Evaluation of the implementation and scalability of the Suicide Observatory in Cork and Kerry

Executive Summary

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Executive summary

1. Background

The Suicide Observatory in Cork and Kerry was established to address the urgent need for timely suicide mortality data in Ireland, as usual processes of data collection and classification can take two years or more. Founded in Cork in 2018 by the National Suicide Research Foundation (NSRF) and University College Cork's School of Public Health (UCC), the Cork Suicide Observatory was operational between January 1, 2019, and May 4, 2022. Its main aim was to generate near real-time data of suspected suicides to monitor emerging trends, inform suicide prevention efforts and support for people bereaved by suicide, and guide appropriate media reporting. The objectives align closely with national and international strategies, including Connecting for Life, National Strategy to Reduce Suicide (Department of Health, 2015), Sharing the Vision - A Mental Health Policy for Everyone (Department of Health, 2020), and the UN Sustainable Development Goals (United Nations, 2015).

The Suicide Observatory gathered detailed demographic and contextual information on suspected suicides, including circumstances of death, history of abuse, and mental health service use. The initiative expanded into County Kerry in 2021, where it remains active. Data collection processes varied slightly by county. In Cork, NSRF-UCC researchers manually accessed records through the Coroner's office, while in Kerry, the Resource Officer for Suicide Prevention (ROSP) collaborated with the Coroner via telephone, with information subsequently shared with the NSRF-UCC researchers.

When Health Research Board (HRB) funding ended in 2022, the Suicide Observatory in Cork operations ceased, though the Suicide Observatory in Kerry is still ongoing. Given the demonstrated value of the model, NSRF-UCC researchers proposed upscaling the Observatory nationally, leading the National Office for Suicide Prevention (NOSP) to commission an independent evaluation. This evaluation, awarded through a competitive tender, was designed to develop evidence-based recommendations for the Observatory's expansion, based on a mixed-methods evaluation involving key stakeholders and oversight from an Advisory Group.

2. Evaluation approach

2.1. Evaluation framework

The evaluation of the Suicide Observatory in Cork and Kerry was guided by the CDC's Updated Guidelines for Evaluating Public Health Surveillance Systems (CDC, 2001), a framework widely applied in assessing the performance of surveillance systems internationally (Calba et al., 2015). These guidelines emphasize integration of health information systems, standardisation of data, electronic data exchange, and alignment of surveillance with emerging public health needs, such as during the COVID-19 pandemic. They also outline essential system attributes, though recommend tailoring the focus to those most relevant to the system under review.

Using this framework, the evaluation examined seven key attributes of the Suicide Observatory: sensitivity, positive predictive value, data quality, timeliness, simplicity, accessibility, and acceptability, alongside its overall usefulness. Table 1 presents brief definitions of these terms. Additionally, scalability was assessed through the Intervention Scalability Assessment Tool (Milat et al., 2019), which considered factors such as reach, fidelity, delivery setting and workforce, implementation capacity, infrastructure, and sustainability (Appendix 1 in the full report outlines the attributes and their definitions, associated with each objective).

Table 1. System attributes and evidence (based on CDC's guidelines) applied to the Suicide Observatory in Cork and Kerry

Seven system attributes	**Definition**
Sensitivity	The ability of the surveillance system to detect confirmed suicides.
Positive predictive value	The proportion of suspected/probable suicides are confirmed suicides under surveillance.
Data quality	The completeness and validity of the data recorded in the surveillance system
Timeliness	The speed between steps in the surveillance system such as the consideration of the time between the initial case capture and the availability of information for use for public health planning and intervention.
Simplicity	The structure and ease of operation of the surveillance system.
Accessibility	The availability and ease of use of data and information within the surveillance system to support the understanding of suicide and its prevention.
Acceptability	The willingness of persons and organizations to participate and/or use the surveillance system.
The level of usefulness	
The ability of the surveillance system to contribute to the prevention and management of suicide, including an improvement in stakeholders' understanding of the public health implications of suicide.	

Data collection relied on three equally important sources: an audit of the Suicide Observatory, semi-structured interviews with stakeholders, and an online survey. Each source was analysed to determine how well the Observatory met its objectives and demonstrated the identified attributes, before findings were triangulated for synthesis (reported in Chapter 6 of the full report). The audit began at the evaluation's outset, while interviews were carried out between February and April 2025 to inform the subsequent survey, which was conducted in July 2025.

2.2. Data analysis and synthesis

Each data source was analysed separately before being triangulated through an iterative process to produce an overall synthesis and understanding of the performance of the Suicide Observatory and its potential for wider implementation. Triangulation enabled validation of the data by cross-verifying findings from multiple sources and testing the consistency of results. The researchers manually triangulated and synthesised the findings, after which they used SparkAI, the University of Melbourne's large language model (https://www.unimelb.edu.au/ai/home/staff/gen-ai-tools), to support the editing of the synthesis. Finally, the synthesis was cross-checked against each data source to ensure accuracy and consistency.

2.3. Governance and lived experience involvement

The research team worked closely with the Advisory Group throughout the evaluation to ensure the findings were both meaningful and useful. Regular meetings allowed the Advisory Group to monitor progress and support access to data and stakeholders. In addition, a lived experience consultant contributed expert advice on data collection and reporting.

2.4. Ethics approval

The University of Melbourne Human Research Ethics Committee approved the evaluation application in January 2025, with updates in March and July 2025 (Ethics ID 30739). The University College Cork (UCC) Social Research Ethics Committee granted ethics approval for the evaluation team to access deidentified data of the Cork Suicide Observatory in January 2025.

3. Summary of findings

3.1. Operation of the Suicide Observatory

The evaluation of the Suicide Observatory in Cork and Kerry showed that they were designed for near real-time suspected suicide surveillance, with data updated fortnightly through coronial sources. The Suicide Observatory in Cork had more comprehensive data, drawing on both Coroners and the Health Service Executive (HSE) Patient Mortality Register, while the Suicide Observatory in Kerry relied mainly on coronial data. Compared to national systems like the Central Statistics Office (CSO), the observatories provided more timely and practical data, valued by stakeholders for its immediacy and relevance.

The audit of the Suicide Observatory in Cork indicated that the data quality was generally high, with demographic and cause-of-death data over 98% complete and acceptable sensitivity and predictive values. Still, gaps were identified in areas such as substance use and domestic violence, where around half of the data was missing due to availability at the time of data collection. Participants worried about underreporting and inaccuracies, and recommended improvements through using multiple data sources, formal data sharing agreements, and more training of staff involved. Still, they also cautioned that expanding data requirements might reduce quality and increase workload for ROSPs. The collaborative processes underpinning the system, including strong links between coroners and ROSPs, were seen as vital for its success, though reliance on informal relationships was noted as a potential barrier to scaling up nationally.

Stakeholders widely recognised the value of the observatories in identifying at-risk groups, guiding interventions, informing resource allocation, and strengthening suicide prevention efforts, including during COVID-19. Strengths included its near real-time capacity, detailed geographic data, facilitating support for families and communities, and potential for expansion. Weaknesses related to resourcing, dependence on goodwill, lack of integrated police data, and delays in coronial confirmation. Looking ahead, participants saw threats in insecure funding, reliance on a single data source, and uncertainty about government support. They also noted significant opportunities to scale up the model, including national reporting, use of online dashboards, integration of additional data, and stronger stakeholder involvement, all of which could enhance and consolidate the Observatory's crucial role in suicide prevention.

3.2. Impacts of the Suicide Observatory

The Suicide Observatory may face several barriers to effective suicide surveillance, including General Data Protection Regulation (GDPR) and data-sharing restrictions, confidentiality concerns in small communities, and hesitance of families or police to view deaths as suspected suicides. Legal thresholds for confirming suicide, and variability across coroners' practices could further limit consistency and

access to data. Variability in coroners' capacity to participate, as well as differences in the ability of ROSPs to act on data, were also identified as challenges.

Despite these barriers, stakeholders highlighted strong demand for expansion, willingness among (some) coroners to collaborate, and the expertise already established through the Observatory. National data-sharing agreements, stronger links between coroners and health services, standardised terminology, and integration of multiple data sources were seen as important enablers for scaling up. Participants also recommended tools such as dashboards, and open-source software, to further improve access and streamline processes, while stakeholder meetings could foster engagement and collaboration.

The Observatory was considered highly acceptable and useful among stakeholders, including ROSPs, coroners, and frontline workers. Participants valued its ease of use, ethical safeguards, and contribution to building trust in data handling. It was reported to improve understanding of suicide trends, inform cautious media reporting, guide targeted preventive interventions and responses to families and communities. Many regarded the Observatory as a potential "game changer" for suicide prevention if expanded nationally, provided that adequate resources, staff support, and clear processes for GDPR and Gardai involvement were in place.

3.3. Scalability of the Suicide Observatory

The evaluation identified strong potential for national scalability of the Suicide Observatory, with its core process of collecting data from coroners proving both consistent and adaptable. Participants emphasised the importance of retaining the Observatory's central purpose while allowing flexibility to include locally relevant data, post-suicide research, and links to other data sources. They also suggested expanding the scope to include self-harm data, for example by linking the Observatory with the national self-harm registry, and providing regular updates and outputs. Most agreed that national rollout is feasible, provided it is supported by staff training, national coordination and leadership, and formal data-sharing agreements to maintain both quality and fidelity.

Embedding the system within suicide prevention policy frameworks and involving a wider range of stakeholders, including ROSPs, Gardai, and local communities, was seen as key to further strengthening acceptance. While some believed upscaling would not require significant additional resources, others highlighted the need for investments in staffing, IT infrastructure, and training to ensure timely responses and effective coordination. A phased approach, beginning with smaller regions, was suggested as a way to manage regional variation in acceptability and capacity.

Key challenges for national expansion were linked to delivery settings, workforce, infrastructure, and sustainability. Participants noted that processes would need to be standardised across regions, with sufficient staff capacity for data collection, analysis, and coordination, supported by a dedicated research team. IT infrastructure was called for along with calls for cloud-based data sharing and lessons from the National Self-Harm Registry. Sustainability was seen as dependent on moving beyond project-based funding toward a stable, long-term model backed by legislation, national leadership, and strong local engagement.

4. Recommendations

4.1. Implementation of the Suicide Observatory

4.1.1. Improving data flow

- Broaden and standardise data sources across regions to improve comprehensiveness and enable more reliable comparisons.
- Standardise data collection procedures to reduce variability caused by regional differences in coronial practices and police involvement.
- Maintain strict data protection measures to safeguard sensitive information and protect the identities of deceased individuals and their families.
- Strengthen links between Suicide Observatory data and local suicide prevention efforts to increase practical impact.

4.1.2. Improving quality and sensitivity of the data

- Cross-check suspected suicide data with data on confirmed suicide from the Central Statistics Office or from the coroners, when available, to confirm the sensitivity and positive predictive value of the Suicide Observatory.
- If the sensitivity and positive predictive value of the Suicide Observatory is <90%, strategies are required to enhance these attributes of the Suicide Observatory (aiming for >90%).
- Address gaps in substance use and domestic violence data by improving access to this information during or after coronial investigations.
- Provide training for staff on data collection and quality control to minimize underreporting or inaccuracies.
- Carefully balance expanding the dataset with maintaining overall data quality and managing the workload of ROSPs to avoid overburdening capacity.

4.1.3. Improving system processes

- Maintain and strengthen the data verification system.
- Formalise communication and data collection processes to ensure the system can operate effectively beyond individual relationships and informal channels.
- Explore strategies to ensure timely data collection in larger regions, such as Dublin, where scaling may be more challenging.
- Expand data collection to include sociodemographic information (e.g., ethnicity, Irish Traveller status) to provide a more comprehensive understanding of suicides.

4.1.4. Improving outcomes and outputs

- Expand data outputs to better support suicide prevention, resource allocation, and bereavement services, and timely information for decision-making.

- Develop national-level reporting tools, such as an online dashboard, to enhance accessibility and usability of data.
- Ensure data availability for research on long-term impacts of suicide, to guide targeted interventions and inform stakeholders about emerging trends.

4.1.5. Addressing weaknesses

- Expand the Suicide Observatory to other regions to enable regional comparisons and national trend analysis.
- Secure sustainable funding and resources to reduce reliance on goodwill and motivated individuals.
- Integrate additional data sources, such as police records, to improve comprehensiveness of data.
- Establish agreements for accessing data from coroners and Gardai, rather than relying on personal relationships.
- Work with coroners to identify issues causing delays.

4.1.6. Addressing obstacles and obtaining opportunities

- Secure stable, long-term funding to reduce operational threats and ensure continuity.
- Establish clear procedures to balance data security with timely access and avoid duplication with other national databases.
- Expand the scope and geographical area of the Suicide Observatory to enhance community awareness and guide targeted interventions.
- Involve local stakeholders more closely in the system to improve engagement and relevance.
- Collect additional sociodemographic and self-harm data (e.g., National Self-Harm Registry) to provide a more comprehensive understanding.
- Implement online dashboards and regular reports to improve timeliness, accessibility, and usability of data.

4.2. Impacts of the Suicide Observatory

4.2.1. Addressing barriers

- Develop clear data-sharing agreements, including Coroners and Gardai, to improve access and collaboration.
- Address GDPR and confidentiality concerns, particularly in small communities, while maintaining secure handling of sensitive data.
- Standardise practices across coroners to reduce variability and ensure consistent data collection.
- Implement procedures that enable timely data sharing while mitigating coroners' concerns about potential perceptions of pre-judging investigation findings.
- Enhance ROSP capacity and resources to act effectively on surveillance data.

4.2.2. Enabling facilitators

- Foster ongoing stakeholder engagement through meetings and collaboration to maintain support.
- Standardise terminology and integrate multiple data sources to improve consistency and comprehensiveness.
- Utilise open-source software to support accessibility and scalability.
- Strengthen national-level connections between coroners, health services, and other key partners to support effective implementation and upscaling.

4.2.3. Improving accessibility

- Develop a dashboard or similar platform to provide broader, direct access to Suicide Observatory data for stakeholders.
- Reduce reliance on personal or local relationships for data sharing to ensure more systematic access.

4.2.4. Increasing acceptability

- Clarify the roles of the Gardai and a data sharing agreement between Gardai and the Suicide Observatory.
- Ensure GDPR compliance and transparent data-handling procedures to maintain stakeholder confidence.

4.2.5. Enhancing usefulness

- Provide adequate resources and support for staff (e.g., ROSPs) to maximize the system's impact.
- Continue leveraging Suicide Observatory data to inform local planning, interventions, crisis response, postvention outreach and follow-up, and resource allocation, particularly in preparation of national scale-up.

4.3. Scalability of the Suicide Observatory and feasibility of its wider implementation

4.3.1. Improving fidelity and adaption

- Preserve the core purpose and methodology of the Suicide Observatory while allowing flexibility for local adaptation.
- Incorporate locally relevant data, qualitative insights, post-suicide research, and additional data sources.
- Consider including data on self-harm and provide regular (e.g., annual) data updates.
- Ensure national scalability by implementing staff training, adequate support structures, coordination, and formal data-sharing agreements.

4.3.2. Increasing reach and acceptability

- Engage a broader range of stakeholders, including ROSPs, the Gardai, first responders, health care providers, and local communities, to strengthen reach and acceptability.
- Embed the Suicide Observatory within a national suicide prevention policy framework to enhance its alignment and credibility.
- Consider a phased approach to national upscaling, starting with smaller regions before wider rollout.
- Allocate adequate resources for staff, IT systems, and training to support data collection, sharing, coordination, and research.
- Integrate Suicide Observatory responsibilities into existing roles where possible to optimize efficiency.
- Ensure sufficient capacity to respond promptly to suicide-related incidents in the community.

4.3.3. Expanding delivery setting and workforce

- Integrate the system into the daily work of ROSPs and coroners, accounting for regional workforce variability.
- Establish a national team to support upscaling, particularly if data from the National Self-Harm Registry will be included.
- Develop a dedicated research workforce to analyse and interpret data effectively.
- Standardise processes across regions to improve consistency and scalability.
- Ensure sufficient staffing, IT infrastructure, and training for data collection, analysis, administration, and coordination.
- Allocate resources for linking the Observatory with other data sources, such as CSO and National Self-Harm Registry.

4.3.4. Securing implementation infrastructure

- Upgrade IT systems to support a national rollout, including cloud-based data sharing.
- Build robust implementation infrastructure to enable accurate and timely data collection.
- Consider structural factors, such as health region restructuring, in planning national implementation.
- Learn from existing models, such as the National Self-Harm Registry, to inform system design and cost estimates.

4.3.5. Ensuring sustainability

- Establish stable, long-term funding supported by national leadership, formal resources, and legislation.

- Address practical challenges in data collection, such as travel requirements.
- Ensure regular technological updates and ongoing staff training to maintain system functionality.
- Promote strong local engagement to support continued use and impact of the Observatory data.
- Leverage learnings from existing systems and the ongoing coronial system review to enhance effectiveness and cost-efficiency.

5. Conclusions

The evaluation of the Suicide Observatory in Cork and Kerry found strong support for its upscaling and wider implementation. The evaluation indicated that its processes for collecting near real-time data of suspected suicides were generally effective, valued by stakeholders, and aligned with national suicide prevention strategies. While data quality was strong overall, gaps remained in areas such as substance use and domestic violence. The Suicide Observatory supported timely interventions, identification of at-risk groups, and resource allocation, including during COVID-19, though participants highlighted the need for more frequent reporting, formal data-sharing agreements, and better integration of multiple sources. Strengths included local collaboration, stakeholder buy-in, and near real-time insights. Weaknesses included reliance on personal relationships, under-resourcing, and lack of standardisation of data sharing.

Looking forward, stakeholders saw significant opportunities for national rollout, provided adequate infrastructure, training, and stable funding are secured. They stressed the importance of maintaining the Observatory's core functions while allowing flexibility for local adaptation and integration with other data sources including regarding self-harm. While demand and acceptability were high, challenges included GDPR constraints, confidentiality concerns, and coroner and workforce variations. Participants viewed the Suicide Observatory as highly useful, acceptable, and a potential "game changer" for suicide prevention if scaled nationally. Ensuring sustainability will require moving from project-based funding to a long-term model supported by national leadership, legislation, IT infrastructure, and ongoing engagement with local stakeholders.

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