost answered question No. 7. How did the decision to adopt your twin sons come about? Did you express a desire to keep your babies at any point during or after your pregnancy? If yes, to whom did you express the desire and, if not, why not?

WITNESS A: Yes, I did on a number of occasions, with my mother. I talked to her about really wanting to keep my babies and trying to work out some way that I could. But she said there was no way she would allow them into the house—that was a fairly conclusive no. I did not really talk to anybody else about it, because in my mind the only options were to adopt or keep them if I had some family support. The only girls at the home that I saw keep their babies were the ones who got support from their families. I saw that as being fundamental. Where would I go and what would I do? I had no idea and no-one ever mentioned that there was any other kind of support that I could have.

The Hon. Dr A. CHESTERFIELD-EVANS: You have partly answered question No. 8. Could you discuss how your treatment by various people during the course of your pregnancy may have influenced the decision to adopt your babies? That would be the non-discussion of options.

WITNESS A: Yes. Once I was put on the track of the Catholic home for unmarried

mothers and St Margaret's Hospital it was assumed that I was going to adopt and that that would be the only reasonable thing to do. I had that pressure. I was wracking my brains over it. I spent probably a great deal of my pregnancy trying to think of some way that I could possibly do it by myself. I did not know how I could do it by myself without any help.

The Hon. Dr A. CHESTERFIELD-EVANS: The Committee has heard evidence from one of the adoption homes that felt that women were in the situation that you have described, that if a woman did not have family support then she could not keep her baby because she would have no way of supporting it—that one either had to adopt or have support from the family. The adoption home felt that it was there to soften the situation rather than influence the situation by perpetuating it. Do you consider that the home itself took a pro-adoption line for any particular reason?

WITNESS A: That would definitely be the line taken by Catholic organisations in those days. It was not the line to encourage young single women to keep their babies. As I have said, in Catholic eyes it was a sinful thing that I had done. The stigma of illegitimacy was really important to my family, it was such a big thing. And it was a big thing. I remember hearing, before I stopped going to church, the Catholic priest going on about what a dreadful thing it was that single mothers sometimes kept their babies and that that should not be allowed. It was the policy. It was just what people expected.

The Hon. Dr A. CHESTERFIELD-EVANS: Your submission includes examples of what you consider to be unethical and unlawful adoption practices. Please describe some of those practices.

WITNESS A: As I said before, until I read that article about a year ago I never knew that the authorities were obliged to offer financial assistance and foster care. I never knew that there was any financial assistance, and it never occurred to me to ask. Even while I was pregnant, although I filled in forms to get a certain amount of money, most of that money went to the home so I did not really have that direct contact with social security to be aware that there were different kinds of allowances. I had no awareness of that. If that was built into the legislation then it was not just unethical, it was unlawful not to tell me about it.

Another aspect was a warning about the risk of dire future regret. Nobody talked to me about that. It was all just, "Do the right thing. You have to adopt and then afterwards you have to go away and forget about it, pretend it never happened, and get on with your life." If that is warning of dire future regret or counselling, it does not rate very highly. A point has been made about women being informed that they had to insist on adoption before any consent was taken. It was always just assumed that I would give my consent. There was no alternative. Nobody talked about it, nobody put any of those things to me. As I have said, until I read about it in the paper about a year ago I did not even know about it. That those things were not done, that is unethical and unlawful.

The Hon. Dr A. CHESTERFIELD-EVANS: Has your experience of adoption affected you and your relationships with your family?

WITNESS A: Yes, definitely. It has had a big effect on me and on my relationship with my family. At the time, when I went home to my mother from the home for unmarried mothers, my mother said, "We'll pretend it never happened. I'll never mention it again." My mother has not

mentioned it again. It is only recently that I mentioned it to her. I have heard other people in my situation talk about this, too. That kind of secrecy creates huge chasms between women and their families. You have gone through this thing that has changed your life. It has been shattering and traumatic, and no-one will talk to you about it or even acknowledge that it happened. How can you be close to people when one of the most important events of your life is treated as though it did not happen? That has a huge effect on families. Even when you start talking about it again after 26 or 27 years, how do you catch up? How do you make up for that lost time? I do not think you do.

The Hon. Dr A. CHESTERFIELD-EVANS: What measures might assist people experiencing distress as a result of past adoption practices?

WITNESS A: I am sure that there are many things that can be done. I do not have an exhaustive list at all. First, it is really important to bring this out into the open and for people to realise the circumstances at the time and how hard it was to make a choice—at that time it was not really a choice. I have heard adoptees speaking about adoption. Sometimes they have not realised just what the social conditions of the time were. That has made it much more distressing for them. They have thought that things were more or less the same as they are now, that social attitudes were different, that pensions existed and that somehow women blithely decided to give their babies away. It is really important that people know just what the circumstances were at the time.

It comes down to giving financial assistance to organisations such as Origins and PARC that provide counselling and support. One needs to be able to talk about this; there is a need for counselling and support. It makes it very hard for people if there are not many places that they can go or if there is not the funding for support. This is not the kind of thing that people could just have a group discussion about a couple of times and then it is over. I find that this is a journey that goes on and on. Just when you think that you have dealt with one thing, something else comes up. That is really important, and it often comes down to financial support. Those are the main measures that I can think of.

CHAIRMAN: Is there anything else you wish to add?

WITNESS A: No.

(The witness withdrew)

(The Committee adjourned at 4.39 p.m.)

TRANSCRIPTS OF EVIDENCE

MONDAY, 19 OCTOBER 1998

ROOM 814, PARLIAMENT HOUSE, SYDNEY

MEMBERS PRESENT:

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

WITNESSES BEFORE THE COMMITTEE:

SISTER ANTIONETTE MARY BALDWIN, Nurse, Sisters of St Joseph (NSW), sworn and examined:

CHAIRMAN: Did you receive a summons issued under my hand?

Sr ANTIONETTE: I did.

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

Sr ANTIONETTE: I am.

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

Sr ANTIONETTE: I do.

CHAIRMAN: Do you want to start off with a brief statement, elaborate on your submission, or go into the questions that we have sent to you?

Sr ANTIONETTE: I will start off with a brief introduction, if I may?

CHAIRMAN: Yes, certainly.

Sr ANTIONETTE: The information contained in my submission is from my archival data, historical records and from interviews with the Sisters of St Joseph who worked at St Margaret's Hospital and St Anthony's Home over the period spanned by the Inquiry. At times during the evidence I will quote from these interviews.

Some of the women interviewed are now quite senior and I have tried to ascertain how they perceive the work done at these places and their attitudes and motivation to take on this work. The interviews were structured and formal.

I personally have never been involved in the policy development, care of the mothers, the adoption counselling or taking of consent. My own area of speciality is as a neonatal nurse and from that role I do have something I would like to share with the Committee and with the mothers who have lost children to adoption. It is a small piece of information that I have never seen documented or supported by research but I believe it belongs to them and not to me.

Memories are precious when we have lost someone we love and everything we can learn about a person is to be cherished. I realise that what I am about to say is a risk and I have thought long and hard about the wisdom of sharing it. I apologise if it causes the mothers who have lost babies to adoption more pain, but I share it because I have read and listened to the evidence in this Inquiry about the pain of one-sided bonding that they feel has occurred because their babies were so tiny when they were separated. From my observation as a neonatal nurse during the 80s I believe that the bonding was there.

I worked in the neonatal nursery at St Margaret's and was privileged to care for the babies while they were awaiting fostering. Time and time again when the mothers came to say goodbye after signing consents we saw the pain of separation that the babies also experienced, they would be restless and unsettled for that day. On that day we would hold

them, sit with them in the rocking chair or carry them round in the mei tai sling, sometimes we cried for them and for the mothers. I do not know how babies know these things but I believe that they do.

CHAIRMAN: The Sisters of St Joseph have provided care for single mothers and their babies at St Margaret's Hospital Darlinghurst since 1934 and St Anthony's Home Croydon since 1952. Could you tell us how the Catholic church's view of adoption and single motherhood changed during the period under review in this Inquiry, this is 1950 to the present?

Sr ANTIONETTE: May I just clarify one point. I do not speak for the Catholic church. I represent the Sisters of St Joseph, a religious congregation of women founded by Mary McKillop. We are separate from the other Catholic groups, the St Vincent de Paul, Catholic Welfare Bureau, Catholic Adoption Agency and Centacare; all of whom I refer to in the submission.

However, I do believe there has been significant attitudinal change in the Church, as in all of society, during the time of the Inquiry. Since the second Vatican Council in the 60s there has been a perceptible change of emphasis from observance of the law to the pastoral and compassionate roles of all those who work within the church. It is the human face of Christ that is becoming more visible.

Prior to the Vatican Council church teaching and documents reflected a much more legalistic and judgmental approach. This did not only apply to areas of marriage and sexuality, but to all areas of Church teaching governed by law. I believe the compassion was there in individuals and I heard it time and time again in the interviews, but the climate and mores of the time made it difficult to express.

Every Sister of St Joseph I have interviewed for this submission has in her own way after 10, 20, 30 or 40 years expressed concern and compassion for the mothers, a concern and compassion stemming from the dilemma of the single mother caught between two agonising alternatives, adoption or trying to rear her baby alone.

CHAIRMAN: Your submission includes the adoption policies of St Margaret's Hospital for 1979, 1984 and 1986. Did St Margaret's or St Anthony's have a formal adoption policy prior to 1979? If not, why not?

Sr ANTIONETTE: The policies attached to the submission reflect the Department of Health & Welfare policies of the time, that in turn became hospital policy. I have not been able to access written policy prior to 1979 but I reasonably assume that policies in regard to adoption would have reflected Department of Health & Welfare policies of that time.

Subsequent policy was developed with the co-operation of the Catholic Adoption Agency and Centacare and this pattern would have been established after the Adoption Act of 1965. Written policy may well have existed but there was not the same appreciation of the need to keep such documentation as there is now.

Mr PRIMROSE: Can you please explain the adoption service provided by St Margaret's Hospital from 1950 - 1965? What happened after 1965?

Sr ANTIONETTE: I will answer those two questions together, I have not made a distinction.

Prior to 1965 adoptions were privately arranged by St Margaret's and I understand that the consents were obtained by the solicitors. When the Sisters of St Joseph assumed responsibility for St Margaret's Hospital in 1937 the care of the waiting girls, as the single mothers came to be known, extended from mid-pregnancy to post-delivery with accommodation within the hospital campus. The provision of a place to live continued only until the late 1960s when all accommodation was transferred to St Anthony's Home.

The girls were allocated light duties, partly to keep them occupied and partly to give them a sense of independence and self-worth. They assisted in the ward serveries, in the office and with sewing and in return were given food, lodging, privacy, security and medical care.

I shall now read quotes taken from interviews with the Sisters of St Joseph who worked at St Margaret's between 1950 and 1967. They give a cameo of the mores and attitudes of the time. The realities of life as a single mother were harsh and the girls would have been aware of the realities they faced. I also quote a year and that represents a year that these Sister midwives started at St Margaret's, most of them worked there for periods of twenty or thirty years and they were all midwives.

1937: "The women came because of the stigma of single parenthood in those days. It was a very different world and the girls did not want anyone to know they were pregnant. They came from all over Australia and we did all sorts of things for them to keep the pregnancy secret. By the time they came they had already made up their minds to adopt out the babies."

Again 1937: "They were lovely girls, some came back time after time. One girl came back five times. I used to worry about some of them. We kept them busy so they would not be out on the streets and in more trouble."

1948: "I admired the girls, they had courage and were accepting and cheerful of what had happened to them. They went through the pregnancies and they were concerned about their babies."

1956: "It was not the right thing to be having a baby out of wedlock at that time. The girls were sent away to visit relatives or on a working holiday or something and then they would come back to the family hoping no-one would know anything about it."

Mr PRIMROSE: Can you please describe the different ways in which a woman could come to reside at St Margaret's prior to 1966? For instance, who made contact with the hospital and what, if any, were the requirements for admission?

Sr ANTIONETTE: The Sisters at St Margaret's at that time recall that while some of the girls made the initial contact with the hospital many of the enquires came from parents, other relatives, the parish priest or others in whom the girls had confided. The Sisters estimate that about half the enquiries came from parents or others and about half from the mothers themselves. By 1950 the criteria for admission seemed to be that one was pregnant, single and in need of somewhere to live during the pregnancy. The girls did not have to be Catholic but many of them were.

Mr PRIMROSE: Was it generally assumed that women who resided at St Margaret's up until 1967 intended to have their babies adopted? What would happen if a woman decided to keep her baby?

Sr ANTIONETTE: The assumption seems to have been that if the girls sought seclusion at St Margaret's they did intend to have their babies adopted. For some of the care givers the very fact of offering shelter and seclusion and arranging adoptions was seen as concurring with the decision of the expectant mother and/or her family. Stories are told of letters posted from other suburbs and even from interstate to concur with the mother's wish to keep her pregnancy and therefore her whereabouts secret. Some of the Sisters and midwives interviewed believe in retrospect that it may have been the wish of the family or fear of a family rather than a choice of the woman herself. The women were known only by their first names.

It is my understanding that if a mother expressed a wish to keep her baby or changed her mind about adoption she would then receive the same treatment as any other mother who was keeping her child and was discharged with her baby post-delivery. I understand they were given some assistance but I do not know what form that assistance took, I understand it was practical help like baby clothes and equipment for the baby.

There is archival and photographic evidence of some women who stayed on in employment at St Margaret's after their babies were born and have kept their babies. There are photos in the archives of children up to seven years of age and the mothers were still working at St Margaret's.

Dr CHESTERFIELD-EVANS: Could you describe the antenatal care, birth practices and post natal care provided to single mothers at St Margaret's between 1950 and 1967? Did this care differ for married women? If so, why?

Sr ANTIONETTE: In this context I would just like to give an overview of how maternity care was at that time in history. The girls were offered the best antenatal care possible through the St Margaret's outpatients clinic. Doctors provided this care on an honorary basis and visits followed the usual pattern of monthly to about 32 weeks, fortnightly till 36 weeks and then weekly until delivery.

Professional medical practice surrounding pregnancy, birth and post natal care has changed dramatically since 1950. Between 1950 and 1967 St Margaret's incorporated what was deemed best practice in maternal and infant care into its policies and procedures.

Women were encouraged to walk round during first stage and pain relief varied according to need. Those working in the labour ward at that time testify there was at St Margaret's no discrimination between the single mother and the married girl in terms of pain relief or sedation. On the other hand, pain relief was not withheld from the girls who were not married. One midwife now in her eighties recalls being told of an unmarried woman in labour "She is well dilated, give her pain relief. Don't you think she has enough to put up with? She doesn't need to suffer any more."

Ether was the drug of choice in late first stage, early second stage of labour. Carbitral, which is Pentobarbitone, was used for pain relief in early labour. Most mothers were semi-anaesthetised during the birth. Some were not aware they had given birth until they woke up

from the anaesthetic. This applied to all women in childbirth. The birth process was conducted more like a surgical procedure than a natural phenomena.

All babies were separated from their mothers at birth and whisked away to sterile nurseries to sleep it off and recover from the trauma of being born. Sometimes mothers who were keeping their babies did not hold their babies for up to three days. Babies who had been delivered by forceps, were bruised or premature, were kept in the nursery on strict cot rest. All mothers were bound around breasts to prevent engorgement and abdomen to aid evolution of the uterus and confined to bed for four to seven days. The average length of stay in hospital in those days was ten days post-delivery.

The Sisters tell me that the single mother was given preferential care in labour. Student midwives as well as the nursing sisters would stay with her during labour, even when they were meant to be off duty because of her youth and her situation. Every effort was made to minimise scarring, particularly for the single mother. This was in accord with the perceived need at that time to respect the privacy of the single mother. The matron reports that in the early days, probably during and after the War, when black silk was used almost universally the newer more expensive dissolving catgut was used if the single mother required surgery. This was to minimise scarring.

It is reported that drug regimes during labour were no different for the single mothers. Staff who worked in labour wards at that time are sure there was no difference in standing orders or in practice. Deviations from the norm were on the basis of individual need.

In view of some of the evidence given at this hearing and published in the media I hope to undertake more thorough research to examine drug regimes during this period.

Babies to be adopted were removed from the room at birth and the birth mothers were not permitted to see them. There is no evidence in St Margaret's of the mothers being restrained or of their faces being covered. The girls at St Margaret's had at this time no access to the babies post-delivery.

The matron at the time explained her policies thus:

> "The girls did not see the babies if they decided to adopt. People say and said I was cruel but I will tell you why I did it. When I first went to St Joseph's in Broadmeadows in Victoria the single girls would breast feed the baby for six months, then they would leave. The babies would stay two to three years and the girls would come back and visit. They did not come very often and the little ones would stand with their noses pressed to the gate waiting for Mummy to come. I knew that if they saw the babies they would fall in love with them there and then and there would be no way they could go ahead with their plans to adopt and there was no way some of them could manage in those days."

The girls were accommodated in single rooms or with other single girls who had given birth. Between 1947 and 1952 this was in the private hospital. When the new public hospital was opened with the provision for single or two bedrooms they received post natal care in the public hospital. The babies were on a different floor in the hospital. The post natal was the same for any younger mother except that the girls were given treatment and medication to dry up their breast milk. This was the same treatment given to mothers who had suffered still birth or neonatal death or who for any reason could not or chose not to breast feed.

As far as I can ascertain these restrictions did not apply to the women who came from St Anthony's. They saw their babies and had access to them.

Dr CHESTERFIELD-EVANS: You have said that there was no difference in pain relief or sedation?

Sr ANTIONETTE: As far as I can ascertain.

Dr CHESTERFIELD-EVANS: You were a neonatal nurse, you said?

Sr ANTIONETTE: I was. I am also a midwife.

Dr CHESTERFIELD-EVANS: Were you doing midwifery at this time?

Sr ANTIONETTE: I would have worked in a labour ward at some stage during this time. I cannot recall looking after single mothers specifically and so therefore I cannot recall any difference in treatment. The evidence that I have given was from the nun midwives and from the midwives who worked in labour wards and on the postnatal wards at that time. As I said, I intend to undertake more research. I have to gain access to the records to do that and that is underway.

Dr CHESTERFIELD-EVANS: Coming from that. The evidence has been from a number of sources that the medical treatment was the same, whereas the anecdotal evidence is that it may have differed. There has not been a systematic look at the records of the married and unmarried mothers' drug regimes.

Sr ANTIONETTE: No, that is what I plan to do. St Margaret's Hospital has closed and the records are in the Government Repository, so I have to gain access to the records before I can undertake that research.

Dr CHESTERFIELD-EVANS: The breast binding and abdomen binding was the same, is that correct?

Sr ANTIONETTE: Yes.

Dr CHESTERFIELD-EVANS: The three day separation was that the same for both married and unmarried? Three days separation seems an extraordinary long time, even in those days.

Sr ANTIONETTE: Yes, it was. The three day separation was only for babies who were on cot rest. The mothers were on bed rest, the babies were on cot rest. Again, this is anecdotal, but I can remember babies being on cot rest in the 60s. I actually started working with mothers and babies in the 60s and then I had a break until the 70s. I did not work with mothers and babies from 1962 to 1972. In 1962 certainly there were long periods of cot rest for the babies and the mothers were confined to bed. These were babies who had had forceps deliveries, and forceps deliveries were rare in those days, or premature babies who were confined to the nursery.

To answer the other part of your question. No, it was not the same for both mothers

because the mothers who had lost babies to adoption did not get to see their babies at all. It was only the other mothers that I quoted who had the three day separation.

Dr CHESTERFIELD-EVANS: You said there was not a procedure though to stop them seeing the babies. There must have been. It would not have been a co-incidence. If you did not want them to see the babies there must have been a policy so that they did not. Some of the other hospitals have said they had sheets and pillows put on their stomach or put up when they were in their stirrups so they could not see. Was that the policy also?

Sr ANTIONETTE: Anecdotally I believe that was not the policy. The policy was to remove the baby from the room immediately after birth.

I have not heard any evidence at St Margaret's that there were sheets put up or pillows put up over the girls' faces. The evidence I have suggests that it did not happen. There may be evidence to the contrary but I have not got it yet.

Dr CHESTERFIELD-EVANS: Given that you were not doing this very often, is there somebody else that we should ask? It seems sometimes we get managers and people who are currently managers at these hospitals, whereas of course the people who were involved are some years older usually because they would have retired by now. Are there people who we should ask? If so, are they still alive and able to answer questions?

Sr ANTIONETTE: I have spoken with the Sisters of St Joseph whom I could access, and who are still living, their perception is that it did not happen. I would have to access midwives who are now scattered all over Australia because St Margaret's has closed. I cannot think of anybody at this stage that could be called for evidence.

Dr CHESTERFIELD-EVANS: They must have had a director of midwifery or a labour ward charge sister or something at that time?

Sr ANTIONETTE: There would have been such people, yes.

Dr CHESTERFIELD-EVANS: Could they be identified?

Sr ANTIONETTE: Yes, I can go back and identify them.

Dr CHESTERFIELD-EVANS: Could you explain the process of taking a consent for adoption prior to 1967 at St Margaret's Hospital. Are you aware of any situation where the consent was taken unethically or illegally?

Sr ANTIONETTE: The process of consent prior to 1967 appears to have been carried out through private solicitors in the Child Welfare Department. Although it was the hospital administration who arranged the adoption, letters of authorisation from the Child Welfare Department are in evidence as early as 1937 indicating co-operation with that department.

The Sisters who worked in this ministry are adamant that consents were always obtained through the appropriate channels. I am not certain what constituted illegal practice prior to 1967 as there was no legislation at that time surrounding adoption. The ethics of adoption and the practice surrounding it is an area in which I intend to do further study, but at this stage

I am not aware of any such systematic practice.

Mr CHESTERFIELD-EVANS: Were all unmarried mothers who resided at St. Margaret's until 1966 seen by a social worker? If yes, from what agency or institution would this social worker have been from? Were the social workers obliged to explore non-adoption options with a mother during her stay at St. Margaret's? Would failure to do so constitute a breach of ethics or of the law?

Sr ANTOINETTE: I am afraid I do not know the answer to that question. I am told the social workers visited the girls, but I do not know which agency they were from, and the people who held that information are no longer living.

Mr CHESTERFIELD-EVANS: Could you please explain the process of taking a consent for adoption after 1967 at St. Margaret's Hospital. Are you aware of any situation where the consent was taken unethically or illegally?

Sr ANTIONETTE: The setting up of the Catholic Adoption Agency in 1967 facilitated the phasing over of consent and counselling procedures in regard to the adoptions, completely to recognised agencies, in compliance with the Adoption Act of 1965. Consents were signed by the mother on Day 5 and then she was given 30 days to change her mind if she decided to keep the baby. Both signatures were witnessed by the appropriate social workers from the independent agencies.

I am not aware at this stage of individual cases where the law was not kept or unethical procedures followed.

Mr CHESTERFIELD-EVANS: Was there any pressure put on the women, do you think, to sign, or do you think - you have said that that was already settled when they came in; do you think there was any pressure, deliberately as policy or intrinsic in the system, to make sure that that was followed?

Sr ANTIONETTE: That I think taps into another question, and I will answer Question 13 now as well.

Mr CHESTERFIELD-EVANS: Okay.

Sr ANTIONETTE: I am not confident that the mothers did not feel some measure of censure for being pregnant and single, nor that they felt pressure to give up their babies for adoption. For many of these women adoption was seen as the only viable alternative in a society that did not condone single motherhood nor offer any assistance to the mother struggling to raise her infant alone. So I think there would have been some real or perceived pressure on the women.

Often the alternatives were seen to lay within the family, and unless the child's father, parents or other family members offered financial or material support, the decision to adopt was seen as inevitable. And the mothers awaiting birth would have been aware of this, so there was probably some conscious or unconscious pressure put on them to adopt the baby.

MR CHESTERFIELD-EVANS: The Committee has heard that some mothers' babies were

placed with the adopting parents prior to the 30-day revocation period. Are you aware of any such instances involving babies born at St. Margaret's Hospital during the period under review for this inquiry?

Sr ANTIONETTE: It is my understanding that this was common practice prior to the Adoption Act of 1965. Following the implementation of the Act in 1967 and until the implementation of the Family Law Act in the mid seventies and the introduction of fostering during the revocation period, the policy was that babies stayed in the adoption nursery until the 30 days were up, and the adopting parents came to collect them.

When the foster mother network was introduced the babies were discharged in the care of foster mothers for the 30-day revocation period.

CHAIRMAN: Do you know whether it was at all common for a woman to change her mind during that period, and for a baby to come back from the foster parents?

Sr ANTIONETTE: I do not know. During that period - I do not have any data on that, and I do not know how many revoked their consent during that period, or how many babies cam back from the foster parents.

CHAIRMAN: And presumably you cannot find out?

Sr ANTIONETTE: Those records would be with the relevant adoption agencies, because they were the ones that handled the fostering.

Ms TEBBUTT: What was the role of the Catholic Family Welfare Bureau in providing counselling and advice on the alternatives to adoption to single mothers at St. Anthony's? Did the Sisters of St. Joseph who worked at St. Anthony's provide counselling or was counselling always conducted by the Catholic Family Welfare Bureau?

Sr ANTIONETTE: The arrangement of adoption and pre-adoption counselling was never the responsibility of the Sisters of St. Joseph. Social workers from the Catholic Welfare Bureau visited the home and it was their role to educate and counsel the girls, and after delivery to obtain the consents. The role of St. Anthony's was to provide accommodation.

Ms TEBBUTT: Your submission states that during the period 1952 to 1966 girls who changed their minds during their time at St. Anthony's could stay at the home for 6 to 12 months, where they could have the baby cared for while they tried to find employment and accommodation. Do you know how many single mothers took this opportunity during this period? Was this option available after 1966, and if not, why not?

Sr ANTIONETTE: I do not have that data about how many - anecdotally I know some did. I do not know how many and I do not know how much it was encouraged. I just know there was a policy. After 1967 this policy changed several times. Up until the introduction of the foster mothers scheme the mothers could stay at St. Anthony's during the revocation period, that is for 30 days. For a time in the 1970's and 1980's they did not return post delivery. In the nineties they are free to return for 3 months, with or without the baby.

Ms TEBBUTT: So there are a number of changes after 1960. Up until 1966, as you

understand it, the option was there to stay at the home, but you are not sure how many people took that up?

Sr ANTIONETTE: No.

CHAIRMAN: I was not sure whether you had given us your whole answer to Question 13 before, or whether you still had other parts of it?

Sr ANTIONETTE: No, I gave you the whole answer.

Ms TEBBUTT These are more general questions. Do you believe there may have been any instances of systematic illegal or unethical practices in adoptions during the period under review?

Sr ANTIONETTE: I have no evidence of systematic illegal or unethical practices. It would seem from the evidence that I have that at St. Anthony's efforts were made to treat the women with dignity and compassion, and to comply with legislation, often in difficult and stressful circumstances, both for the care givers and certainly for the mothers who lost babies to adoption.

Ms TEBBUTT: What measures do you consider might assist people experiencing distress as a result of past adoption practices?

Sr ANTIONETTE: I cannot even begin to imagine the pain of losing a baby to adoption, nor can I presume what is best for the mothers who have suffered this loss. The mothers who have come to the Sisters of St. Joseph in recent times have come with a variety of needs. They have come to share memories, to vent their anger, to cry, to express gratitude, to give support, to relive the past, and above all they have come to be heard with respect and with openness.

We have tried and we will try to meet the individual needs of each mother, and this seems to have helped some. We will continue to listen in openness and to help in any way that is possible and appropriate.

Ms TEBBUTT: Do you think an apology made by the relevant agencies would assist these women?

Sr ANTIONETTE: Again, individual needs seem to differ. I have heard some mothers say that an apology would help. Others do not want an apology. Our practices as Sisters of St. Joseph have evolved with the times, and no doubt at times mistakes were made. Those who were hurt while in our care are entitled to an apology. We would encourage those who feel that they suffered while in our care to make contact with us so that their needs may be addressed. It is our sincere hope that this adoption inquiry will be the means of determining measures to assist those who experienced distress due to past adoption practices.

CHAIRMAN: There are no further questions. Thank you Sister Antoinette.

(Short Adjournment)

, sworn and examined, and

, affirmed and examined:

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

Mrs As a mother who lost her child through adoption.

Mr I am the husband of and the father of the child who was adopted.

CHAIRMAN: And you received a summons issued under my hand?

Mrs Yes.

Mr I did.

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

Mrs Yes.

Mr Yes I am.

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

Mrs. Yes.

CHAIRMAN: Your submission was a joint submission, was it not?

Mr Yes.

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

Mr I do.

CHAIRMAN: Can I ask you jointly, do you wish to elaborate on your submission by starting off with a statement, or shall we go straight into the questions?

Mrs I am happy to go straight into the questions.

CHAIRMAN: Question 1 is to you please tell the Committee about the circumstances surrounding the confirmation of your pregnancy early in 1965. For instance, how old were you, how did you feel about the pregnancy and with whom did you discuss your situation?

Mrs Well, I was sixteen years old, unmarried, living with my parents and studying fashion design at the time that I became pregnant, and it was confirmed. It just felt unreal to me. I could not believe it, to be honest. I confided in My mother noticed something was wrong, but we did not actually speak about it and I did not tell her what was going on.

She was upset, wanted to help me, so she just took me to her gynaecologist, to a doctor she trusted. He had operated on her some years previously. I felt really distressed and a nuisance to my parents, basically. I was the oldest of three children also. That is about it.

CHAIRMAN: Just following on from that, I guess in your submission you explained that you were taken to your mother's gynaecologist. Could you describe for us the treatment and advice you received about adoption and/or the alternatives to adoption during this visit?

Mrs. Well, the doctor greeted us, because Mum had rung beforehand and we got an emergency sort of consultation. Mum told him I was late. She was in a bit of a panic. He examined me and said I was six weeks pregnant. Mum and I both cried.

Nothing really was discussed. Adoption was not mentioned specifically on that visit. He basically sent us away to discuss it with my father, discuss that and other options. Well, we all knew what the options were, so it was just a matter of working them out.

My parents and I were against abortion, and it did not look likely that . ___ and I would be getting married because of our youth and little money.

CHAIRMAN: I guess you have answered in part our third question, that we are keen to understand the role of the mother's family. Do you want to say any more about the role your family played in the decision to adopt?

Mrs Sure. Well, after that first visit to the doctor my parents talked to him alone, probably on the 'phone. I was not a party to these conversations. Apparently Mum and Dad wanted to keep the child in the family, and they proposed to adopt him themselves. I did not actually know this at the time. The doctor told them that was a really bad idea, that you cannot do that sort of thing, and he promoted adoption arranged by him, to one of his wealthy clients. He gave all the reasons, the usual reasons given for adoption.

Now I was never consulted by anybody. My feelings never came into it, and as my parents, both parents, were not keen on us marrying, they became persuaded to believe his professional advice, and they just accepted it.

I do not think they were very happy about it. Well, none of us were very happy, and I know now that my mother was quite unhappy, but she felt pressured to conform. But she and I never discussed the impending adoption.

Most importantly, I was never counselled independently. I never saw a social worker and I was given no information about non-adoptive alternatives, specifically any kind of monetary help to keep the baby with me if I had no other means of support.

CHAIRMAN: And your mother and father, when you say your mother, your mother and

father were in agreement?

Mrs : On adopting the baby themselves, yes they were. They were very prepared to do that, I was told years later.

CHAIRMAN: You have told us about the role the doctor played in the adoption arrangements, and mentioned that you believed the doctor was involved in choosing the adoptive parents. In your submission you also suggested a fee was paid to the doctor by the adoptive parents for his role in arranging the adoption of your baby?

Mrs Yes.

CHAIRMAN: Can you tell us what evidence you have that a fee was paid to the doctor?

Mrs Well, I will just go through it as it starts. The doctor played the central role in the whole thing. He was God as far as I was concerned, and my baby's future was in his hands. He arranged everything. Sometime during the pregnancy he told me two different sets of prospective adoptive parents he had in mind. He always promoted adoption. If I looked sad or worried he brushed my concerns away.

He told me my parents would not pay any of my medical or hospital fees. It would all be taken care of. Solicitors acted under his instructions to prepare and witness my consent, and the adoptive parents were named on that consent. However, that was covered up when I signed, that part of the document.

My doctor was a member of Sydney's eastern suburbs Jewish community. He had many wealthy clients. The adoptive parents turned out to be Jewish also, recently arrived from South Africa as migrants. They had one older child about eighteen months old. I am certain they approached him directly to arrange an adoption. The mother was also in the medical profession. They probably were unable to adopt any other way but privately, as they were not citizens and the father was well over 40 years old.

They also had a special requirement, a Jewish child, preferably a boy. The adoptive mother confirmed that fact with me when we first made contact with the family after searching in 1984. She was very upset. They had been lied to by the doctor and told that I was Jewish.

My son horrified me two or three years ago by asking if I received money for him, and how much. I was astounded as I had been naïve enough to think that could not happen. He feels very strongly that his parents paid money for him, and he is willing to sign something to say that.

So in summing up, my doctor played a very large role, and I have no doubt that he sold my son as a Jewish baby to Jewish adoptive parents. He lied to them, and I was kept totally in the dark.

CHAIRMAN: And just to confirm one thing you said there, you know as a fact that neither you nor your parents paid for any of the medical treatment?

Mrs Correct. Even though Dad had medical benefits fund coverage. No,

we never received any bill for any of it. My father is dead now, but Mum can confirm it.

CHAIRMAN: And from what you said, you had several appointments with the gynaecologist?

Mrs Yes, right through the pregnancy. He looked after me medically right through to delivery.

Mr MOPPETT: Mr. , could you tell the Committee how you felt about the pregnancy, and were you able to discuss the situation with your family or with medical or other professional people?

Mr The pregnancy obviously was not planned, but nor was it an absolute surprise to us. At the ripe old age of seventeen at the time I just assumed we would get married. I felt I could persuade my parents that was the way forward.

In terms of being able to discuss it with the medical profession, no. I have a recollection of visiting the doctor's surgery once with but I did not get past the waiting room at that time.

Mr MOPPETT: And what role if any did you play in the decision to adopt the baby, or have the baby adopted?

Mr None. I was not consulted. The decision to adopt was being well and truly driven by Dr. X. He was just calling the shots all the way.

Mr MOPPETT: And your family, did they play any part? Are you aware that there were discussions?

Mr There was one meeting between my parents and parents to discuss the situation. As said, they were not keen that we get married at that age, although we did get married two years later. We had saved in that period and bought a house, albeit up the mountains. But I still believe that we could have pressured and got their concurrence to marriage then.

Mr MOPPETT: My next question actually is to Mrs. gs now. Please describe your treatment at St. Luke's Private Hospital before, during and after the delivery of your baby. Do you consider any aspect of this treatment to have been unethical or illegal?

Mrs Well, I was treated with courtesy at St. Luke's. I was called Mrs., my mother's name, which was rather strange because I did not answer to that normally. I was in a ward with two other women, married, keeping their babies. I do not think there were any other unmarried mothers there.

I was kept in the dark about my labour and delivery by staff and the doctor. I was going to have a breech birth, but I had no idea about that, and apparently it could have ended up being a caesarean, but he was a skillful doctor and saved me from that at least.

I was very sedated during my labour and delivery, in fact probably partly anaesthetised,

because I do not remember any pain during the delivery. It was like a dream. I woke at one stage and asked if my baby had been born, and fell asleep again. Next time I woke I was receiving some stitches, the doctor was there doing that, and I asked to see my baby.

I could not hear anything. I never heard him cry at all. So the doctor told the sister on duty to bring the baby to me - very quickly, he was fairly impatient about it - but I was most definite I wanted to see the baby.

I saw him for about thirty seconds. I reached out and touched his face and said he was beautiful, and then the nurse sort of quickly whisked him away. I just saw his face really, no other parts of his body. I never saw him again until he was nineteen years old. After the birth he was kept hidden from me in the hospital, and from my family and He was just nowhere to be seen.

On the fifth day I signed the consent. The solicitors came and visited me at the hospital. They read it to me. They announced that the adoptive parents were named on the document, which was a big shock to me because I just was not expecting that.

They omitted to inform me that there was any period of revocation, in fact they said the opposite, that he would cease to be my child upon me signing that document, and that I would no longer be his mother. It was as if born to the adoptive parents. Likewise, no medical staff or social worker or doctor informed me of my rights as a mother, for example that he was legally mine until I signed. I just never had any idea myself. I was also administered tablets to dry up the milk while I was in the hospital.

So as for unethical and illegal, I would suggest that hiding the baby was highly unethical, sedating me heavily, keeping me ignorant and giving me tablets to dry up the milk even before I had signed the consent, were all highly unethical things to do.

Mr MOPPETT: Now to you again. I understand that you visited the hospital at the time of the birth. Could you explain to the Committee the experiences that you had at that time, and also could you comment on any aspects of the treatment that either you received or received, that you might consider to be unethical or illegal?

Mr I was working in the city at the time, Elizabeth Street, and used to go down after work each day to visit I guess I had become the invisible man. I was tolerated but not really encouraged. Most of the time I would visit her we would spend outside rather than in the ward, and I guess looking back that was because we were made to feel uncomfortable being together.

Unethical and illegal - at the time I cannot remember feeling that, it was just sort of all happening around us and we had no control, but given what we now know about what was supposed to happen, I would summarise it as being highly unethical and certainly illegal. The treatment from the doctor mainly. The hospital, they were doing their job, and they had looked after her, they allowed me on the premises. They did not hunt me away or anything. But as I said, I was never recognised on my own, I was sort of tolerated rather than consulted.

Mr MOPPETT: Do you feel that that was at the express direction of the consulting gynaecologist, or general policy?

Mr No, my paranoia is not such even today that I would suggest that. He just expected that I would disappear, I think. Certainly during the period of pregnancy he had done nothing to encourage or acknowledge that I existed. I was just a nuisance.

Ms TEBBUTT: My question can be answered either by or , whichever you feel most comfortable, or you both might want to add information. I think the first one, you have probably answered, about whether you received any information about the revocation period, because you said you did not. But did you receive any information on the alternatives to adoption prior to or during your stay in hospital, and did you express any desire to keep your baby at any point during or after the pregnancy?

Mrs Alright. No information was ever given to me by anyone involved about alternatives, for instance keeping the baby, getting monetary support, etcetera. That was neither the doctor, parents, or hospital staff or solicitors. I never saw a social worker. It was never mentioned that I could change my mind after signing. I was firmly told it was irrevocable.

I probably never expressed a desire to keep the baby verbally, but it should have been obvious to anyone close to me that I was having trouble accepting the idea. I did not want to be a burden on my parents either. It was a horrible choice. I just drifted along hoping that something might happen to make things different.

After the birth, several weeks later, I was so distraught that my mother rang Dr. X to ask if it was possible to reverse what had happened. He basically told her no, and asked her to send me along to see him. He acted sympathetic, but sort of irritated as well.

He said there was no way things could be changed now. The baby was adopted and in another State. Now I know that that was not true and I knew then it was not true that he was in another State because when I signed the consent I saw the last line of the parents' address and it was in a suburb of Sydney. He told me I should get on with my life and forget about it. I obviously did not do that. I never forgot about it. I never really accepted it at all and I tirelessly searched until I found our son, actually.

Ms TEBBUTT: Just to clarify the period of time in which your mother re-contacted the doctor, do you think that would have been within the revocation period or not, was it 30 days?

Mrs I think when our baby was born it was prior to the time that that 30 days came in, so as far as I am aware I had up until the adoption order was signed to revoke my consent, which turned out to be about five months, but I did not know anything about that. I would have had to approach the court, I suppose.

Ms TEBBUTT: In your submission you explain that you eventually married and had two daughters. How has the experience of adoption affected you and your relationship with your families and what is the nature of your relationship with your son?

Mr We got married two years after was born and then four years after that we had our first child of the two girls that we kept. So there was a six year period between and , the first daughter. The girls from a very early age were made aware that they had a brother. It was not something they dwelled on. It was something the concept

of which was exciting to them. We moved to Canberra in 1974 After moving to Canberra became very active searching for . We were all to some degree involved and kept abreast of that. Likewise independently my mother started some action in setting up trust funds to try and flush him out that way and of course parents were very keen.

I can remember about five years ago I 's mother saying to me that she was relieved and how good it was that we had sorted the business out in that we had located him and we were actually starting to form a relationship.

The girls were very excited. They were keen to meet the brother that they had never had. Once that was achieved and it was achieved by the eldest one before the youngest one, she actually started to feel threatened I think that there was somebody else in the family that was actually the first child, but all that has sort of settled down now though. They are very accepting of each other.

We see I ' regularly now, at least weekly. It took quite a long time to happen, the first couple of contacts were false starts. He certainly had a chip on his shoulder and resented what had happened to him. But today we have got to the position where we have managed to convince him that we did not make our fortunes by selling him off to his parents. He would certainly see far more of us and our family than he does of his adoptive parents.

We are still getting to know him. The relationship will continue to develop. Just little snippets have come out that indicate what a torrid childhood he had and he just didn't feel like he fitted in; silly things like he said his parents did not smell right, whereas we do. Just stuff like that. We are far more fortunate than most of the people I have met through s activities with the adoption agencies in that we have actually reconciled, we have regular contact. There is a long way to go but at least we are on the road.

Ms TEBBUTT: What measures do you consider might assist people experiencing distress as a result of past adoption practices?

M I do not think there is any panacea for the situation. The various people I have met through the association since has been active in, all the individuals are effected differently, as we all are in our lives. But for those that have a sense of justice there is some comfort from the fact that we are able to expose some of the guilt, particularly when that exposure involves acts of inhumanity and corruption that I believe has taken place, and particularly when those acts have been undertaken by people who would represent themselves as pillars in our society. These acts, or atrocities as I would call them, that were perpetrated against what were vulnerable young women who were denied their legal rights to one degree or another in almost every case, every case that I have shared.

Ms TEBBUTT: I did you have anything you wanted to say about assistance or measures that might assist people?

Mrs I think it is very good to hold an Inquiry such as this and the publicity that goes along with it, to notify the wider community of what happened, because a lot of people have no idea about this type of thing, unless you are involved, especially for the children who were adopted out who blame their parents for what happened which is the worse thing I believe, the most upsetting thing that I have found.

I would really like to see adoption made illegal in most situations. I think there should be free counselling or government meet the costs of counselling for parents and children affected by these practices. The information held by government departments, like Community Services and the Supreme Court should be free of charge to people like us. I was most upset when I had to pay to get information that I felt was my right. And an apology from those involved in the past adoption practices. That is about it.

Dr CHESTERFIELD-EVANS: You touched on an area we have not had much evidence of, at least not in my time - I have not been on the Committee for the full time of the hearing - that is the effect on the adopted children. You have a perspective on that. What do you think is the effect of the adoption on the child? What is the effect of them finding their parents later. How does that effect the relationship with the adoptive parents, do you think?

M : I suppose I can only speak from my particular situation. I would like to read out something about how my son felt about his adoption. He felt rejected as he believed he was not wanted. He actually hated the idea of being adopted. His adoptive mother confirmed that to me the first and only time I ever spoke to her. She did not want to meet us and still does not.

He hated the idea of being adopted, he never accepted it and from a young age he felt a misfit in his family. They were Jewish, they raised him in the Jewish religion. His father was an older man, there was a generation gap, he was largely absent from his life emotionally and physically.

He turned out to be the black sheep of the family. He ran away quite a few times. He did not even complete year 10 at school. He finally left their home permanently at age 16 after many many troubles.

He felt his parents to be overly strict and punitive. He could never please them. They expected him to attend the synagogue and observe all the rules associated with it. Now he tells me they have disinherited him and they say his elder sister will be the only beneficiary of their wills. He does not have much contact with them. I think he is quite emotionally damaged by it now.

The next part of your question was the effect of him meeting us and how it effected his relationship with them. His relationship with them was already not good at all.

Dr CHESTERFIELD-EVANS: Before you met him?

Mrs : Yes. He had separated from them long before and was living his own life, a life they did not approve of at all. When we met him, I don't know, it did not seem to have much effect on him at first. We lived in Canberra. He lived in Sydney. I went to meet him and it was very nice and we chatted and seemed to get on very well. Then he moved away to the Gold Coast, so we were a long way away and we had very sparse contact for a long time. He would ring and ask for money often. He did not treat us very well for quite a long time. We did not get on that well for quite a long time. He was very resentful of us still, because he believed that we wanted to give him away. It has only been in the last few years that he has become reconciled and he understands what really happened. He is following this with great interest.

Mr He is 33 now and he left the home of his adoptive parents when he was 16. I think I first meeting with him was when he was 19. He was, he was screwed up, very cynical. It has taken us probably till about three or four years ago to actually break down the barriers of suspicion.

It was only two, perhaps three years ago that the question of us receiving payment for him came out, once we got through that barrier I think it has gone a hell of a lot better, doing things that you would expect to do.

It is not the same relationship as the girls but if you look at his background, where he is today in his life compared to what the girls have achieved, they have stuck through school and been to university and they are successful and have children of their own now, our grandchildren, and that will all come to him I guess, just a bit later.

Mr PRIMROSE: I do not expect you to have any statistics or anything on this but from other people that you have spoken to, how prevalent do you think was the role of medical practitioners in organising private adoptions? Was yours a common experience, uncommon?

Mrs We do not seem to have any way of knowing that.

Mr I think the private adoption by medical practitioners probably was not all that common. The common thread seems to be the lack of any information being given to these young women about what their rights were at the time. They were just treated as an incubator to carry the baby and pass it on. Now you go away and get on with your life. You have no rights.

Mrs I just do not know anybody else who had that experience personally.

(The witnesses withdrew)

DIANA MARGARET EAGLES, sworn and examined:

CHAIRMAN: Did you receive a summons issued under my hand?

Ms EAGLES: I did.

CHAIRMAN: You are conversant with the terms of reference of the Inquiry?

Ms EAGLES: Reasonably, yes.

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

Ms EAGLES: Except for the page marked *confidential*.

CHAIRMAN: Yes. Do you want to make a short statement or shall we go into the questions that we sent to you?

Ms EAGLES: I have a typed statement here which I would like to read.

CHAIRMAN: Yes, go ahead.

Ms EAGLES: I have agreed to give evidence today because I think it is important that adoptive parents, adopted children and the wider community have a clear understanding that many birth mothers relinquished their babies because they were given no choice other than adoption.

I was told that as I was under 18 years of age and was not allowed to marry I either allowed my son to be adopted or he would be made a ward of the state.

The 60s was a different era with a different morality, but that in no way diminishes the fact that the law as it stood at the time was broken. Apart from the withholding of information that I was entitled to receive, I was asked to sign adoption papers the day after my son's birth. I refused until I had been given access to my child and then thinking that I really had no other choice I signed after three days. I only recently learned that it was illegal to be asked to sign prior to five days after the birth and only then after counselling.

Many adoptive parents honestly believe that the children they adopted were unloved and unwanted and maybe some were but there were thousands who were removed through illegal practices. Many adopted children fear they will appear ungrateful to their adoptive parents if they search for their natural parents and this, coupled with the fear of rejection, makes them reluctant to search for their origins. It is time that the many thousands of children who were adopted in the 60s to the 90s learned the truth of what went on in their particular case and that adoptive parents also accept that in many instances they received the gift of a child because of illegal practices.

CHAIRMAN: Please could you tell the Committee about the circumstances surrounding the confirmation of your pregnancy in 1962? For instance, how old you were, how you felt about it and who you discussed the situation with?

Ms EAGLES: I was 16 years old. I had known the father of my child since I was 14. I was in my last year of high school doing my year 12 exams, matriculation exams. I had told nobody about the fact that I was pregnant in the beginning.

CHAIRMAN: What about as time went on?

Ms EAGLES: I kept it to myself for the first three and a half months. Then I realised I was not going to be able to keep it to myself forever. On the way home from school one day I approached my family doctor who told me what I already knew and asked me to attend with my mother, which I did. That was the first that she knew about it.

I have three older sisters and they were not aware until very late in my pregnancy when my mother told my older sister.

CHAIRMAN: You worked as an unpaid assistant nurse for the three months prior to the birth of your baby at the Braeside Church of England Maternity Hospital, Stanmore. Can you tell us how that came about?

Ms EAGLES: I at the time was attending the Church of England church and I assumed, although it would not have been arranged through my home town church, that my mother who was not terribly well at the time had contacts in Sydney through her doctors and I think that is possibly how it was arranged. It was not a home where unmarried mothers went, it was a private hospital as far as I know and there was only one other girl there at the time who was much older than I was.

CHAIRMAN: So you obviously, from what you say, were not consulted about where you should go or what you should do?

Ms EAGLES: Not at all.

CHAIRMAN: It sort of happened?

Ms EAGLES: Yes.

Mr PRIMROSE: Ms Eagles, in your submission you explain that you were informed that because you were under 18 years of age you had no choice but to have your baby adopted, or otherwise he would be made a 'ward of the state'? Who told you this? Did you speak to a social worker at any time during your pregnancy abut adoption or alternatives to adoption?

Ms EAGLES: My mother first told me this. It was then reiterated by the matron of the Braeside Hospital who interviewed me before I was accepted as able to have my child there. I was not given any other information.

Mr PRIMROSE: You did not speak to a social worker? There was no-one such as that who was made available to you?

Ms EAGLES: No.

Mr PRIMROSE: The Committee is keen to understand the role of a mother's family and the father of her baby in the decision to adopt. What role did your family and/or father of your baby play in the decision to adopt?

Ms EAGLES: My mother and father made it clear that I could not keep the child at home. As I have said, it was either adoption or he was to be made a ward of the state, as I was under 18. I was virtually led to understand that I really did not have any rights, both by my parents and by the matron of the hospital.

My eldest sister's husband asked if I would allow them to adopt my child. I thought about this but I thought firstly her husband asked me, she did not ask me and secondly I really felt that I would eventually marry the father of the child and so I said no.

Mr PRIMROSE: Could you explain to the Committee the circumstances surrounding your request to have your baby adopted into a Church of England family? What do you believe happened to that request?

Ms EAGLES: I was attending a Church of England church at the time and I felt that by having my baby adopted into a Church of England home he would grow up with the same values as I had because I eventually intended to find him.

As to what happened to my request. It was rewritten to read:

"My religion is Church of England and I desire that my said child shall be brought up in the Methodist or any other Protestant religion."

I believe that my request was ignored as the adoptive parents had already been selected and my request did not entirely fit with the adoption order which stated that the adoptive mother was Methodist and the adoptive father belonged to the Church of England church. As it turned out neither parent was practising either religion, but they must have been aware of my request because they had him christened Church of England.

Mr PRIMROSE: Can you please describe your treatment in hospital before, during and after the delivery of your baby, and in particular the taking of consent for adoption? Do you consider any aspect of the treatment to have been unethical or illegal?

Ms EAGLES: My treatment by the hospital before I gave birth was very good. I worked as an assistant nurse and had a nurse's flat across the road from the hospital where I stayed and I helped with the babies and the mothers each day. I ate with the staff and was treated as such. No mention was ever made of my pregnancy and I kept pretty much to myself.

Two weeks before my baby was due I was moved into the hospital and stopped working. The delivery was normal and I was treated well except that I was not allowed to see the child. A pillow was held up and when I protested I was told that it should not concern me as he was not mine.

From this point I was put into a private room and it was there that I was asked to sign the adoption papers on the day after his birth. No information was given to me. I was not told I was even seeing a social worker, even though obviously the person who asked me to sign

the adoption papers was a social worker.

I was fairly quiet and did not ask questions as the atmosphere was pretty authoritarian and inhibitive and I had already been led to believe that I did not have rights anyway.

Of course I now realise that if I had asked questions I may have been given answers, but after such a traumatic experience I was bewildered and had no support other than that of the father.

I was given some type of sedative on a regular basis which did not make me sleep but kept me feeling drowsy. I took them for one day and threw them out after that.

During and after the birth I was treated in an illegal and unethical way.

Dr CHESTERFIELD-EVANS: In your submission you explained the father of the baby visited you in hospital prior to and after the birth. What happened to your request that the father's name be included on the birth certificate?

Ms EAGLES: It was ignored. The reason I asked for his name to be included on the birth certificate was because I felt that if he at some stage wanted to trace us it would be easier. I was only recently told that it was not normal after I applied for his original birth certificate and queried the fact that his father's name was not on it. I was told that he would have had to have given written permission. Even though I requested that his name be included I was never asked that he give that permission.

CHAIRMAN: The people asking you to give your consent and so on were aware that he was visiting you in hospital?

Ms EAGLES: To begin with he was not visiting me in hospital, he was visiting me because I had a nurse's flat across the road. He would visit me on a regular basis. I stayed at the hospital two weeks prior to the birth. After he was born they were aware, yes, and he was ignored, made to feel uncomfortable.

Dr CHESTERFIELD-EVANS: You write in your submission that "there was every indication that I was not in favour of adoption", but by the withholding of critical information you were coerced into unwittingly complying with the 'adoption industries polices'.

a) Did you discuss your reservations about adoption with the adoption professionals or seek information about the alternatives to adoption from adoption professionals? If not why not?

b) Who was withholding this information and why do you think adoption professionals may have been committed to adoption?

Ms EAGLES: I was not aware as a 16 year old schoolgirl that there were adoption professionals to discuss matters with, or to seek information from about my predicament. I was pretty naive and unworldly and usually did as I was told.

I believed that because I was under 18 years that I had no say in the outcome and this is

what I had been told by my parents and the matron of the hospital. I was told many times that if I opposed adoption my child would be made a ward of the State and I believed this.

My pregnancy was not spoken about at home, at school nobody knew and in the hospital it was as though it did not exist. I was healthy and active and carried on normally. Although I was not in denial that I was pregnant it was as though those around me were and the subject itself was taboo.

As the subject of pregnancy was not discussed I guess it was fairly natural that I did not proceed with the questions that I probably normally would have asked - and that certainly were on my mind. You have to remember it was the 60s.

Dr CHESTERFIELD: Did you get support from the birth father?

Ms EAGLES: What sort of support? During my pregnancy?

Dr CHESTERFIELD: Yes, and in your decision-making process. It seems that the fathers are often invisible in this process.

Ms EAGLES: Certainly I agree with that. I had no intentions of telling him I was pregnant. He found out I was pregnant quite late in my pregnancy at about six and a half months when my eldest sister felt he should know. Even though we were going out together, he was not aware that I was pregnant.

I was then told by my parents that there was no question of getting married because I had to have their permission. We did discuss it. He was three years older than I and had a decent job, so had we received counselling we may possibly have married, I don't know. But no, he was treated as if he was not there. He was not given any say in what went on at all. He understood, as I understood, that we did not have any rights. We did as we were told.

Dr CHESTERFIELD-EVANS: Could you tell the Committee what happened three weeks after signing the consent when you inquired about the possibility of being re-united with your son?

Ms EAGLES: I knew nothing about the revocation period. I just enquired to see whether there was any possibility and if there had been I really had not thought about how I would have coped if I had been able to re-unite with my son, but I was told no, there was not possibility.

Dr CHESTERFIELD-EVANS: So you were misinformed deliberately?

Ms EAGLES: Deliberately.

Dr CHESTERFIELD-EVANS: What measures do you consider might assist people experiencing distress as a result of past adoption practices?

Ms EAGLES: I think my last submission outlines what I think.

There are no measures which can be taken to adequately compensate mothers for the loss of a child. The Government should publicly acknowledge the illegalities which occurred. The

law was broken, lives were torn apart and destroyed. Many mothers, not having the mental strength to cope with such trauma, were unable to lead normal lives.

Every adopted child who has not posted a veto on contact should receive information which explains how many birth parents were not informed of their rights and how it was possible that they were illegally adopted against their birth mother's wishes.

Many adopted children would like to know their identity but they feel that it would be being disloyal to their adoptive parents if they began searching. Also, they are in a position of uncertainty, feeling rejection as they were mostly told that they were unwanted and that they were chosen by their adoptive parents.

The false scenario of uncaring birth mothers giving away their unwanted babies should be exposed and erased. Many adopted children would then begin to be proud of their genetic heritage.

Adoptive parents should also receive information relating to the unlawful practices which occurred; although not to blame, they perpetuated the myth of the unwanted child and the caring adoptive parents. Good versus bad.

Many of the adoptive parents in the late sixties were totally unprepared for the change of law in 1991 which resulted in adopted children and parents making contact. The Government owes them an apology for the resulting anguish which they have had to endure.

By making the wider community aware of illegal practices relating to adoption it will make it much easier for adopted children, birth mothers and adoptive parents to understand the individual circumstances surrounding their particular situation. Matters will be more easily discussed and bridges built, resulting in less trauma for all concerned.

CHAIRMAN: Could I just repeat, as I said earlier, that we will be mailing out copies of the transcript to all those whose names are on the list, so if there is anyone here who thinks their name is not on a mailing list, please say so before you go.

That process takes a little time because we always give each witness an opportunity to read and correct the transcript of their own evidence, if they feel that something has gone wrong in it, but we will be sending that out.

Probably most of you are aware that the Committee will - these will be the last hearings for quite some time on this matter because once Parliament rises, probably at the end of November, we expect the Parliament to be prorogued, and therefore the Committee members cannot sit until after the election. This is something that happens prior to every election.

So it means, with the election being on 27 March, and the usual delay as you have seen in the Federal election in working out the seats and so on, that effectively the Committee will not start operating until May. So we will not have any more Parliamentary hearings until then.

But we are discussing further witnesses who should come before us, and the Committee secretariat will also be carrying out a variety of research during that period, so it will not be that everything will stop. We will basically try to do everything we can in relation to getting further evidence, for instance from the doctors involved, carrying out some research with

some of the agencies that have written material, and doing a whole lot of other things that we can do while we cannot actually have this kind of hearing, though certainly we will resume hearing from individual witnesses again about next May.

So thank you all for coming, and I guess we expect to see a lot of you again next year.

(The Committee adjourned at 12.05 p.m.)