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Collecting and using information about suicide

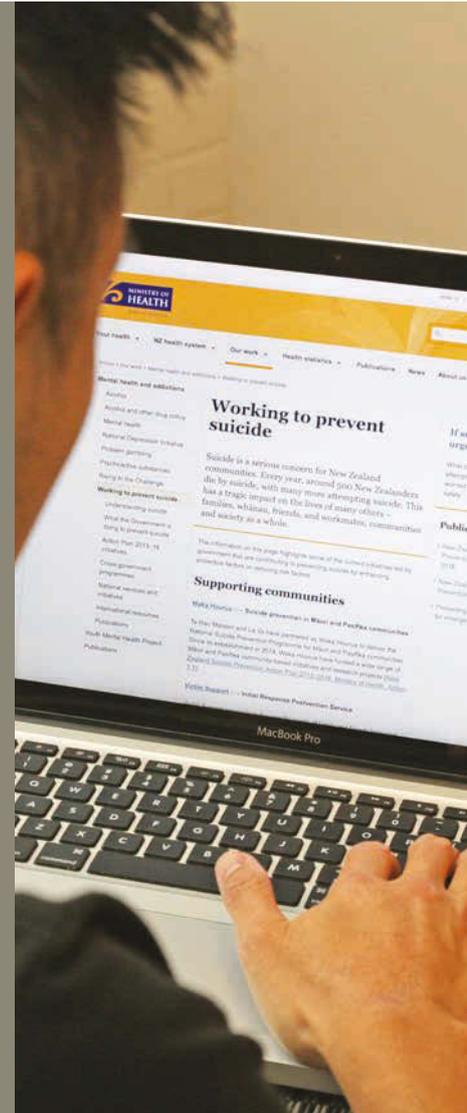


Photo acknowledgement: Chris Tse,
Office of the Auditor-General

Collecting and using information about suicide

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Auditor-General's overview

Suicide is a tragedy for everyone involved, and is difficult to discuss. In 2013, it was the third leading cause of premature death in New Zealand after heart disease and lung cancer. There were 508 suicides, or about one every 17 hours, and about 3000 people spent one night or more in hospital being treated for intentional self-harm. People with less severe intentional self-harm injuries had short stays in emergency departments or were treated by their doctors. Many people were attended by police officers following emergency calls.

There are many potential pathways to suicide, and the reasons for it may be complex and particular to each person. This makes it difficult to determine what can increase or reduce the risk of suicide, and means that there is no single solution for preventing suicide. Therefore, it is important that public agencies in New Zealand collect and use good information about suicide to help them find ways to prevent it. I decided to look at how well agencies collect and use information about suicide to understand it and, where possible, to prevent it.

In general, some information is collected and used well. However, there are gaps – most of which agencies have identified and are taking steps to fill. They include inconsistency in the information collected and delays in collecting it and sharing it, which in turn affects the timely analysis of this information for preventative purposes.

Suspected suicides are notified to a duty coroner. Some early information about suspected suicides is shared with district health boards (DHBs) shortly after a duty coroner is notified. One reason for doing this is to provide support to the bereaved, who can be at increased risk of suicide at this time and in later years, and to consider whether any immediate actions are needed to reduce the risk that someone else might take their life in similar circumstances. This early information is also used to spot any emerging trends and respond to them, and correct any misunderstandings in the community about recent suspected suicides. The Ministry of Health has not yet got assurance that DHBs are responding appropriately to the information they get from the coroner, and I encourage it to do so.

Two standing mortality review committees review about 30% of suicides. They review mostly child, youth, and maternal suicides. This means that about 70% of suicides – mostly of people aged 25 years and older – are not reviewed by a mortality committee. The Ministry of Health was tasked with trialling mortality review methods with a focus on suicide. The trial was completed in late 2015, and a decision about whether a suicide mortality committee will be established is expected in 2016/17. The Health Quality and Safety Commission and Ministry of Health have told us that, if a suicide mortality committee is not established, they will look at other ways of reviewing adult suicides in more depth.

The Child and Youth Committee's process for collecting and considering information is systematic, but is not described clearly or implemented fully. However, the Health Quality and Safety Commission is in the process of ensuring that data collection is consistent and that reviews of suspected suicides are completed within twelve months of a coroner's decision on the cause of death. Until these aims are achieved, the Child and Youth Committee will get partial information, which means that its analysis and reporting will be less effective. The Perinatal and Maternal Mortality Review Committee's approach to collecting and considering information is clearly described and systematic.

Agencies should work together to give coroners more consistent and comprehensive information, for example by introducing a standardised reporting form for health or social services to complete. This would help the coroners in their work and help with suicide prevention measures.

We found that the average time for coroners to complete suicide inquiries increased between 2010/11 and 2014/15, from an average of:

- 318 days to 509 days for inquiries without an inquest; and
- 676 days to 778 days for inquiries with an inquest.

Nearly all coronial inquiries need to be completed for the year being reported on before the Ministry of Health can release the latest statistics, which is why reports are published between two and three years later. The Ministry of Justice is aiming to complete all coronial inquiries within 300 days, so that families get decisions sooner. This will also mean that suicide and other mortality statistics can be published sooner.

Information about suicides is used to form plans and strategies to prevent suicide in New Zealand. For example, the Ministry of Health used information about suicide from a wide range of sources to inform the 2006-16 national suicide prevention strategy, which will be updated in 2016/17. The Ministry plans to release a new national suicide prevention action plan at the same time.

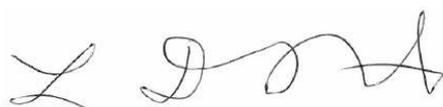
The Ministry of Health draws on population statistics and reports about suicide to identify the community groups that are affected more by suicide than others. This information has influenced the strategy and the action plan's priorities, and it forms the basis of guidance for DHBs on preparing local suicide prevention action plans. The DHBs' plans will run from July 2015 to June 2017, and DHBs will report on their implementation to the Ministry. It is too soon to know whether these local plans will contribute to reducing suicide. I expect the Ministry to assess the value the plans have added before directing the DHBs to update or renew their plans in 2017.

The Ministry of Health's population statistics about suicide are valuable for looking at changes in suicide rates over periods of 20 years or longer. However, the statistics are not useful for assessing the effectiveness of suicide prevention actions in the shorter term because it is difficult to make a link between specific actions and changes in data at the population level.

For this reason, the Ministry of Health is creating a suicide prevention outcomes framework and is in the process of selecting indicators for it, in the hope that the indicators will help assess the effectiveness of suicide prevention actions in the short and medium terms. The Ministry plans to complete this work in 2016/17.

It is too early to tell whether the Ministry of Health's and other agencies' planned improvements in their collecting and use of information about suicide will be effective. The next one to two years are important. Agencies need to carry out their plans and report whether they are working as well as expected toward preventing suicide.

I want to thank the public entities that took part in the audit, particularly the Health Quality and Safety Commission, the Ministry of Health, and the Ministry of Justice. I also thank the Chief Coroner and coroners for their involvement and support.

A handwritten signature in black ink, appearing to read 'Lyn Provost', written in a cursive style.

Lyn Provost
Controller and Auditor-General

13 June 2016

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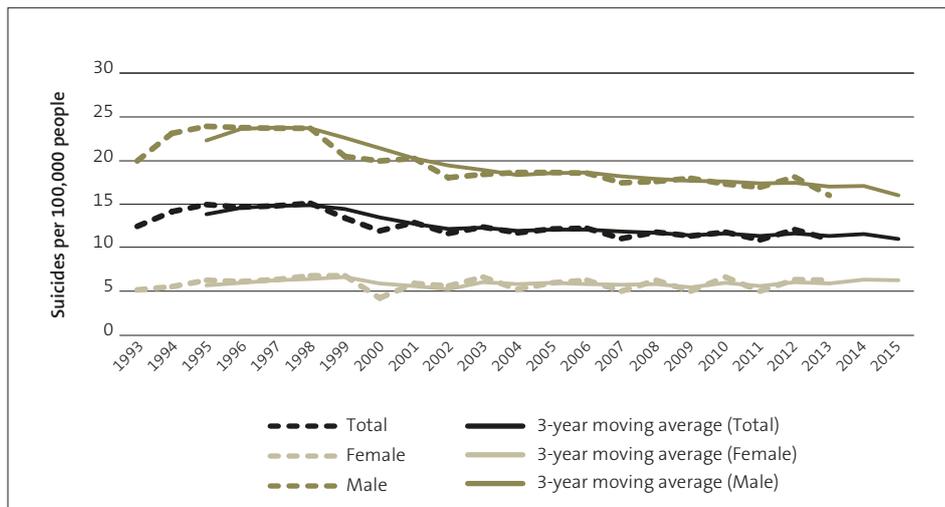
Introduction

- 1.1 In this Part, we explain:
- why we did our audit;
 - what we did and did not look at; and
 - the structure of this report.

Why we did our audit

- 1.2 In 2013, suicide was the third-leading cause of premature death behind ischaemic heart disease and lung cancer in New Zealand.¹ Figure 1 shows that the suicide rate in New Zealand has been steady for much of this century.

Figure 1
New Zealand's suicide rate for every 100,000 people, 1993-2013



Note: The rates are age-standardised rates for every 100,000 people, standardised to the WHO world standard population. Three-year moving averages smooth out year-to-year variation and help to identify and forecast trends. The extensions to 2014 and 2015 are estimates.

Source: Ministry of Health.

- 1.3 When there is a steady suicide rate and an increasing population (as in New Zealand), the number of deaths from suicide each year increases.
- 1.4 Suicide affects all parts of the population, but some parts are affected more than others. Suicide rates for males, Māori, people aged 59 years and younger, and people living in greater deprivation are higher than rates for females, non-Māori, people aged 60 and older, and the less deprived.

¹ In 2013, the age-standardised rates for every 100,000 people for Years of Life Lost for were 1353 for ischaemic heart disease, 571 for lung cancer, and 512 for suicide. Source: www.healthdata.org/new-zealand.

- 1.5 To try to estimate the financial cost of suicide to society, the Ministry of Health has completed two studies, 10 years apart, and published reports showing the method used to estimate the costs and the results. The latest study, which used 2002 data, estimated that the economic cost of a single suicide was \$448,250, and the non-economic cost was \$2.5 million.² We estimate that, with inflation, these figures would be about \$602,700 and \$3.4 million respectively in 2015.³
- 1.6 The World Health Organization considers that many deaths from suicide are preventable.⁴ The main aim in suicide research is to find out why some people with problems and in distress deliberately end their lives and others do not. No one has yet produced a comprehensive theoretical model that explains the causal processes for suicide and the interaction between different risks.
- 1.7 There are many potential pathways to suicide, and the reasons for it may be complex and individual.⁵ Cultural factors can play a part, which means that analysis cannot rely wholly on information collected in other countries. Understanding the factors that increase or reduce the risk of suicide in New Zealand is important for introducing effective actions to prevent it.
- 1.8 Even with better information, it could still be difficult to predict which individuals will have suicidal thoughts and who will act on them. Researchers have found that it is difficult to be certain which, if any, are the most useful risk scales for self-harm risk assessment.⁶
- 1.9 We consider that good information supports good decision-making, leading – eventually – to better results. So, we carried out a performance audit to determine whether information is used effectively to understand suicide and, where possible, prevent it. We hope that our audit and this report will help make collecting, using, and reporting suicide information more effective and efficient.

2 O’Dea, D and Tucker, S (2005), *The cost of suicide to society*, page ix, Ministry of Health, www.health.govt.nz. The calculations used are complex and were the best estimates possible at the time. Briefly, economic costs refers to the resources that would be saved by reducing the suicide rate, such as police, healthcare, and coroners’ costs, added to estimates of the value of lost contribution to gross domestic product because of suicide. Non-economic costs estimate the value of years of life lost (with every year lost being valued the same) plus the value of healthy years of life lost.

3 We used the Reserve Bank’s calculator to estimate the costs. We used first-quarter 2002 costs and fourth-quarter 2015 costs.

4 World Health Organization (2014), *Preventing suicide: A global imperative, Executive Summary*, page 2, www.who.int.

5 A diagram on page 16 of the *New Zealand Suicide Prevention Strategy 2006-2016* shows the range of potential pathways to suicidal behaviour. The strategy is available on the Ministry of Health’s website: www.health.govt.nz.

6 Quinlivan, L and others (February 2016), “Which are the most useful scales for predicting repeat self-harm? A systematic review evaluating risk scales using measures of diagnostic accuracy”, *BMJ Open* 2016;6:e009297 doi:10.1136/bmjopen-2015-009297. This article reports that no scales performed well enough to be recommended for routine clinical use.

What we looked at

- 1.10 There is nothing standalone that you could call a “suicide information system”. Rather, information on suicide is collected by multiple other systems, such as those established:
- to record births, marriages, and deaths;
 - for expert committees to look into the deaths of individuals and groups to see what could be done to prevent deaths in similar circumstances;
 - for coroners to inquire into certain deaths, such as those with an unclear cause or in special circumstances (including any suspected suicide); and
 - to collect and report statistics about the causes of death in New Zealand.
- 1.11 For our audit, we took a high-level look at the information that those systems collect on suicide, how they interrelate, and what the information is used for.
- 1.12 Overall, we expected that good quality data would be systematically collected about suspected suicide and suicide. We expected that data would be systematically analysed and shared, and fit for purpose. And we expected data and analysis to be used to help prevent suicide.
- 1.13 We completed our audit at a time of change. Agencies finished some work during our audit, and will complete or decide on other work in 2016/17. This means that it is too early for us to comment on the effectiveness of some measures. Where this is the case, we say so in this report. We summarise in the Appendix how we did our work.

What we did not look at

- 1.14 We did not audit:
- any services available or delivered to people experiencing or displaying “suicidal behaviour”⁷ or to people bereaved by suicide, including making information available to the public;
 - how effectively or efficiently any suicide prevention action plans have been implemented;
 - the suicide prevention plans prepared by district health boards (DHBs);
 - coroners’ decisions or how they plan or carry out an inquiry, because they are independent judicial officers and therefore excluded from the Auditor-General’s mandate; or
 - any research on or evaluation of suicide or suicide prevention.

⁷ Suicidal behaviour includes thinking about suicide, making a plan to deliberately end one’s life, or attempting suicide.

The structure of this report

- 1.15 The ultimate aim of collecting information on suicide is to use it for suicide prevention. In Part 2, we discuss how the Ministry of Health has used information from New Zealand and overseas to produce a national **suicide prevention strategy** and suicide prevention **action plans** at the national level and local (that is, DHB) level.
- 1.16 An important part of local suicide prevention plans is the **immediate response** to individual suspected suicides. In Part 3, we discuss the information-sharing system that the Ministry of Health, the Ministry of Justice’s Coronial Services Unit, and the Chief Coroner have set up to tell DHBs about suspected suicide and to respond to it. We also discuss the measures that the Ministry of Health has taken to identify **emerging trends** in suspected suicides.
- 1.17 Expert committees – called **mortality review committees** – have been established to review the deaths of individuals with the aim of reducing preventable deaths, illness, and injury, and of continuously improving the quality of services provided. The committees make up the National Mortality Review Programme, which is managed by the Health Quality and Safety Commission. The committees relevant to our audit are the **Child and Youth** Mortality Review Committee and the **Perinatal and Maternal** Mortality Review Committee. In Part 4, we discuss how these committees do their work.
- 1.18 The Ministry of Health regularly produces and publishes **reports** on the **causes of death** for New Zealanders, including suicide. These are called *Mortality and Demographic Data* reports. The Ministry of Health also publishes **special topic reports on suicide**, called *Suicide Facts*. The reports rely on information supplied by coroners and others. In Part 5, we discuss how the statistics are collected and reported.
- 1.19 Whether or not someone has died from suicide is a legal decision made by coroners, not a medical decision made by doctors. In Part 6, we discuss the information typically collected during **coroners’ inquiries** into suspected suicide, how they report their decisions, and the Chief Coroner’s reports on **suspected suicide statistics**. We also discuss the coroners’ role in helping to prevent suicide.

2

Suicide prevention strategy, action plans, and reporting

- 2.1 In this Part, we discuss how suicide information is used for:
- suicide prevention strategies and action plans;
 - monitoring the effectiveness of suicide prevention work; and
 - reporting progress in reducing suicide.

Suicide prevention strategies and action plans

- 2.2 Information from many sources – including research and evaluation in New Zealand and overseas – is used for suicide prevention by many people and organisations. Our audit focused on the health sector’s use of information for suicide prevention.
- 2.3 In 2005-06, the Ministry of Health used the best available research, data, and other information to prepare a national strategy for preventing suicide. The *New Zealand Suicide Prevention Strategy 2006-16* (the Strategy)⁸ provides a framework to guide national efforts during the period and help government agencies and others understand how various activities in different sectors fit together to prevent suicide. The Strategy replaced the *New Zealand Youth Suicide Prevention Strategy*⁹ and extended suicide prevention efforts to all age groups. The Ministry of Health plans to complete its work on updating the Strategy in 2016/17.
- 2.4 The Strategy has been implemented through two national suicide prevention action plans running from 2008-12¹⁰ and 2013-16.¹¹ We did not audit the plans’ implementation.¹² Each action plan sets out priorities and actions to achieve them:
- The first action plan’s focus was on providing accessible services to help families, whanau, and communities respond to people with suicidal behaviour. The plan had five priority areas, 23 key action areas, and 53 actions.
 - The second action plan is more focused on supporting families and communities and helping them to prevent suicide, and on suicide prevention for Māori and Pasifika. It has five objectives, 11 sub-objectives, and 30 actions. As the lead agency for the plan’s implementation, the Ministry of Health reports to Cabinet six-monthly on progress in implementing the 30 actions; they have now been implemented by several government agencies.

8 Associate Minister of Health, Wellington: Ministry of Health, www.health.govt.nz.

9 Ministry of Youth Affairs, Ministry of Health, Te Puni Kōkiri (1998), *The New Zealand Youth Suicide Prevention Strategy: In Our Hands and Kia Piki te Ora o te Taitamariki*, Wellington, www.health.govt.nz.

10 Ministry of Health (2008), *New Zealand Suicide Prevention Action Plan 2008-12: The Summary for Action*, www.health.govt.nz.

Ministry of Health (2008), *New Zealand Suicide Prevention Action Plan 2008-12: The Evidence for Action*, www.health.govt.nz.

11 Ministry of Health (May 2013), *New Zealand Suicide Prevention Action Plan 2013-16*, www.health.govt.nz.

12 Nor did we audit the value of actions in the Strategy and suicide prevention action plans.

- 2.5 With national plans in place and more information on suicide prevention available, the Ministry of Health has extended suicide prevention work to the local level. In 2015, the Ministry brought together the most up-to-date suicide prevention information into a “toolkit”¹³ and issued it to DHBs. The toolkit also included guidance to help DHBs prepare, for the first time, local suicide prevention and response plans.
- 2.6 DHBs led the plans’ preparation and work with stakeholders. The Ministry of Health expected DHBs to focus on current risks, but also to pre-empt risk (by considering the effects, for example, of proposed closures of firms employing many workers). DHBs are expected to work with government agencies and community groups to carry out the plans from July 2015 to June 2017. We did not audit the DHBs’ plans. In Part 3, we discuss one element of the local plans, which is the DHBs’ response to suspected suicides.
- 2.7 The Ministry of Health plans to complete a new national suicide prevention action plan in 2016/17.

Monitoring the effectiveness of suicide prevention actions

- 2.8 It is common practice to monitor the effectiveness of suicide prevention by monitoring the suicide rate (deaths for every 100,000 people) and the suicide toll (the number of deaths in a year). However, these high-level measures are only useful over the long term. They have limited value for assessing the effectiveness of suicide prevention activities in the short and medium terms. This is because it can take years for changes to show at the population level, and it is difficult to establish cause and effect at that level.
- 2.9 In the late 1990s, for example, suicide prevention actions were targeted at 15-24-year-olds. About 20 years is needed for population data to show whether the suicide rates for the target groups are going down. Currently, primary school children are being taught about feelings and how to talk about them. It remains to be seen whether they will have lower suicide rates when they are older.
- 2.10 The 2013-16 suicide prevention action plan tasked the Ministry of Health with preparing, for the first time in New Zealand, an outcomes framework for suicide prevention. A main aim of the framework is to show whether specific suicide prevention actions are effective in the short and medium terms. If actions are not as effective as expected, changes can be made. The framework will have a set of indicators, which may help to decide priorities.

13 Ministry of Health (February 2015), *Suicide prevention toolkit for district health boards*, www.health.govt.nz. The Ministry of Health describes its approach to working with DHBs as one of “learning and sharing”. The toolkit is a “living document” and will be updated as the results of further research, evaluation, and in-depth reviews become available. For example, the DHBs can share their experiences with other DHBs and agencies, and some of their experiences are available on the Ministry’s website.

- 2.11 The Ministry of Health has prepared the framework and aims to have the corresponding set of indicators ready in 2016/17. We understand that decisions about the framework's implementation, and whether it will be reported on publicly, will be made by the Ministry as it updates the Strategy and prepares a new national suicide prevention action plan.

Reporting progress in reducing suicide

- 2.12 The current Strategy explains how progress in reducing suicide is to be reported. The plan was to produce a special trend report on suicide showing three-year moving averages over the long term. (We show three-year moving averages in Figure 1.) A special trend report was published in 2007, showing three-year moving averages, but one has not been published since.¹⁴ The Ministry of Health's *Suicide Facts* reports should report trends showing three-year moving averages, but they do not.
- 2.13 We discussed this with the Ministry of Health during our audit. We suggested that the Ministry change the focus of its annual *Suicide Facts* reports to focus on trend reporting, and to show trends as three-year moving averages.¹⁵ Moving average trend lines smooth out annual variations, making it easier to spot trends. They also help to ensure that any single year's data is considered as part of a bigger picture.
- 2.14 The Ministry of Health agreed with our suggestion. It plans to implement the new approach in *Suicide Facts 2014*, which is scheduled for publication in 2017. This means that *Suicide Facts 2013*, to be published in 2016, will be the last report in the existing format.
- 2.15 In the last couple of years (2013/14 and 2014/15), the Ministry of Health has reported on two suicide-related outcomes measures in its annual reports to Parliament. The measures were that:
- the youth suicide rate is reduced; and
 - the suicide rate for all ages is reduced.
- 2.16 We suggested to the Ministry of Health that the measures would be clearer if they were more detailed. For example, they might specify the period over which the rate should be reduced (such as a rolling twenty years) and whether changes should be measured using annual or average suicide rates. The Ministry has agreed that more detailed measures would be useful.

14 Ministry of Health (2006), *New Zealand Suicide Trends: Mortality 1921-2003, hospitalisations for intentional self-harm 1978-2004*, www.health.govt.nz.

15 The current approach is to include some trend data in each report, but most of the data gives an in-depth look at the latest year. We discuss the *Suicide Facts* reports in more detail in Part 5.

Conclusions

- 2.17 The Ministry of Health has used and is using data and analysis from a range of sources to prepare:
- a toolkit to help DHBs to prepare local suicide prevention action plans;
 - a national suicide prevention strategy; and
 - a series of national suicide prevention action plans.
- 2.18 The DHBs' new local suicide prevention action plans are in the first year of implementation.
- 2.19 The Ministry of Health plans to update the national suicide prevention strategy and release a new national suicide prevention action plan in 2016/17. We support this intention, and encourage the Ministry and DHBs, as lead agencies for suicide prevention, to work with government agencies and community groups to implement their plans.
- 2.20 The Ministry of Health has recognised that population-level data is useful for showing progress in reducing suicide long term, but has limited value for monitoring the effectiveness of suicide prevention activities in the shorter term. To address this limitation, the Ministry has prepared a new suicide prevention outcomes framework to link the long-term measures with new short-term and medium-term indicators. The Ministry is in the process of picking indicators for the framework and plans to complete this work in 2016/17. We support the Ministry's introducing such a framework, which is a complex piece of work and may take time to fine tune.
- 2.21 The Ministry of Health has been publicly reporting on progress in reducing suicide using population-level data in recent annual reports to Parliament and annually in *Suicide Facts*. We are pleased that the Ministry has agreed with our suggestion that it change its *Suicide Facts* reports to focus on trends.

3

Local responses to suicides

3.1 In this Part, we look at how information is used in the period immediately after a suspected suicide. We discuss:

- the rapid advice system for notifying DHBs of suspected suicides in their area, and how they should respond; and
- the steps being taken to identify emerging suspected suicide trends.

Rapid advice system and local responses

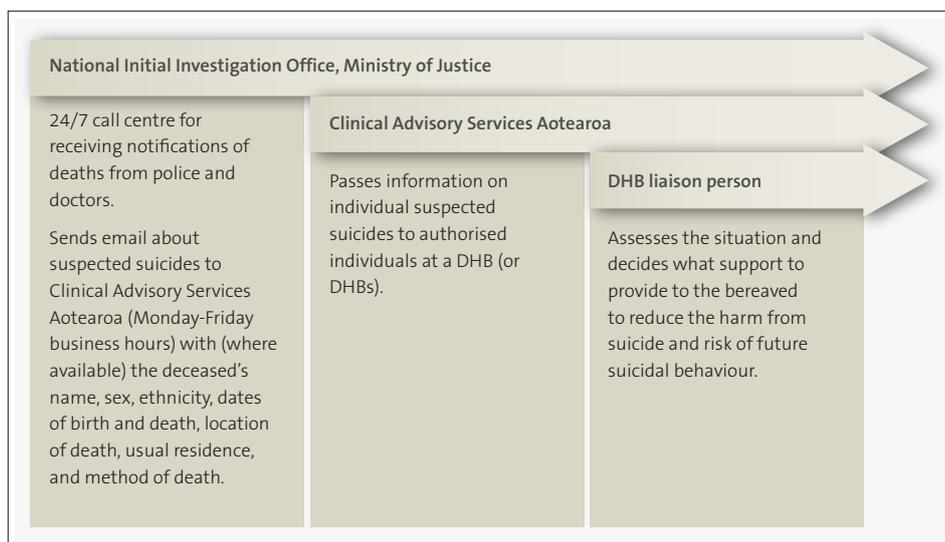
3.2 A nationwide rapid advice system for responding to suspected suicides has been used since January 2015. It is called the Coronial Suspected Suicide Data-sharing Service. It aims to give DHBs an early opportunity to reduce the harm that suicide causes in the community by providing support to the bereaved. This support is considered to be a form of suicide prevention because it also aims to decrease the risk of self-harm by the bereaved.

3.3 Several agencies have a role in the Coronial Suspected Suicide Data-sharing Service:

- the National Initial Investigation Office (NIIO), Ministry of Justice;
- DHBs;
- the Ministry of Health; and
- Clinical Advisory Services Aotearoa, which is a community organisation.

3.4 The Chief Coroner and the Ministry of Health have signed an agreement with each DHB for the service. The Ministry has the contract with Clinical Advisory Services Aotearoa for its work. Figure 2 summarises each party's role and how they interrelate.

Figure 2
Overview of the Coronial Suspected Suicide Data-sharing Service



- 3.5 The Ministry of Health has explained to DHBs what support they are expected to provide after a suspected suicide. Briefly, possible support includes:
- crisis response services;
 - specialist grief education programmes; and
 - guidance and advice prepared by the Mental Health Foundation of New Zealand.¹⁶
- 3.6 DHBs must also have plans to respond rapidly to a potential “suicide cluster”. Suicide clusters are rare events in which multiple suicides or suicide attempts occur closer together (in terms of time, area, or people’s social connections) than would normally be expected. Suicide clusters may lead to wide community concern and increase the risk of suicidal behaviour (this is known as “suicide contagion”).
- 3.7 The Ministry of Health has said that DHBs should have working relationships with important community stakeholders (such as educational institutions, New Zealand Police, social services, and Victim Support or Kia Piki te Ora) to create a base for effective responses. We agree that such working relationships are important.

Next steps

- 3.8 We did not audit how well the rapid advice system is working. We encourage the Ministry of Health to get assurance that DHBs have effective systems for considering and responding to information they get from the NIIO and Clinical Advisory Services Aotearoa.
- 3.9 The methods used by emergency planners could be adopted by the Ministry of Health and DHBs to test the common understanding of how the DHBs’ plans are working or would work. Various types of exercises could be used and it is good practice to start with the simplest exercise first, such as:
- a **test** with an element of passing or failing – for example, testing that messages from the NIIO and Clinical Advisory Services Aotearoa are received by the right people within the expected time;
 - a **walk-through exercise**, which is a simulation where participants review and discuss (not perform) the methods, procedures, and resources associated with activating each part of the response plan;
 - a **table-top exercise**, where each DHB and other agencies carry out the response plan verbally; or
 - a **live exercise**, which could involve suspending normal services.

¹⁶ More details about the DHBs’ expected response is in the Ministry of Health’s *Suicide Prevention Toolkit for District Health Boards*, Appendix 1, www.health.govt.nz.

Identifying emerging suicide trends

- 3.10 Clinical Advisory Services Aotearoa analyses data received through the Coronial Suspected Suicide Data-sharing Service to identify any emerging trends, for example in methods being used or potential clusters. If emerging trends are found, Clinical Advisory Services Aotearoa is to alert the appropriate DHBs and the Ministry of Health. If there is doubt about whether a trend is emerging, the Ministry can be contacted for advice.
- 3.11 The Ministry of Health told us that the Coronial Suspected Suicide Data-sharing Service has been useful – as it expected – for telling communities and government agencies the facts when there are misunderstandings about the number of recent suspected suicides in an area.

Conclusions

- 3.12 Since January 2015, there has been a nationwide system for the Ministry of Justice to give rapid advice to DHBs about suspected suicides in their area. To reduce the harm caused by suspected suicide, the Ministry of Health expects DHBs to provide suitable support to the bereaved. We encourage DHBs to ensure that they have the necessary relationships with stakeholders to provide effective support after suspected suicide. We encourage the Ministry of Health to get assurance that DHBs' responses meet an acceptable standard.
- 3.13 The Ministry of Health has contracted a community organisation to watch for emerging suicide trends, and DHBs must have response plans in place.

Mortality review of suicide deaths

4.1 In this Part, we discuss:

- mortality review and mortality review committees;
- which suicides are covered by mortality review committees;
- how the committees collect information;
- how the committees report on their work; and
- some observations about the National Mortality Review Programme as a whole.

Mortality review and review committees

4.2 Mortality review uses applied research methods to examine the circumstances resulting in death. Mortality review committees review the deaths of individuals or groups with the aim of reducing preventable deaths, illness, and injury, and continuously improving the quality of services provided.

4.3 In 2010, changes to the New Zealand Public Health and Disability Act 2000 enabled the Health Quality and Safety Commission to appoint mortality review committees. (Before this, the committees worked independently and reported to the Minister of Health.) The existing committees were brought together under a National Mortality Review Programme managed by the Health Quality and Safety Commission.

4.4 Generally, mortality review committees work by:

- collecting data;
- analysing the data and other information;
- having experts review any preliminary analysis and some or all cases;
- issuing reports to share information for others to use; and
- making recommendations and checking on their implementation.

4.5 Committees may use different methods depending on the analysis that they are doing and as more information is gained about the value of different methods in particular circumstances.

Suicides covered by a mortality review committee

4.6 The mortality review committees that have suicide within their scope are the Child and Youth Mortality Review Committee (the Child and Youth Committee) and the Perinatal and Maternal Mortality Review Committee (the Maternal Committee). They were established in 2002 and 2005 respectively.

- 4.7 The Child and Youth Committee's scope allows it to look into the deaths of children and people aged 24 years and younger from any cause, including suicide and other self-inflicted harm, such as accidental deaths.
- 4.8 The Maternal Committee's scope enables it to look into the deaths of women of any age while pregnant or within 42 days of the end of pregnancy. These are called maternal deaths. The Maternal Committee also collects data on some maternal deaths up to one year after childbirth. It focuses on deaths where pregnancy or pre-existing or new health conditions contributed to the death, including suicides and some other kinds of self-inflicted harm. The Maternal Committee does not look into deaths from events unrelated to pregnancy or health, such as road crashes.
- 4.9 For the two years' suicide data we looked at (that is, total suicides in 2011 and 2012), we calculate that the Child and Youth Committee and Maternal Committee between them can review about 30% of suicides. This means that a national mortality committee does not review about 70% of suicides. These are mostly suicides of people aged 25 years or older who would not be considered maternal deaths.
- 4.10 Recognising this, the *New Zealand Suicide Prevention Action Plan 2013-16* tasked the Ministry of Health with testing mortality review methods specific to suicide for broader age groups. The Ministry of Health and the Health Quality and Safety Commission together designed a trial.
- 4.11 The Health Quality and Safety Commission set up a time-limited Suicide Mortality Review Committee to test methods for analysing suicide during 2014-15. The Committee tested its analysis on three population groups that accounted for 71% of suicides from January 2007 to December 2011. The trial excluded open coronial inquiries from the period. The three groups were:
- Māori youth aged 15-24 years;
 - males aged 25-64 years; and
 - people who had face-to-face contact with specialist mental health or addiction services in the year before their suicide.
- 4.12 The Suicide Mortality Review Committee's final report and recommendations were sent to the Ministry of Health and the Minister of Health in late 2015. The Health Quality and Safety Commission published the report in May 2016. We understand that the Government is considering the recommendations and announcements about them are expected in 2016/17, as the Ministry updates the Suicide Prevention Strategy and prepares a new national suicide prevention action plan.

- 4.13 If a Suicide Mortality Review Committee is re-established, the Health Quality and Safety Commission and mortality review committees have told us that they will decide jointly which committee would take principal responsibility for reviewing the suicides that are the Child and Youth Committee's and the Maternal Committee's responsibility at present.
- 4.14 If a Suicide Mortality Review Committee is not re-established, government agencies have told us that they will consider other ways to analyse adult suicides in more depth.

How the committees collect information

- 4.15 We looked at how the Child and Youth Committee and the Maternal Committee collect, analyse, and report information. Both committees start collecting information as soon as they are told about deaths, including suspected suicides.
- 4.16 The committees told us that they want early access to copies of initial police reports and post-mortem reports, including the results of toxicology and other tests. They had access to this information in the past, but for reasons that we are not clear on, the previous Chief Coroner stopped releasing the police reports about two years ago. The post-mortem report and other test results are shared after coroners complete their inquiries. The Chief Coroner and the Health Quality and Safety Commission are considering how to resolve this matter. We encourage them to do so, and to involve New Zealand Police in their discussions.

How the Child and Youth Committee collects information

- 4.17 The Child and Youth Committee's approach to collecting information involves national and local review processes, and national and local information collection processes. We consider that the approach used is systematic.
- 4.18 However, the published information about the approach does not give a clear account of how the Child and Youth Committee, Mortality Review Data Group,¹⁷ and DHBS' interagency mortality review groups, which we call local review groups, work together to collect information and consider it.
- 4.19 Figure 3 summarises the approach. It is derived from an unpublished document, the Child and Youth Committee's 2015 Policy. Appendix B of the Child and Youth Committee's Fifth Report gives more details.¹⁸ We suggest that the published information about the Child and Youth Committee's methodology be updated to explain more clearly who does what when.

¹⁷ The group is a third-party contractor.

¹⁸ Child and Youth Mortality Review Committee (2009), *Fifth Report to the Minister of Health Reporting Mortality 2002-08 Appendices*, Appendix B, www.hqsc.govt.nz.

Figure 3 Overview of child and youth mortality review

Following a death, the Mortality Review Data Group is notified and collects data from certain government agencies and enters it into a centralised database. This data is made available to DHB co-ordinators who decide whether the death will be reviewed. The Child and Youth Committee has set the method for selecting cases.* Each DHB is to review at least 70% of deaths in their area.

For the deaths being reviewed, the local co-ordinator contacts local organisations that are involved with the safety and well-being of children and young people and asks them to send in any information that they hold about the deceased.

The co-ordinator is to ensure that a standard set of information is collected. The co-ordinator enters the information into the database. All data entered by the local co-ordinator is available to the Mortality Review Data Group as soon as it is entered.

The local review group meets to review the data and identify opportunities for system improvement. One or more meetings may be needed, and extra data may be collected between meetings.

Local co-ordinators' last step is to complete an electronic post-review form for each case. This makes the local review group's findings and recommendations available to the Mortality Review Data Group.

The national and local data is analysed to identify actions aimed at reducing morbidity and death. This could include identifying and forwarding national recommendations to the Child and Youth Committee for its consideration.

* For example, preventable non-medical deaths (such as suicide) and deaths where the rate of death is higher than other age groups or for the same age group in other countries. However, this does not mean that all suspected suicide deaths would be reviewed at a local meeting.

- 4.20 In 2015, the Child and Youth Committee reviewed the way the local review groups were working, noting what was working well and suggesting areas for improvement. Of relevance to our audit is the information collection process and its completeness. The review found that some groups completed reviews at a high volume and to high quality standards, while others did not as they lacked the skills or experience necessary to do so.
- 4.21 DHBs told the Child and Youth Committee that the standardised form is long and complex, and not all fields are relevant to all deaths. The Child and Youth Committee revised the form to collect more meaningful information that is relevant to all deaths (including suspected suicides). The new form is being tested in the first half of 2016. The aim is for local review groups to complete all questions on the form and collect extra information about each type of death. Local co-ordinators were trained in using the form to promote consistency.

- 4.22 Local co-ordinators sometimes do not complete post-review forms for cases reviewed by local groups. When the forms are not completed, we consider that:
- some of the value of the work done by local review groups is limited to their area;
 - the important “learning and sharing” aspect of the Child and Youth Committee’s approach is undermined; and
 - the ability to make effective recommendations at the national level is constrained.
- 4.23 To get the most out of local review, it needs to be done as close as practicable to the time of death. Therefore, the Child and Youth Committee is planning to establish systems and processes to enable all local reviews (including those of suspected suicides) and post-review forms to be completed within twelve months of death, and no later than twelve months after a coroner’s decision on the cause of death. This means that, if coroners’ decisions into suspected suicide could be completed within 300 days (see paragraph 6.29), then local reviews could be completed within 665 days (about 22 months) after death.
- 4.24 The Child and Youth Committee and the Health Quality and Safety Commission plan to provide support to the DHBs and local review groups that need help to meet the quality and completeness standards required. We consider that this is crucial to ensure that the Child and Youth Committee’s approach is effective.
- 4.25 We encourage the Child and Youth Committee and Health Quality and Safety Commission to ensure that case completion rates are monitored constantly so that timely information is available for effective and efficient national analysis. This would allow local recommendations to be collated, shared, and discussed promptly, and would enable the Mortality Review Data Group to recognise any need for new recommendations on suicide prevention at the national level.

How the Maternal Committee collects information

- 4.26 The Maternal Committee’s approach is systematic and described clearly. Figure 4 summarises its approach, which is described in more detail in its annual reports.¹⁹

¹⁹ For example, see the *Eighth Annual Report of the Perinatal and Maternal Mortality Review Committee: Reporting mortality 2012* (June 2014), www.hqsc.govt.nz.

Figure 4 Overview of maternal mortality review

Since 2007, coroners must be told about all maternal deaths. The Ministry of Justice tells the Maternal Committee's national co-ordinator about each maternal death shortly after coroners are notified.

The national co-ordinator issues a 50-page form to a local DHB co-ordinator who ensures that it is completed. The form helps to standardise much of the information collected, which makes analysis easier.

Local co-ordinators send the completed form and relevant supporting documents (such as copies of health records, correspondence between health professionals, written reports from an anaesthetist or critical care staff, and reports from the local review of the case) to the national co-ordinator.

Coroners' reports are sent when they are available.

The information is analysed to identify factors contributing to the woman's death and actions that might have prevented death.

In 2013, a dedicated maternal mortality database was created. The Maternal Committee considers that this has improved the quality of data collected and access to it.

Note: Groups set up under the Health Practitioners Competence Assurance Act 2003 to carry out approved quality assurance activities could also complete local mortality and morbidity (that is, illness, disease, or injury) reviews of maternal (and perinatal) deaths.

Reporting on their work

- 4.27 The Child and Youth Committee and the Maternal Committee publish reports online²⁰ with the aim of sharing them with researchers, healthcare workers, and others, and to demonstrate accountability for their work. The Child and Youth Committee's comparatively broad scope and the Maternal Committee's comparatively narrow scope are reflected in their reporting practices in ways that we consider are appropriate.
- 4.28 Since 2010, the Child and Youth Committee has produced an annual statistical report and released special topic reports, which include analysis and recommendations, when they were ready. (The Committee focused on suicide in its fifth report.) The Child and Youth Committee's special topic reports clearly state the report's aims, and we consider that the reports achieve the aims. The Committee's annual data reports do not have clearly stated aims, and they should. Without stated aims, we could not assess the reports' success, although we assume that transparency and accountability are two reasons for publishing some data. The Committee and the Health Safety and Quality Commission plan to address this in future reports.
- 4.29 The Child and Youth Committee also sends more detailed confidential reports to authorised persons, which is appropriate.

- 4.30 The Maternal Committee's annual report follows a similar structure and content each year. Some reports focus on certain types of deaths in more detail in some years; for example, the committee's sixth report discussed maternal suicide in depth. The Maternal Committee's reports clearly state the report's aims and its intended audience. We consider that the Maternal Committee's reports achieve their aims.

Some general observations about the National Mortality Review Programme

- 4.31 The focus of our audit was on suicide information. We did not audit whether the National Mortality Review Programme as a whole is effective or efficient. Nevertheless, we make some observations that we encourage the Health Quality and Safety Commission to consider.
- 4.32 We expect procedures for collecting and disclosing information to enable committees to share information when it is needed. For example, because of the different kinds of expertise involved, there could be value in the maternal suicide of a 20-year old being looked at by both the Maternal Committee and the Child and Youth Committee (and any future Suicide Mortality Review Committee). At the same time, we expect duplication to be avoided where possible.
- 4.33 Over time, it is logical to expect changes in the number and scope of mortality review committees. We expect the Health Quality and Safety Commission to ensure that any changes to the number of committees and their scope maintain access to information already collected. We expect the information technology used to store data to be compatible, or all data to be held in a single database with suitable restrictions on access.

Conclusions

- 4.34 Two mortality review committees have scopes that allow them to review the roughly 30% of suicides that are child, youth, and maternal suicides. This means that about 70% of suicides – mainly of people aged 25 years or older – are not covered by a mortality review committee. A decision on whether a mortality review committee will be established specifically for suicide is expected in 2016/17. If a suicide mortality review committee is not re-established, government agencies have told us that they will consider alternative methods of reviewing adult suicides in more depth.

- 4.35 The Child and Youth Committee's process is systematic, but is not clearly described or fully implemented. However, the Health Quality and Safety Commission is in the process of ensuring that data collection is consistent and that reviews are completed. Until these aims are achieved, the Child and Youth Committee will get partial information, which means that its analysis and reporting will be less effective. The Maternal Committee has a clear, systematic process for collecting and analysing data, and reporting its conclusions.
- 4.36 The committees want to get early access to copies of the initial police report and the post-mortem report, including the results of toxicology and other tests, before coroners complete their inquiries. The Chief Coroner and the Health Quality and Safety Commission are considering how to resolve this matter. We encourage them to do so and to involve New Zealand Police in their discussions.

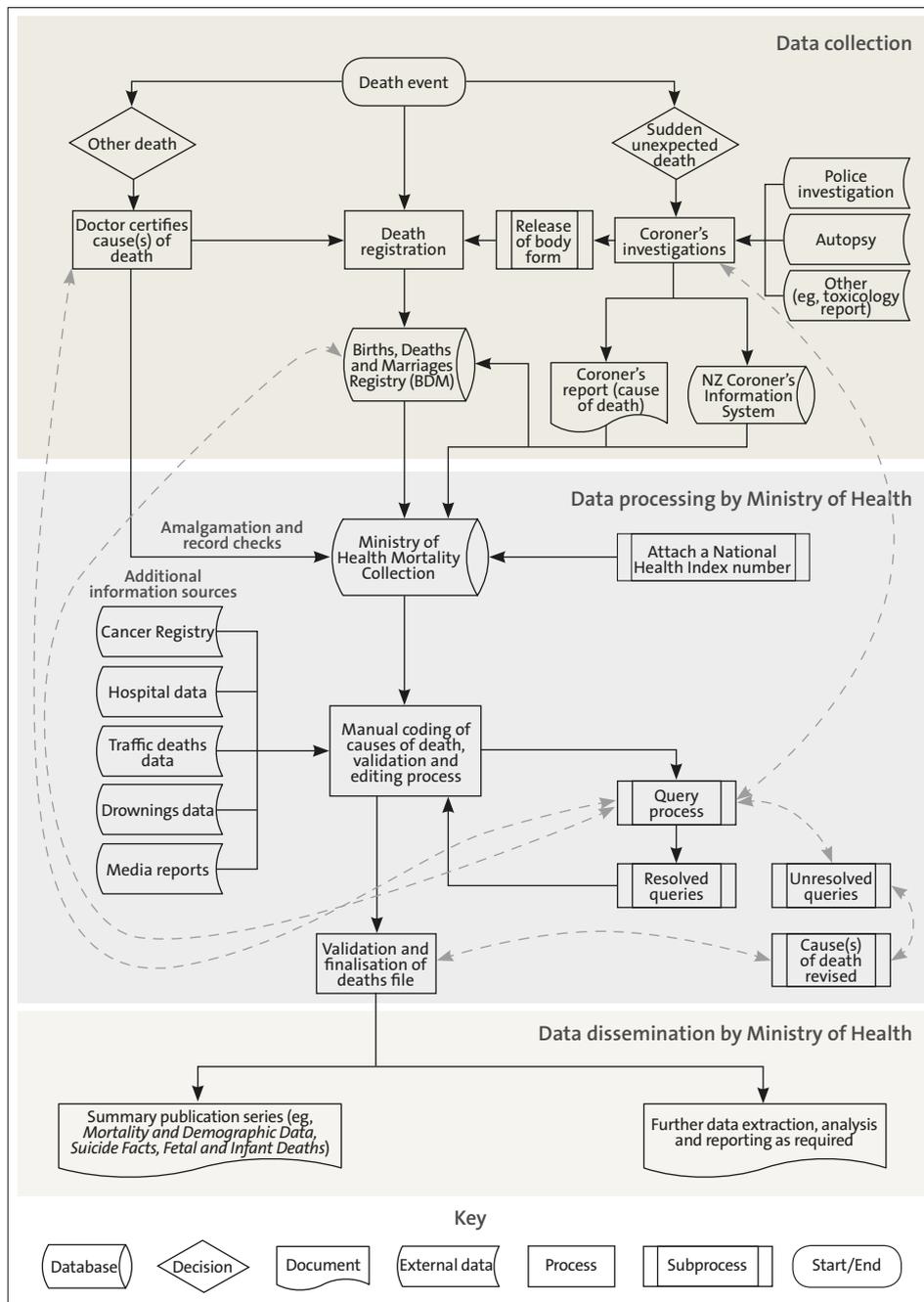
Suicide statistics and reports

- 5.1 In this Part, we discuss:
- how mortality data is collected;
 - the Ministry of Health's reports on suicide statistics; and
 - the factors affecting when mortality and suicide statistics are released.

How mortality data is collected

- 5.2 Collecting suicide statistics is part of the wider system for recording births, deaths, and marriages, and for collecting mortality data. Mortality data is used to identify population groups that experience diseases or injury disproportionately, show high-level progress in reducing preventable deaths, and set research priorities.
- 5.3 The New Zealand Mortality Collection (the Mortality Collection) is a database that was established in 1988. (Data from earlier years is held elsewhere.) It holds data on causes of death, and personal details about a person such as their name, sex, and age. Data is collected for all deaths registrable in New Zealand, including stillbirths. An international coding system is used to code the main and any secondary causes of death. The Ministry of Health sends data to the World Health Organization for use in international comparisons.
- 5.4 Figure 5 indicates how data is collected, processed, and disseminated. It shows the relationship between coronial inquiries and reports, the Births, Deaths, Marriages, and Citizenship Registry, and the mortality collection and other data sources. It also shows some of the checks that are made to ensure that data is accurate. The figure refers to the *Mortality and Demographic Data and Suicide Facts* reports, which we discuss in this Part.

Figure 5
Overview of mortality data collection, processing, and dissemination



Note: This chart appears in every *Mortality and Demographic Data* report.
Source: Ministry of Health.

- 5.5 The staff working with the Mortality Collection are long serving and their experience in data validation helps improve the quality of coding, and so confidence in the statistics. The Ministry of Health checks on the quality of coding. One way to do this is to compare the percentage of deaths where a cause has not been identified with the same codes in other countries. A low percentage of deaths coded to non-specific causes is good. The Ministry found that for 2011, the percentage of deaths coded to selected non-specific causes was about 1.7% for New Zealand, 4.3% for Australia, 5.3% for England and Wales, and 5.4% for Canada.

Reports on suicide statistics

- 5.6 In our view, there are three purposes for reporting population-level data on suicide:
- making detailed data tables publicly available as soon as possible, for anyone to use;
 - informing the Ministry of Health’s analysis of the data and comments on major suicide trends; and
 - producing regular reports, for accountability purposes, on progress in reducing suicide rates.
- 5.7 The Ministry of Health’s reports mostly meet our expectations, although some improvements could be made.
- 5.8 The Ministry of Health publishes online data tables for all causes of death (including suicide) and more detailed data tables for suicide and non-fatal intentional self-harm.
- 5.9 Data tables for all causes of death are published along with the *Mortality and Demographic Data* series of reports. The data tables are released online before the Ministry of Health’s written report is prepared and released. This makes the data available promptly to other government agencies and the public so that it can be used as soon as possible.²¹
- 5.10 Data tables for suicide are published as part of the *Suicide Facts* series of reports. The data tables and the written reports are published at the same time. The reports also give an in-depth look at data for people treated in emergency departments for non-fatal intentional self-harm who stayed in hospital for one night or longer. It is common practice for this to be reported with the aim of finding intervention points to prevent suicide. We consider that the data tables

21 In the *Mortality and Demographic Data* reports, suicide is called “intentional self-harm”. There are 17 different codes for suicide. Two codes are for “intentional self-harm by smoke, fire, and flames” and “intentional self-poisoning by and exposure to narcotics and psychodysleptics [hallucinogens] not elsewhere classified”. There are other groups of codes for self-inflicted accidental deaths and self-inflicted deaths of undetermined intent (that is, the coroner did not decide whether death was accidental or intentional).

could be released as soon as they are ready, rather than withheld until the reports are also ready.

- 5.11 For both series of reports, the Ministry of Health publishes analysis and commentary on the data in a written report, and discusses notable trends. Because the *Mortality and Demographic Data* reports focus on the leading causes of death, they discuss suicide.
- 5.12 The *Suicide Facts* reports look in depth at the latest year's demographic data on suicide, and discuss trends.²² The Ministry of Health is clear that its data and reports do not explain causes of suicide and non-fatal intentional self-harm, or give reasons for changes in the data. This is because it is difficult to attribute changes to particular events or actions (see Part 2). We suggested, and the Ministry agreed, that the *Suicide Facts* would have more value if they focused on trend reporting (see Part 2). In our view, limited insight can be achieved from a detailed examination of a single year's demographic suicide data.
- 5.13 Both series of reports help the Ministry of Health to meet its responsibility to report mortality statistics generally and to report on progress in reducing suicide (see also Part 2).
- 5.14 These two series of reports are the main source of statistical information about suicide. We found the format and content of each set of reports is largely consistent from year to year.
- 5.15 We consider that both series of reports are fit for purpose and well presented. Nevertheless, we suggested some relatively minor changes that we consider would improve them. The Ministry of Health has already started work on adopting some of our suggestions and is considering how others could be taken up.
- 5.16 We suggest that the Ministry of Health:
- use consistent starting years for trend reporting to avoid the risk of biased reporting;²³
 - comment when changes in suicide rates are statistically significant, to prevent relatively small year-to-year changes being misinterpreted;
 - make more use of confidence intervals for selected suicide data to make the potential range of error clear;

22 Data is reported by sex, ethnicity, age, deprivation quintile, DHB, and suicide method. The last three reports also included data by urban/rural profile.

23 The Ministry has used a range of starting dates for trend reports. We suggested that it select two or three starting dates and use them in all their reports. For example, we suggested that they pick one starting year for historical reporting (such as 1948 or 1950, which are currently used) and another showing more detailed trends for a minimum of 20 years. This is partly because three-year moving averages are not useful for shorter periods, such as 10 years. There is also a time lag between changes in society and suicide rates, which are more obvious over longer periods.

- report only suicide rates that are statistically credible;²⁴
- make the *Suicide Facts* data tables available online as soon as they are ready to publish so that people can use them;
- include statistics on deaths from undetermined intent in the *Suicide Facts* reports;²⁵
- change the *Suicide Facts* reports to focus on trend reporting; and
- include a technical note in the *Suicide Facts* reports that when coroners do not specify whether self-inflicted poisoning is accidental or with intent to harm, the coding rules require the death would be coded to accidental poisoning (not undetermined intent). The note should also explain that this rule could lead to an overstatement of accidental poisonings and an understatement of deaths from undetermined intent.

5.17 In May 2016, the Chief Coroner issued a practice note intended to improve the quality and consistency of findings. It includes a requirement for coroners to specify in their Certificates of Findings whether or not they have found a death to be suicide. We consider that adopting the practice note will ensure that coroners' decisions are clear to the bereaved and to agencies. It will reduce the risk of overstating accidental poisonings and understating deaths from undetermined intent.

Looking ahead

5.18 During our audit, it became clear that some proposed changes in the next 12-18 months could affect the way suicide statistics are reported. Such changes include:

- whether a Suicide Mortality Review Committee is re-established and how it will report on its work;
- the implementation of the new suicide prevention outcomes framework; and
- the release of an updated *New Zealand Suicide Prevention Strategy* and new suicide prevention action plan.

24 The Ministry of Health publishes suicide rates for each DHB. We questioned the value of the results produced for some DHBs when the range of error is more than half of the data range.

25 Coroners may not be able to decide whether someone's death was an accident or suicide because the person's intent was unclear or there was a lack of evidence. From a suicide prevention perspective, the person's intent is not necessarily the only factor determining which deaths could or should be studied. The method is also important. Looking at data on deaths from undetermined intent helps to increase the opportunities to prevent suicides and accidental deaths by the same methods. Because the number of suicides is relatively small compared to deaths from other causes (such as ischaemic heart disease) it is harder to spot patterns below the population level. This makes it harder to work out how to intervene to prevent suicide and to determine whether prevention actions are effective. We noticed that the Scottish Government uses data on "probable" suicides (deaths from suicide and undetermined intent) to assess and report on progress in preventing suicide. See The Scottish Government (2013), *Suicide Prevention Strategy 2013-16*, www.scotland.gov.uk.

- 5.19 We asked the Ministry of Health to consider a “stocktake” of suicide publications to be clear about each report’s contribution to good quality information about suicide. The Ministry and the Health Quality and Safety Commission should aim to prevent “data clutter”, which is a risk when data is published in multiple reports using data extracted on different dates.
- 5.20 We are pleased by the Ministry of Health’s early response to our suggestions and encourage them to discuss their plans with stakeholders, such as the Health Quality and Safety Commission, the Ministry of Justice, the Chief Coroner, and frequent users of the data (such as researchers). The Health Quality and Safety Commission told us that it supports a stocktake, even if a Suicide Mortality Review Committee is not re-established.

When statistics are released

- 5.21 To ensure public confidence in mortality statistics, the Ministry of Health waits until it holds full information on nearly all deaths before it publishes data and reports on the cause of death for a specified period (a calendar year). The pace at which coronial inquiries are completed is the main factor affecting data completeness.
- 5.22 For the *Mortality and Demographic Data* series, data is considered good enough to publish when there are fewer than 10 deaths remaining for the reporting period on which nothing is known or the cause of injuries is unknown.
- 5.23 For the *Suicide Facts* series, data is considered good enough to publish when there are fewer than 30 remaining deaths on which nothing is known or the cause of injuries is unknown. Because there could be up to 30 deaths on which data is missing (which is a lower standard than applied to the *Mortality and Demographic Data* report), the Ministry of Health considers that the latest year’s suicide data is provisional. In this case, provisional means that the number of suicides could increase until all coronial inquiries for that year are complete. To decide when to publish, the Ministry considers three factors:
- the total number of deaths awaiting coroners’ decisions (not the total number of suspected suicide deaths awaiting coroners’ decision);
 - whether staff have been able to assign provisional codes for some deaths using available data; and
 - whether data processing is complete.
- 5.24 Reports are published when these completeness requirements are met, which is why data for a reporting period is published between two and three years later and reports may not be published at the same time each year. If all (or nearly all)

coronial inquiries could be completed sooner (see paragraph 6.29), the Ministry of Health would be able to publish mortality statistics sooner.

- 5.25 Any missing information is included in later reports and any errors corrected, which is why the latest report always has the most reliable data. The latest report is also the most reliable because there could have been changes to the way that data is coded. When such changes are made, the Ministry of Health usually recalculates older data using the new method so that data can be compared.

Conclusions

- 5.26 The Ministry of Health produces two series of reports that make detailed statistics on suicide available to the public. The reports are made up of detailed data tables and written reports that discuss the Ministry's analysis of the data, including trends. The reports help the Ministry meet its responsibility to publish mortality data and report on progress in reducing suicide.
- 5.27 We consider that the Ministry of Health's reports on suicide statistics are fit for purpose. Nevertheless, we suggested some relatively minor changes that would improve them. The Ministry welcomed our suggestions and is already planning to implement some of them in 2016 and others in 2017.
- 5.28 When statistics are released depends on the time taken to complete coronial inquiries. If inquiries could be completed sooner, the Ministry of Health could publish mortality data sooner.

6

Coronial inquiries

- 6.1 In this Part, we:
- discuss who decides when a death is suicide;
 - give an overview of the coronial inquiry process;
 - discuss coroners' reports and recommendations, and who gets them;
 - discuss the time taken to complete inquiries;
 - explain who can get access to coronial information and when; and
 - discuss the Chief Coroner's reports on suspected suicide statistics.

Deciding whether a death is suicide

- 6.2 Whether or not someone has died from suicide is a legal decision made by coroners, not a medical decision made by doctors. New Zealand coroners have legal training and are independent judicial officers.
- 6.3 Coroners inquire into about 3300 deaths each year. There is limited investigation into about half of these, involving obtaining witness statements and a report from the deceased's general practitioner, for example. Coroners complete more extensive inquiries into the other 1600 deaths, which include all suspected suicides.²⁶ There are about 500 suicides each year, which means that suspected suicide inquiries make up about 15% of the coronial caseload.²⁷ On average, each coroner inquires into about 31 suspected suicides each year.
- 6.4 Coroners collect information to find out, as far as possible:
- the deceased's identity;
 - when and where the person died; and
 - the cause(s) and circumstances of their death.
- 6.5 There is a high threshold for deciding that suicide is the cause of death. Coroners must be sure that the deceased *intended* to end their life. Coroners must rule out all other explanations.²⁸ A coroner may find that the cause of someone's death is "undetermined" if it is not clear whether death was accidental or suicide.²⁹

²⁶ The Coroners Act 2006 requires coroners to inquire into all cases of suspected suicide.

²⁷ About 30,000 people die each year in New Zealand. Anyone who finds a body must report it to the New Zealand Police or a doctor. A duty coroner is contacted when a doctor is not certain that they could or should complete a death certificate. Coroners settle most cases after a discussion with the doctor or after a post-mortem shows that death was from natural causes.

²⁸ *R v Lagos and Her Majesty's Coroner for the City of London* [2013] EWHC 423 (Admin), which we saw cited in several coroners' decisions.

²⁹ If a coroner does not specify whether a self-inflicted poisoning is accidental or suicide, for example, the coding rules require the death be coded to accidental poisoning, not undetermined intent (see paragraph 5.16).

Overview of the inquiry process

- 6.6 Suspected suicides are notified to a duty coroner by police officers or doctors through the National Initial Investigation Office (NIIO). After the body is released to family, the NIIO transfers information that it collects during the initial investigation period (about 48-72 hours after the person is found) to the coroner who will be inquiring into the death. In most cases, coroners are assigned the cases of people who died in their region. Coroners then write to people and agencies asking them to supply further information. Coroners may also ask police inquest officers³⁰ to collect information for them.
- 6.7 We looked at files on completed inquiries where suicide was the cause of death. All files contained some common documents, but there were differences depending on the circumstances of each case and how people collected and reported information. Figure 6 lists typical documents found in these files.

Figure 6
Documents commonly collected during a coronial inquiry into suspected suicide

Certification of life extinct form	Copy of email telling the DHB of a suspected suicide
Certificate of Findings	Post-mortem and toxicology reports
Form ordering a full or lesser post-mortem [†]	Reports from police and ambulance officers attending the death
Suicide note	Form allowing release of body to family
Police form documenting officers' observations of the scene and other circumstances	Photographs of the body, the place it was found, and any belongings found nearby, including any material used to cause death
Reports from primary or secondary health services about care provided to the deceased	File notes of a coroner's reasons for certain decisions
Report of reviews or investigations by institutions where a death occurred [^]	Statements confirming the person's identity and from the person who found the body
Correspondence with family updating them on progress of inquiry	Correspondence with agencies attaching the coroner's decision
Provisional death certificate [∞]	Telephone and computer records

Notes:

[†] A lesser post-mortem would be likely to involve an external physical examination and blood tests.

[^] Examples of authorities that may provide reports to the coroner are the Department of Corrections, DHBs, and New Zealand Police.

[∞] A final death certificate is issued after a coroner has determined the cause of death.

³⁰ Inquest officers help coroners with their inquiries and liaise with coroners. They are sworn officers who make formal investigative inquiries for coroners and attend and represent New Zealand Police at inquests and hearings.

- 6.8 Most of the information that coroners collect is found in documents. Coroners can carry out inquests³¹ to ask questions of people who knew the deceased (such as family, friends, and service providers) or who looked into the circumstances of the person's death.
- 6.9 The information that coroners get is printed and put in a physical file, which is the principal record of each inquiry. Documents created by coroners and the Ministry of Justice are also printed and kept as a record of decisions made and actions taken.
- 6.10 A few agencies we spoke to during our audit want coroners to systematically collect more details on suspected suicides, which could be used for mortality review or by government agencies responsible for helping to prevent suicide. If this were to be done, we consider that agencies should work together to decide what standard information should be collected and how they could ensure that coroners were given this information to consider. For example:
- We saw letters that coroners had written to people and organisations who provided the person who had died with health and other services, asking them to provide a written report on their contact with the deceased person. The reports provided are not standardised, but they could be if the agencies jointly created a reporting form. The coroner could issue the form when asking for a report.
 - The form that police officers use to record information when they attend a suspected suicide could be changed to ensure that standardised information is collected.³² There is a precedent for this: the Maternal Committee worked with New Zealand Police to introduce a special form for infant deaths.
- 6.11 We are not aware of any projects involving government agencies and coroners to enable coroners to collect a standardised set of information during suspected suicide inquiries. We understand that any such work could depend on the Government's decisions on the recommendations made in the Suicide Mortality Review Committee's report. If the committee is not re-established, we consider that the relevant government agencies should work together with the coroners to decide what information they want to collect and how. The Ministry of Health and the Health Quality and Safety Commission would be the main agencies for such work.

31 Inquests are hearings held in a court. They are less formal than a criminal court hearing and there is no jury. The coroner may be given extra documents during an inquest and court staff keep a written record of what is said.

32 New Zealand Police told us that it is considering producing an app to replace the handwritten forms that police use to record information at the scene of a sudden death, including suspected suicide. They could design the app to ensure that essential information is collected every time and in the same format for coroners, and for later use by others. Many police officers now have hand-held electronic devices, which makes this a realistic proposition.

Coroners' reports and recommendations

- 6.12 When they have all the available information, coroners produce a Certificate of Findings that states, where they are known, the:
- deceased's full name and last address, date of birth, sex, and occupation;
 - place and date of death;
 - cause(s) of death; and
 - circumstances of death.
- 6.13 Certificates of Findings from inquiries where suicide is the cause of death are routinely sent to:
- family of the deceased;
 - the Director of Mental Health;
 - any government agencies involved in the inquiry or to which coroners' make comments or recommendations;
 - any relevant mortality review committee;
 - the National Coronial Information System (a copy of the post-mortem and toxicology reports and the written report of the police investigation are also sent); and
 - any other people identified during the inquiry as interested parties.
- 6.14 The aims of distributing the Certificates of Findings are to tell people about the cause of death and to allow responsible agencies to find opportunities for improving public health and safety.
- 6.15 Anyone can ask the Ministry of Justice for a copy of a Certificate of Findings on any death. The Certificate of Findings will state what information in it can be published. Unless the coroner has directed otherwise, there are restrictions on publication when suicide is the cause of death.
- 6.16 Coroners gave varying amounts of detail on the circumstances of the person's death and reasons for finding that suicide was the cause of death. A few Certificates of Findings we saw stated only the method of death, and that information was withheld for reasons of personal privacy or in the interests of justice. We understand that coroners have good reasons for doing this. Where it is possible for them to do so, we suggest that coroners include any information that could be used by the receiving agencies to help their suicide prevention work.
- 6.17 Coroners can make recommendations or comments aimed at preventing deaths in circumstances similar to the case they are reporting on. We asked the Ministry of Justice how often suicide Certificates of Findings included recommendations. The

Ministry told us that coroners made fewer recommendations regarding suicides than other causes of death. From January 2007 to October 2015, 5% of suicide inquiries included recommendations, whereas 13% of all Certificates of Findings included recommendations.

- 6.18 We do not want to suggest that coroners should have made more or fewer recommendations. But we wanted to understand the factors that influence whether coroners made recommendations on suicide cases. The coroners told us that they tended to make recommendations when suicides happened within an institution, such as a hospital, prison, or police station. They were less likely to make recommendations if the institution was already acting on recommendations made in its own reviews and the coroner had agreed with them.
- 6.19 The coroners told us that their counterparts in Victoria, Australia, have access to a Recommendations Unit to help them arrive at recommendations. Similar support is not available in New Zealand. The coroners consider that such support would allow the information they hold to be researched to make recommendations from a broader base than the single case that is the focus of an inquiry.
- 6.20 Whether such a coronial recommendations unit is established in New Zealand is a matter for the Ministry of Justice to consider. In our view, the current reliance on physical files would make it difficult for any such unit to research and analyse coronial information. An electronic database would be needed to make a research-based approach feasible. From a whole-of-government perspective, care would need to be taken that such a database did not unnecessarily duplicate any databases already established by mortality review committees.
- 6.21 Perhaps a first step should be to make more use of information already held in the National Coronial Information System. The Ministry of Justice told us that it is training coroners on how to use the system to detect similarities between deaths that might otherwise seem unique. This might help coroners to make recommendations more frequently, but it is too soon to know.
- 6.22 Coroners do not necessarily direct their recommendations to individual government agencies. However, Certificates of Findings are distributed to relevant government agencies for them to consider. Each agency should have in place a system documenting how they have considered them and what action, if any, they will take in response.
- 6.23 The Coroners Act 2006 does not require government agencies to tell coroners what they have done in response to the Certificates of Findings sent to them. However, the Ministry of Justice told us that the Department of Corrections

and the New Zealand Transport Agency usually do this.³³ We consider that it is important for government agencies to be accountable for their decisions, and that all agencies sent copies of Certificates of Findings should respond to coroners.

- 6.24 The Office of the Chief Coroner keeps track of responses received on individual cases, and since 2007 has published the responses online on the website of the New Zealand Legal Information Institute (NZLII).³⁴ The Chief Coroner's staff send through the information after a Certificate of Findings is released and when case managers pass responses on to them.
- 6.25 Since 2012, the Ministry of Justice has published Recommendations Recap reports on its website, which summarise all coronial recommendations made during a reporting period and any responses received from government and community organisations.³⁵ The Recommendations Recap reports may also include case studies on particular topics.³⁶
- 6.26 Although the responses section of the Recommendations Recap reports are not updated after publication, anyone wanting to see any later response could find it on the NZLII's website. We suggested to the Ministry of Justice that the reports include a comment to this effect and it has agreed to do this in future reports.

Time taken to complete suicide inquiries

- 6.27 During its targeted review of the Coroners Act 2006 in 2013, the Ministry of Justice recognised that coronial inquiries were taking longer. It said that coronial inquiries that take a long time to complete may increase the distress experienced by the bereaved, delay their ability to move on with their lives, and delay the adoption of public health and safety measures (because recommendations are made only in Certificates of Findings, which are released when inquiries are completed). The time taken to complete inquiries also affects when the Ministry of Health produces reports on mortality statistics (see Part 5).
- 6.28 Since 2013, the Ministry of Justice has focused on closing the oldest coronial cases, which has increased the average age of cases at completion. This can be seen in Figure 7, which shows the average number of calendar days taken to complete inquiries where suicide was found to be the cause of death. It shows that the average time taken has increased for inquiries with and without inquests.

33 For example, the Department of Corrections sends quarterly reports to the Chief Coroner updating its progress in responding to findings and recommendations.

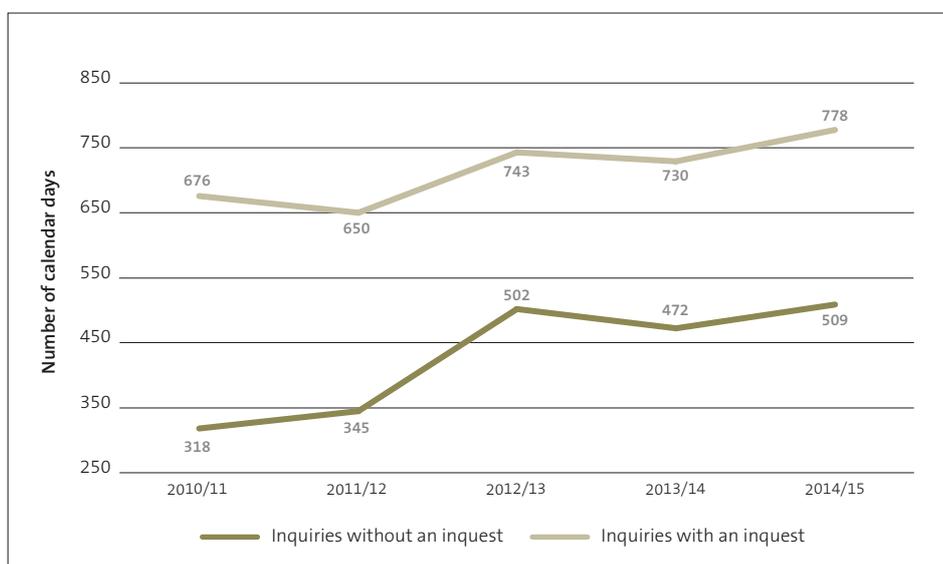
34 This organisation provides legal information free to the public.

35 www.justice.govt.nz.

36 For example, one case study brought together the cases, comments and recommendations, and any responses received on deaths where immunisation might have had a preventative effect. The case study discusses background information about the government's policy on immunisation, the supporting legal framework, and research results on vulnerable parts of the population.

The Ministry expects the average time taken to decrease as older cases are resolved.

Figure 7
Average calendar days taken to complete suicide inquiries, 2010/11 to 2014/15



Notes: The graph excludes data on cases of suspected suicide where coroners decided that the cause of death was accidental or of undetermined intent. 778 days is about two years and seven weeks, and 509 days is about 17 months. We calculate there has been a 60% increase in the time taken to complete inquiries without an inquest and a 15% increase in the time taken to complete inquiries involving inquests.

Source: Ministry of Justice.

6.29 The coroners and the Ministry of Justice recognise that they need to complete all coronial inquiries more quickly and have introduced workflow targets to help with this. The Ministry produces monthly reports from the coronial case management system to show the:

- number of cases accepted by each coroner each month (target 17);
- number of cases completed by each coroner each month (target 17);
- percentage of active cases that have been open for less than 12 months (target 65%);
- time each coroner takes to decide the cause of death for each inquiry (target 300 calendar days or about 10 months).

- 6.30 To help achieve the targets, the Ministry of Justice is working to set timeliness benchmarks for the parts of inquiries that are within its influence or direct control. For example, an early benchmark is to complete 90% of coronial cases where death is from natural causes within one month of receiving the post-mortem report. The aim is to set suitable internal benchmarks for other coronial work and introduce timeliness requirements in contracts with external services providers. The Ministry says that it is “early days” for this work.
- 6.31 The Ministry of Justice told us that it has also increased its staffing and is centralising some functions to free up staff to manage cases. And it is working with the Chief Coroner to ensure that coroners are well supported with resources, training, and useful data reporting.
- 6.32 We support the Ministry of Justice’s efforts to complete inquiries more quickly. This will mean that families get decisions earlier and information about each case will be shared with government agencies so that they can take any necessary steps to improve public health and safety. The Ministry of Health will be able to publish mortality data earlier. Quicker inquiries would allow more timely mortality reviews.

Access to coronial information

- 6.33 Access to coronial information on suicide inquiries varies depending on when it is sought:
- during the initial investigation period;
 - during the inquiry; or
 - after the inquiry is complete.
- 6.34 The initial investigation period is the first 48-72 hours from the NIIO being first told of a suspected suicide to a regional coroner being assigned the case. The Chief Coroner shares some information with DHBs during this period, to allow the DHB to decide on its local response (which we discuss in Part 4).
- 6.35 After a regional coroner takes over a case, they decide whether to grant requests for information while the inquiry is in progress. Inquiries are legal proceedings, and this discretion is appropriate.
- 6.36 After a suicide inquiry is completed, access to any information collected during inquiries or about inquiries generally depends on whether it is allowed by legislation or coroners’ decisions. However, reliance on physical files also affects whether information is easily retrievable for release. For example, the Ministry of Justice can produce quantitative reports on information held in its electronic case management system easily. However, for physical files, someone would need to read all the files to produce data on the percentage of suicides who were addicted

to alcohol or other drugs. Whether the Ministry should be able to produce such information is another matter. We do not have a definite view on this because it depends on whether such quantitative data is available from another source, such as a mortality review committee.

- 6.37 Anyone wanting information from the National Coronial Information System in Australia can apply through its website, which explains who can get access and under what circumstances.³⁷

Chief Coroner's suspected suicide statistics

- 6.38 Once a year, the Chief Coroner releases a report on the number of suspected suicides in the preceding financial year. The reports are available from the Ministry of Justice's website and aim to provide the most up-to-date, accurate, complete information available on suspected suicide and raise awareness of suicide. The first report was released in 2010.
- 6.39 The reports usually include data on the number of suspected suicides and the national suspected suicide rate. As far as it is known, data is reported by sex, DHB, ethnicity, employment status, the methods used to cause death, and the number of suspected suicides reported each month. The reports also highlight data on the number of suspected suicides before and after the major earthquakes in Canterbury in 2010 and later years. However, it is not clear whether the data is for Christchurch City, Greater Christchurch, or Canterbury. It would be helpful if data was for the DHB region so that it aligned with the Ministry of Health's reports.
- 6.40 The reports sometimes have inconsistent or incomplete technical notes, which means that they are not as clear as they could be. This contributes to some confusion over the Ministry of Health's reports. We consider that this could be easily resolved by including:
- fuller technical notes in the reports;
 - referring to "suspected suicides" instead of "provisional suicides";³⁸
 - grouping data on methods into the same groups as are used by the Ministry of Health; and
 - calculating suicide rates using the methods used by the Ministry of Health or Statistics New Zealand.³⁹

³⁷ See www.ncis.org.au.

³⁸ In the Chief Coroner's reports, provisional means the number of confirmed suicides is likely to be fewer than the number of suspected suicides. In the Ministry of Health's reports, provisional means the number of suicides is the least number of suicides for that year. The number could increase until all coronial inquiries for that year are complete.

³⁹ Statistics New Zealand publishes some high-level statistics on suicide as part of its annual reports on serious injury outcome indicators. It calculates rates based on the New Zealand population.

- 6.41 We discussed our suggestions with the Ministry of Justice, so that the Chief Coroner can be provided with the support needed to adopt them.

Conclusions

- 6.42 For coroners to find that suicide was the cause of death, they must be sure that the person intended to end their life and that all other explanations have been ruled out. Coroners collect information for this purpose. The information is mainly held in physical case files, which makes it more difficult to analyse groups of cases.
- 6.43 There is a desire for coroners to collect a standardised set of information on suicide, to help coroners with their inquiries and to make the information available for further study by appropriate agencies, such as mortality review committees. We consider that relevant government agencies should work together to decide what standard set of information should be collected and how to ensure that coroners get the information. We are not aware of any current projects with this purpose. We acknowledge that this could depend partly on the Government's decisions on the recommendations of the Suicide Mortality Review Committee.
- 6.44 Coroners' findings are proactively sent to relevant people and organisations. We expect all government agencies sent Certificates of Finding to consider them systematically and tell the coroners the results of their deliberations. Any responses to recommendations are published online on websites managed by the Ministry of Justice or the NZLII.
- 6.45 From 2010/11 to 2014/15, the average time taken to complete suicide inquiries without an inquest increased by 60%, and with an inquest by 15%. The Ministry of Justice is aiming to complete coronial inquiries within 300 days, but considers that this will take some time to achieve. We support the Ministry's aim of completing inquiries more quickly so that the bereaved can get a timely decision, the Ministry of Health can publish suicide and other mortality statistics sooner, and mortality reviews can be completed. More timely information will help government agencies' decision-making to efficiently improve public health and safety.
- 6.46 The Ministry of Justice is planning to provide the Chief Coroner with support to improve the reports on suspected suicide statistics as we have suggested.

Appendix

How we did our work

We talked with staff from the Ministry of Health, the Health Quality and Safety Commission, and the Ministry of Justice about their respective roles in collecting and using information about suicide. We reviewed documents they gave us or that they have published online. We also read research reports from New Zealand and overseas, and important World Health Organization publications on suicide.

We met with the chairs of the three mortality committees and they commented on our audit questions. The Health Quality and Safety Commission forwarded to us some comments from the four most northern DHBs. We met with experienced suicide researchers from the University of Otago, who worked with the Suicide Mortality Review Committee, to discuss their work and suicide data generally.

We met with New Zealand Police inquest officers based in Wellington, and attended an inquest into the suspected suicide of a person who was in an institution. We reviewed some recently closed coronial files where suicide was the cause of death. We read the files at the Ministry of Justice's offices, and did not look at highly sensitive information, such as photographs or documents that were kept separately in an envelope in each case file. We got an understanding of the Ministry of Justice's electronic case management system for coronial inquiries. The Ministry of Justice showed us the National Coronial Information System, which is an Australian database holding information supplied by Australian and New Zealand coroners.

We wrote to government agencies that are members of an officials' Interagency Committee on Suicide Prevention, and offered them an opportunity to comment on our audit questions. We wrote with the same offer to some other agencies whose work sometimes involves looking into suspected suicide or controlling a potential method of suicide, such as access to harmful substances. We got comments from the:

- Accident Compensation Corporation;
- Department of Corrections;
- Ministry of Business, Innovation and Employment;
- Ministry of Education;
- Ministry of Social Development;
- New Zealand Defence Force; and
- New Zealand Police.

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Office of the Auditor-General
PO Box 3928, Wellington 6140

Telephone: (04) 917 1500
Facsimile: (04) 917 1549

Email: reports@oag.govt.nz
Website: www.oag.govt.nz