Submission to Te Rua Mahara Archives New Zealand - Have your say on the scope and definition of care records

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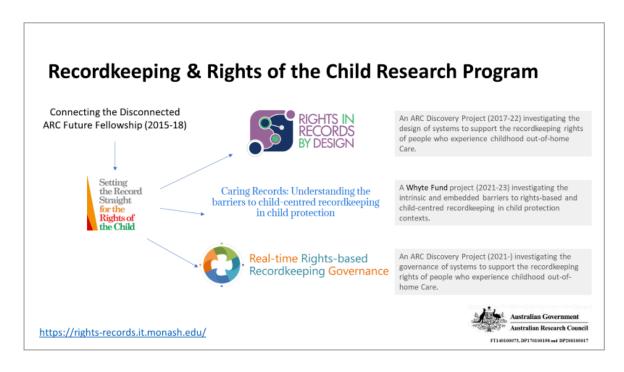With contributions from A/Prof Joanne Evans and Dr Jade Purtell

About us

Thank you for the opportunity to provide feedback on this draft scope and definition of care records. We are researchers from Monash University working on Real-time Rights-based Recordkeeping Governance, which is part of the Recordkeeping and Rights of the Child Research Program, a transdisciplinary research agenda investigating how multiple and lifelong rights in records and recordkeeping can be recognised, respected and enacted in child welfare and protection systems utilising digital and networking technologies.

Our research imagines future digital systems for the Care sector capable of real-time, proactive and transparent accountability to the principles of provision, protection and participation in the best interests of the child enshrined in the United Nations Convention on the Rights of the Child, and for upholding rights to dignity, autonomy and identity in the Universal Declaration of Human Rights.

It brings together researchers from a range of academic, community and organisational contexts, and disciplinary perspectives to tackle this complex problem using participatory research and design methodologies. It also seeks to give voice and agency to Care Experienced people in research to better address their recordkeeping and archiving needs. Key projects are represented below and more details are available at https://rights-records.it.monash.edu/research-development-agenda/

Our Response

Question 1. There are five different information types in our draft. These are listed below. Please select the information types you think should be in scope.

Question 2. Are there any information types missing? Please add them here.

- Records of the core identity of people in 'care'
- Records of incidents, responses and decisions affecting the safety and wellbeing of people in 'care'
- Records of providing services to people in 'care'
- Records about meeting recordkeeping requirements for people in 'care'
- Records of State and non-State 'care' settings.

The information types proposed in the draft represent a nuanced understanding of the types of information that care records can contain and we believe fully address that which should be considered within scope.

Question 3. What information or records do you think are most valuable and need to be protected most for care-experienced people and their whānau?

In Section 2.7 of *He Purapura Ora, he Māra Tipu*, the report notes that "For some survivors, access to records may be the only redress they want." Being able to facilitate this access for survivors is vital, particularly because these records, "can help survivors understand their experience more fully and connect or reconnect with their whakapapa, whānau and sense of identity" (Royal Commission of Inquiry into Historical Abuse in State Care and in the Care of Faith-based Institutions 2021).

These statements are corroborated by research conducted by our team (see, amongst others, Evans et al. 2020) as well as others working with care leaver communities in Australia (Humphreys & Kertesz 2012; Swain & Musgrove 2012; Golding 2016) and elsewhere (Access To Records Campaign Group 2016; MacNeil et al. 2018).

When and how care leavers seek to engage with their records can be understood in the context of redress, but should also be understood to occur for a multitude of reasons. The UK-based MIRRA (Memory – Identity – Rights in Records – Access) Project researchers Hoyle et al (2020), for example, shared from their work with care leavers:

"Each person's decision to seek access to their care records was individual and contextualized in the diverse circumstances of their lives … Often revisiting childhood coincided with significant moments of reflection, for example, when leaving care (Rosie, Sam), when moving into a new career (Darren, John-george), while in prison (Andi, Emmanuel, Brett), on the birth of a child (Gina, Mel, Luke) or at retirement (Mo, Terry, Shefali). For others, it took place in the context of mental health recovery (G016, Susan). The coincidence of these key events with the turn to memory is consistent with understandings of how the self is reconstructed at moments of personal change (McAdams, 1996)" (4).

These findings from the MIRRA project (along with other projects that have explored care leavers' needs and interest in interacting with records such as Rolan, Phan & Evans 2020) demonstrate that there is no one moment in which a record holds value and then, once past, suddenly does not. Instead, a record's value can shift and change and records can hold different meanings at different stages in one's life. It is impossible to assert that a type of record or category of information should be seen as the most valuable to care experienced people because care experienced people are not stagnant in their needs, dreams, or desires.

To assume that what is valuable to one person is equally valuable or insightful for another is also problematic. The patchwork nature of the recordkeeping that each individual care experienced person's case entails (in both the Australian and Aotearoa New Zealand systems) renders it impossible to view any particular record as a sufficient and authoritative account of a care leaver's past. It must be acknowledged that "formalised records may be part of the records system, and perhaps even documents against which accountability is monitored, but they are not the entirety of the records. Other records will include case notes, instructions, local procedures, emails, messages etc made by social workers and carers. … All records are potentially relevant to the child" (McKemmish et al. 2021a, 4).

While there is no perfect answer for what records are most valuable, it is possible to construct a picture of what it is that the information in the records represents. The Charter of Lifelong Rights in Childhood Recordkeeping in Out of Home Care [henceforth 'the Charter'] presents us with 'framing rights' that help to contextualise what it is we are protecting when we protect care records as a whole:

"Individual and collective **memory rights** to:
• remember/forget
• be remembered/be forgotten

Individual and collective rights to:
• **cultural, family and self-identity**
• know who you are, where you belong

• practice your culture
• have one's cultural or community recordkeeping practices recognized in legal, bureaucratic and other processes that involve records creation
• have one's self-identity acknowledged in records about oneself, including, but not limited to name, gender, and ethnicity

Individual and collective right to:
• hold society, governments and service providers to **account for actions** that impact on you as an individual or community
• governance frameworks and accountable systems that support transparent decision making based on accurate, complete and reliable evidence"

(McKemmish et al 2021b, 6; emphasis added)

With these rights in mind, we believe that the 'most' important information is that which answers questions of memory, identity, and accountability that cannot be answered by other sources that might otherwise, in a 'typical' family situation, be available to a child or young person.

Question 4. Are there any information or records you think should not be kept?

Following on from our previous discussion of the unique value of care records – both in terms of being unique experiences for every individual and unique sources of information for care leavers generally – it is difficult to say that any particular records could be immediately identified as ones not to keep.

However, when considering the nature of the level of surveillance that children in care experience as part of their growing up, and the fact that many of these records cannot be equated to 'family' records even if they are records of childhood, the privacy of a care-experienced person should be heavily taken into account in the context of keeping information. Rather than a discussion of retention and disposition, the conversation that must be had regarding records of care is one of purpose and use.

Melanie Senior (2023) draws our attention to the idea of records creating a static picture of an individual that is judged based on their unchangeable paper self. She writes, "The 'fixing' of identity is devastating, as Care records are often used in other legal proceedings. In allowing this, Care experienced people are reduced to an unchanging subject, narrated as a non-developing, one-dimensional stereotype" (Senior 2023, 1515). When records of incidents, responses, and decisions are used to penalise or judge care leavers, the nature of corporate parenthood turns from necessary guardian to unwelcome informant or judgemental gossip.

Purtell et al. (2021) provide a concrete example of the potential harms of this information remaining with the system in their work with care leaver parents:

> "the ability of protective services to review the child protection file of a parent who was in care to make assessments about their suitability as parents. … In contrast, protective services are not able to access the details of other parents' highly sensitive life histories if they did not have any previous involvement with child protection." (362)

As these records can provide important answers about past decisions and actions that may be of value to a care leaver, rather than not keep these records, strict consideration of how and when they can be accessed and used in decisionmaking should be a priority. Identifying records that have the potential to reduce care leavers' autonomy and to have significant impact on their ability to access services should be a priority when considering guidance on access and use.

Aside from government-led initiatives focusing on retention and disposition (and/or access), in accordance with the Charter as well as the MIRRA Framework for Person-Centred Recordkeeping, we believe that care leavers have the right to request that records or information about their time in care be destroyed or restricted and that they should be supported in understanding how to do so. While records of their time in care may represent an important part of a care-experienced young person's history, it is vital that we view any retention of their records as an act of supporting their continued growth and development as an individual. Self-determination theory posits that in order to achieve psychological growth, people need senses of autonomy, competence, and connection or relatedness (Ryan & Deci 2020). It should be noted that both autonomy and competence relate to a person's ability to feel in control and empowered by knowledge. Just as records have the capacity to offer information, they also have the ability to be looming reminders of the past.

Empowering care leavers to understand/articulate this duality of the records and giving them the intellectual and practical tools to make decisions about retention and disposition of information about themselves should be a central element of disposition practices.

Question 5. Please let us know your comments on the draft scope and definition of care records. You can comment on either the [Plain Language summary](), or the [Detailed text]().

The draft scope and definition of care records is a highly comprehensive document that addresses the breadth of events and contexts through which the provision of care is facilitated.

We wish offer the following suggestions:

1. **Reconsider the order of information types as listed in the document**. As we have mentioned in our discussion of keeping documents, there is a culture of emphasis on negative experiences in care. By putting complaints/allegations second, one runs the risk of reinforcing the connotation of what a file will look like as well as what someone might expect to find. If one were to model the order of information types progression of care provision, it would follow that 'Provision of Services to Individuals in Care Settings' should come before 'Complaints, allegations and incidents, responses and decisions affecting the safety and wellbeing of Individuals in Care Setting.' This has the added benefit of mirroring a strengths based mentality when presenting the information types.

2. **Increase the capability of the document to act as ready reference**. Although the level of granularity in the document is appreciated, we are concerned that the detailed text might feel overwhelming for practitioners who are looking to consult it. Providing a tabular version of record/information types might help to improve the ability of an individual to use the scope and definition of care records as a ready reference document.

3. **Remind readers why this understanding and identifying care records is important**. While we acknowledge that this document will be made accessible with additional information and documentation, we encourage the authors to consider including a statement about why a nuanced understanding of the definition and scope of care records is important for a reader to understand. This could help to remind someone why they might reference this document and to emphasise the value of identifying these records overall. Including mention of access to these records by care leavers could help to contextualise purpose as well.

4. **Emphasise the overlap between the personal and the bureaucratic**. Although it is useful to separate out information types and records types as done in the draft scope and definition, we encourage the authors to consider including a statement that acknowledges that information types and value can overlap.

5. **Create a version (or versions) that have care leavers as the audience**. While the plain language summary draft is useful as a high level explanation

of the information types, we would encourage the authors to consider creating a version that is addressed to care leavers.

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