

**December 2009**



MINISTRY OF  
**JUSTICE**  
*Tāhū o te Ture*

# Injury Information Forum

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CORONIAL SERVICES  
OF NEW ZEALAND  
*Purongo O te Ao Kakarauri*



# Overview

- Changes in data collection capabilities
- Link up with NCIS
- Implementation of the Information Management Strategy and Information Dissemination Strategy
- Relationships with external stakeholders



# Changes in CMS Capabilities

- Increased capacity in location event text fields from 200 – 2000 in all *Incident*, *Death Occurred*, *Body Found* and *Last Seen Alive* screens.
- This will enable greater detail capture into circumstances of the death, including: medical history, mental health history and risk factors. All of these fields are key-word searchable.



# Information Management Strategy

## *Guiding principles*

- Raise awareness and prevent deaths to the betterment of the public
- Balance fair and timely access of coronial information for all while acting with integrity as guardians of coronial data.
- Understand the public need by collecting relevant information for public access.
- Safeguard sensitive information, vet release of public information.
- Understand and monitor trends.
- Select delivery method for communication
- Communicate trends and collaborate and co-operate with key players in injury prevention.
- Develop an Information Dissemination Strategy
- Develop a framework to track, monitor and understand trends.
- Formalise relationships with key stakeholders through MoU's



# Quality Objectives

- Maintain systematic quality analysis and monitoring through the role of the System Administrator
- Provide coder and data input training to all CMS users
- Review and update CMS and CSU procedure documents – NZ input into NCIS' Data Dictionary, Coding Manual, and CMS' User Manual
- Collaborate on established procedures of ICD-10 coding with the Ministry of Health and NCIS
- Provide Help-desk assistance through the System Administrator and CMS super users
- Review coding classification and ensure the codesets reflect current international standards and concepts



# Relationship with NCIS

- Link up in the new year
- All core coronial reports will be available for download on NCIS
- New Zealand specific coding definitions will be available in the NCIS Data Dictionary
- We will be documenting our datasets online in the new year
- All parties with a bone fide interest in NZ coronial data will be granted access following ethics committee review



# Relationship with NCIS

## Disruptions to the process:

- Privacy concerns
- Legal concerns
- Decision as to whether open or closed Coronial case information will be available on NCIS
- Will third party users be granted access to both Australian and NZ data?
- Who will be responsible for quality checks?
- Will NZ researchers and agencies pay a subscription to NCIS for NZ Coronial data?



# Information Dissemination Strategy

- **In development**
- Will see a more streamlined process
- Investigate how we can make it easier to continue/increase the flow of information to core injury prevention stakeholders
- Review of relevant legislation
- Develop a clear process that will allow information flow while complying with privacy and OIA Act concerns
- Clarify roles within the CSU to enable this and review the financial cost – will need to be sustainable
- Endeavour to maximise the mortality data available for coding and injury prevention stakeholders needs



# Relationships with stakeholders

## Future developments

- Formalise relationships and communication channels
- Research project collaborations
- Publish an ongoing series of stakeholder newsletters
- Increase mutually beneficial information sharing with primary stakeholders – e.g. recent MoU with the Ministry of Health and the Office of the Chief Coroner regarding H1N1



# Ongoing issues

- Balance between the importance of prevention and public learning against the privacy of families of the deceased
- Limited resources and staff to deal with the overwhelming demand for coronial information
- Consistency across CSU regional offices – how to best maximise the system’s capabilities



# Coronial statistics: Coroner's work during the July 08 - June 09 year

- some 5,785 deaths were reported to coroners
- the proportion of all registered deaths reported to coroners rose from 13 % in 2005 to 23 % during the first year under the new system (from July 07 - June 08), 3 % higher than expected.
- in 58 % of these deaths, Coroners accepted jurisdiction.
- coroners, on average, had an annual case load of 223 cases.



# Long term trends

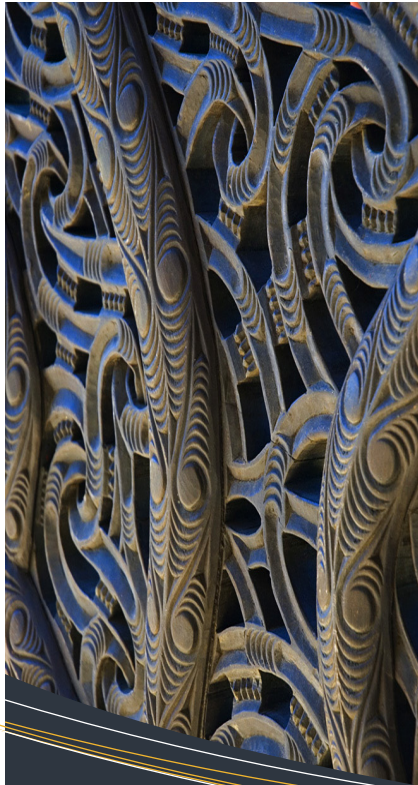
- the long-term trend, as well as that of the proportion of deaths reported, is upwards.
- following the UK concerns and the Law Commission report, there has been more concern about the death certification process.
- in the shorter term, this rise is also due to the establishment of the after-hours coronial service, implemented under the new system.
- this is also due in part, to an increased knowledge of the Coroners Act amongst health care professionals and more efficient channels of communication with GPs, Police and hospitals, leading to greater referrals to Coroners.



# For the future

- we have made considerable progress (especially in light of a total revamp of the NZ coronial system, zero HC objections, establishing productive, collaborative relationships with external stakeholders and move from part time to 24 hr coronial system )
- continue working towards national consistency
- continue ongoing training of Coroners and CSU staff
- Asia Pacific Coroners Society Conference, Auckland, NZ  
November 23 – 26, 2010





Asia Pacific  
Coroners  
Society  
Conference  
November 23-26  
2010

**WHAT CAN A MODERN CORONIAL SYSTEM DO TO SPEAK FOR  
THE MOST VULNERABLE MEMBERS OF OUR SOCIETY  
– OUR MOKOPUNA**

ORGANISED BY:  
Asia Pacific Coroners  
Society and the Coronial  
Services Unit,  
New Zealand



**AUCKLAND CITY**  
New Zealand

**DECEMBER 2009**

# Questions?

