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Via email

Tēnā koe

Official Information request for Adverse events – inpatient suicides

Thank you for your request seeking information under the Official Information Act 1982.

Your requested information

You asked for numbers of inpatient suicides by DHB for the previous ten years.

The information provided in appendix one is drawn from severity assessment code (SAC) one and two adverse events reported to us. Unfortunately, we only have clean data available for the last nine years, as the Commission was only established in 2010. Appendix two sets out some caveats and limitations of the data supplied.

Please note, the Commission publishes some of its OIA responses on its website, after the response is sent to the requester. The responses published are those that are considered to have a high level of public interest. We will not publish your name, address or contact details.

You have the right to seek an investigation and review by the Ombudsman of this decision. Information about how to make a complaint is available at www.ombudsman.parliament.nz or freephone 0800 802 602.

Ngā mihi

Dr Janice Wilson

Chief Executive

Appendix one

Source: HQSC Adverse event database									
10/07/2020									
DHB	**2019-20**	**2018-19**	**2017-18**	**2016-17**	**2015-16**	**2014-15**	**2013-14**	**2012-13**	**2011-12**
Auckland	1	3	2	0	2	0	0	2	3
Inpatient suspected suicide	1	1	2	0	1	0	0	0	0
Absent without leave suspected suicide	0	0	0	0	0	0	0	1	1
On approved leave suspected suicide	0	2	0	0	1	0	0	1	2
Bay of Plenty	0	0	2	0	0	1	1	1	0
Inpatient suspected suicide	0	0	1	0	0	0	1	0	0
Absent without leave suspected suicide	0	0	1	0	0	0	0	0	0
On approved leave suspected suicide	0	0	0	0	0	1	0	1	0
Canterbury	3	1	0	3	1	1	3	3	4
Inpatient suspected suicide	1	0	0	1	0	1	2	0	2
Absent without leave suspected suicide	1	1	0	1	0	0	0	1	1
On approved leave suspected suicide	1	0	0	1	1	0	1	2	1
Capital Coast	1	0	1	1	0	1	0	1	3
Inpatient suspected suicide	1	0	1	1	0	1	0	0	2
Absent without leave suspected suicide	0	0	0	0	0	0	0	1	0
On approved leave suspected suicide	0	0	0	0	0	0	0	0	1
Counties Manukau	0	2	1	1	1	1	0	0	2
Inpatient suspected suicide	0	0	1	0	0	1	0	0	2
Absent without leave suspected suicide	0	2	0	1	1	0	0	0	0
On approved leave suspected suicide	0	0	0	0	0	0	0	0	0
Hawke's Bay	0	0	0	0	0	0	0	0	1
Inpatient suspected suicide	0	0	0	0	0	0	0	0	1
Absent without leave suspected suicide	0	0	0	0	0	0	0	0	0
On approved leave suspected suicide	0	0	0	0	0	0	0	0	0
Hutt Valley	0	0	0	0	0	0	0	0	0
Inpatient suspected suicide	0	0	0	0	0	0	0	0	0
Absent without leave suspected suicide	0	0	0	0	0	0	0	0	0
On approved leave suspected suicide	0	0	0	0	0	0	0	0	0
Lakes	0	0	0	0	0	0	0	0	0
Inpatient suspected suicide	0	0	0	0	0	0	0	0	0
Absent without leave suspected suicide	0	0	0	0	0	0	0	0	0
On approved leave suspected suicide	0	0	0	0	0	0	0	0	0
MidCentral	0	0	0	2	0	0	2	1	0
Inpatient suspected suicide	0	0	0	0	0	0	2	0	0
Absent without leave suspected suicide	0	0	0	2	0	0	0	0	0
On approved leave suspected suicide	0	0	0	0	0	0	0	1	0

DHB	2019-20	2018-19	2017-18	2016-17	2015-16	2014-15	2013-14	2012-13	2011-12
Nelson Marlborough	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Inpatient suspected suicide	0	0	0	0	0	0	0	0	0
Absent without leave suspected suicide	0	0	0	0	0	0	0	0	0
On approved leave suspected suicide	0	0	0	0	0	0	0	0	0
Northland	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Inpatient suspected suicide	0	0	0	0	0	0	0	0	0
Absent without leave suspected suicide	0	0	0	0	0	0	0	0	0
On approved leave suspected suicide	0	0	0	0	0	0	0	0	0
South Canterbury	**0**	**1**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Inpatient suspected suicide	0	0	0	0	0	0	0	0	0
Absent without leave suspected suicide	0	1	0	0	0	0	0	0	0
On approved leave suspected suicide	0	0	0	0	0	0	0	0	0
Southern	**0**	**1**	**1**	**2**	**1**	**0**	**1**	**1**	**1**
Inpatient suspected suicide	0	0	1	0	0	0	0	1	0
Absent without leave suspected suicide	0	0	0	1	1	0	0	0	1
On approved leave suspected suicide	0	1	0	1	0	0	1	0	0
Tairawhiti	**0**	**1**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Inpatient suspected suicide	0	1	0	0	0	0	0	0	0
Absent without leave suspected suicide	0	0	0	0	0	0	0	0	0
On approved leave suspected suicide	0	0	0	0	0	0	0	0	0
Taranaki	**0**	**0**	**1**	**0**	**0**	**0**	**0**	**0**	**1**
Inpatient suspected suicide	0	0	1	0	0	0	0	0	0
Absent without leave suspected suicide	0	0	0	0	0	0	0	0	0
On approved leave suspected suicide	0	0	0	0	0	0	0	0	1
Waikato	**3**	**0**	**0**	**3**	**0**	**0**	**0**	**1**	**1**
Inpatient suspected suicide	0	0	0	0	0	0	0	1	1
Absent without leave suspected suicide	2	0	0	0	0	0	0	0	1
On approved leave suspected suicide	1	0	0	3	0	0	0	0	0
Wairarapa	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Inpatient suspected suicide	0	0	0	0	0	0	0	0	0
Absent without leave suspected suicide	0	0	0	0	0	0	0	0	0
On approved leave suspected suicide	0	0	0	0	0	0	0	0	0
Waitemata	**0**	**3**	**5**	**0**	**0**	**1**	**0**	**2**	**0**
Inpatient suspected suicide	0	2	4	0	0	0	0	0	0
Absent without leave suspected suicide	0	1	0	0	0	1	0	2	0
On approved leave suspected suicide	0	0	1	0	0	0	0	0	0
West Coast	**0**	**1**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Inpatient suspected suicide	0	0	0	0	0	0	0	0	0
Absent without leave suspected suicide	0	1	0	0	0	0	0	0	0
On approved leave suspected suicide	0	0	0	0	0	0	0	0	0

DHB	2019-20	2018-19	2017-18	2016-17	2015-16	2014-15	2013-14	2012-13	2011-12
Whanganui	**0**	**0**	**0**	**1**	**0**	**0**	**0**	**0**	**1**
Inpatient suspected suicide	0	0	0	1	0	0	0	0	1
Absent without leave suspected suicide	0	0	0	0	0	0	0	0	0
On approved leave suspected suicide	0	0	0	0	0	0	0	0	0
Total	**8**	**13**	**13**	**13**	**5**	**5**	**7**	**12**	**17**

Appendix two

The Commission encourages DHBs to report all SAC 1 and 2 adverse events openly and transparently, including those relating to the mental health and addiction sector. As of the 2017/18 financial year, we have reported these events in our annual *learning from adverse events* report. The Office of the Director of Mental Health and Addiction (ODMHA) in the Ministry of Health also produces annual reporting on mental health adverse events.

The information released is broken down by DHB, and this process of classification creates individual local tables that can include small numbers of cases, or even individual cases. Under the Official Information Act 1982 any concerns about potential identifiability need to outweigh the public interest in releasing the information for us to refuse or suppress the information. We are following the approach of the Office of the Director of Mental Health and Addiction for such releases, which is that the public interest should be foremost in the decision to release aggregated information. More detailed OIA requests about individual cases will be considered by individual DHBs on a case-by-case basis but are likely to be declined on the grounds of respecting the privacy of natural persons.

Differences in reporting across agencies

DHBs report SAEs relating to mental health service clients to the Commission in accordance with guidance in the National Adverse Events Reporting Policy 2017. It is important to note that comparison between individual DHBs is difficult. High numbers may indicate that a DHB has a good reporting culture, rather than a significantly high number of adverse events. In addition, DHBs that manage larger and more complex or regional mental health services may report a higher number of adverse events. Regional service information is too complex to be easily explained in a data table, therefore we recommend that queries about regional mental health service provision be directed to the DHBs concerned, who are best placed to speak to the services they deliver regionally. One example of this is regional forensic mental health services provided by Waitemata, Waikato, Capital & Coast, Canterbury and Southern DHBs.

A 'live' database

The Commission's database is constantly edited as new information comes to hand, whereas published figures are by necessity a snapshot of a point in time. Event totals always fluctuate after publication because some events are reclassified more accurately after reviews and are either 'elevated' to SAE status or are 'downgraded' and therefore fall outside criteria. This means our current totals for any particular time period may not match the published figures.

Impact of improved reporting culture

The age of reports also influences the reliability of data. The system of adverse events reporting has matured considerably in the past decade, and we are now more confident that the culture of reporting is sufficiently strong to capture the right events. Ten years ago, national reporting consistency and the Commission's own reporting system were in their early stages and therefore we can be far less confident of their accuracy and completeness. As always, the ODMH and the Commission welcome increases in reporting rates, because rather than representing worsening rates of adverse events, we believe they represent more thorough and consistent reporting of the events that have always been a part of the system. This stronger reporting culture creates real opportunities for improvement across the system.

Changing definitions and reporting periods

Definitions of adverse events and the time periods over which they are defined have also evolved with time, further limiting the comparability of earlier and more recent reporting. Current definitions of adverse events can be found on our website www.hqsc.govt.nz/our-programmes/adverse-events/publications-and-resources/publication/2938/

2019/20 data

Data from the 2019/20 year has not been reconciled with DHBs. This means that while the figures presented here are an accurate representation of what has been reported to us they may change as events are reclassified by DHBs post review.