



National Coroners Information System

Annual Report 2004 / 2005

National
Coroners
Information
System





NCIS Manager Jessica Pearse with (L-R) Karen Holley, Marde Hoy and Leanne Daking.

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01 | Director's report

The 2004/05 financial year saw the National Coroners Information System (NCIS) operating steadily under the new management and governance structure to increase the use and value of the NCIS to the Australian Community.

Highlights of the year included:

- the inaugural meeting of the NCIS Committee and the NCIS Board of Management;
- the incorporation of additional information into the NCIS collection, such as South Australian autopsy and toxicology reports, and codes from the Australian Bureau of Statistics (ABS); and
- Increased awareness and usage of the system by coroners, policy makers and researchers.

Further improvements were made over 2004/05 to the quality assurance process, to ensure the accuracy, consistency and reliability of data on the NCIS. Much work has also been undertaken to assist the Coroner's Offices around Australia to improve data entry timeliness, coronial awareness and usage of the system.

From the objectives outlined for the 2004/05 year in the NCIS Business Plan, 33 out of the 39 objectives (or 85%) were fully achieved. These objectives related to the five priority areas for the NCIS as outlined in the Business Plan, being Data Quality, Data Completeness, System Awareness and Usage, Stakeholder Relationships and Communication, and Administration.

In terms of the application of NCIS data to injury prevention initiatives, a national safety campaign concerning working safely under vehicles was launched

by the Federal Government on the basis of NCIS data, and injury prevention researchers released a number of state and national reports where NCIS was the primary data source used.

The value of the NCIS as a useful injury surveillance tool has also been highlighted in a report produced by the Australian Institute of Health and Welfare, which found the NCIS

"... has added substantially to the extent of information relevant to injury surveillance which is accessible in Australia ..." and "The coded and text data in the NCIS provide a detailed and flexible information resource for injury research".¹

The increasing use of the system by death investigators, policy makers and researchers in 2004/05 has been heartening, as has the continued support of the NCIS by funding agencies, coronial offices and users.

I would like to take this opportunity to recognise the enormous contribution made by the Manager of the NCIS, Jessica Pearse, this year. This system has been working under a brand new management and governance structure that has worked extremely well, and much of the credit for this goes to Jessica.

We look forward to continuing to improve the quality, quantity and accessibility of national coronial information via the NCIS during the 2005/06 financial year to assist preventing death and injury in the Australian Community.



Director NCIS

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Endnote

- 1 Driscoll T, Henley G, Harrison JE. 2003. The National Coroners Information System as an information tool for injury surveillance. Injury Research and Statistics Series Number 21. Adelaide: AIHW (AIHW cat no. INJCAT 60)

02 | Achievements for the year

2.1. Official transfer of NCIS management from Monash University to VIFM

On 21 March 2005, legal documentation was signed to enact the transfer of the NCIS from Monash University to the Victorian Institute of Forensic Medicine (VIFM). This transfer arose as one of the conditions of continued government funding of the NCIS past June 2003. Management of the NCIS is now undertaken by the VIFM.

A new governance structure for the NCIS was also confirmed and endorsed via this transfer process, and can be viewed in Appendix 1.

The transfer of management to the VIFM has also allowed the Department of Justice Research Ethics Committee to commence consideration of NCIS applications, replacing the Monash Ethics Committee. The DOJ Ethics Committee considered their first NCIS application on 22 March 2005.

The transfer of management of the NCIS to the VIFM and the adoption of a new governance structure during 2004/05 has ensured a clearly defined accountability and reporting mechanism for NCIS funding, strategic direction and future developments. This is evidenced by the fact that in 2004/05, the newly comprised NCIS Committee, the VIFM Council and NCIS Board of Management strongly endorsed the NCIS Business Plan for 2004-06, NCIS policies and procedures, and the annual report for 2003/04.

2.2. New NCIS web site launch

An updated and revised NCIS information website was designed and launched in 2004/05.

The new website provides updated information about the management and governance structure of the NCIS; the drugs and police form projects; and the government bodies which currently fund the NCIS. New information has also been added to the site about the NCIS quality review process, statistics concerning document attachment and case closure rates; and references to publications and reports in which NCIS data has been featured.

2.3. Australian Bureau of Statistics data on the NCIS

In June 2005, codes used to classify the geographical area of a deceased's residence (ASGC codes) the occupation of the deceased (ASCO codes) and all injuries sustained by the deceased (ICD-10 Cause of Death codes), were added to the NCIS.

These codes were provided by the Australian Bureau of Statistics (ABS) as part of a reciprocal data exchange agreement, and will enable researchers to interrogate the NCIS using nationally recognized coding structures.

These new fields will enable NCIS users to conduct searches based on the Statistical Division or Local Government Area of the deceased's residence; search via the international coding system for the classification of injuries; and perform more consistent searches for cases of a particular occupational grouping. The implementation of this feature also allows for the comparison of coronial data with other data-sets that use these codes. This has not previously been possible in Australia or internationally. A new ABS search screen was developed for the NCIS to allow searching to be performed on these codes.

The codes for deaths reported in 2000, 2001, 2002 and 2003 were provided by the ABS in late June 2005, with those for deaths reported in 2004 to be available on the NCIS at the end of 2005. The provision of codes by ABS for the previous years' deaths will occur on a yearly basis, once the codes are publicly released.

2.4. Increase in usage and outcomes relating to national coronial data accessed via the NCIS

During the 2004/05 year, there were significant gains made in terms of coronial and third party awareness and usage of the system. There were over 1,800 direct searches of the NCIS conducted by death investigators in 2004/05, the number of new applications from third party users remained steady with 11 new applications approved this year (compared to 10 new applications in 2003/04), and the NCIS team conducted a number of coronial awareness sessions with coroners. Further information about the nature and extent of NCIS usage in 2004/05 is contained in Sections 8 & 9.

One of the largest areas of growth was in the information request service, where 25 requests from government, researchers, media and private organisations were made to obtain statistical information from the NCIS for a relevant fee. Refer to Appendix 6 for information about the nature of these requests.

The recognition of the NCIS as an available and well respected research tool concerning mortality data by a variety of industry areas was therefore further enhanced during the 2004/05 year.

Aside from an increase in the frequency of system usage, there was also an increase in the use of NCIS data to contribute to practical death and injury prevention measures.

02 | Achievements for the year continued

This can be evidenced in a number of different ways including references to NCIS data being made in coronial findings where recommendations were made; the number of external research reports which used NCIS data to contribute to a further understanding of death and injury; and the development and implementation of safety or injury prevention campaigns based on NCIS data. An example of the latter involved the launch of a national safety campaign concerning working under vehicles based on the number of deaths identified on the NCIS. Further information on this safety campaign is provided in Appendix 2.

2.5. Agreements with funding agencies

Another achievement during 2004/05 related to the further development of the relationship between the NCIS and the government agencies which fund the system. Negotiations and agreements were made with the relevant funding agencies as to what access their agency, (or their contractors) would receive from the NCIS in recognition of the core funding that they provide. In some cases this involved agreements being made with the Departments of Justice around Australia detailing the other State Government agencies that would be able to access the NCIS without incurring direct user fees. In terms of Commonwealth funding agencies, agreements were reached about the types of services that would be provided for the agencies' nominated users (or contractors) without incurring any additional fee under the user pays system.



Applications Officer Marde Hoy works on updating the NCIS website.

03 | NCIS Business Plan Objectives

Of the objectives to be achieved in 2004/05, 33 of 39 were fully completed. Four (4) activities were partially achieved, and 2 were not achieved within expected timelines, due to external factors outside the control of the NCIS team.

Some of the more significant business objectives that were achieved in 2004/05 were:

- redesign of Fatal Facts publication which summarises coronial recommendations made;
- finalisation of legal transfer of operations;
- implementation of new governance structure;
- creation of NCIS Advisory Group (comprised of NCIS users) to provide feedback to the management team;
- establishment of regular teleconferences with coronial registrars and data entry coders; and
- provision of refresher coder training sessions.

An overview of the achievements of the NCIS within each of these priority areas during 2004/05 is outlined below.

3.1. Data Quality

The outcomes of data quality efforts can be evidenced by the fact that over 55,000 or almost 60% of all cases have now been quality assured by the NCIS team. (see Table 1). Please refer to Section 7, Quality Assurance for more detailed information.

3.2. Data Completeness

The outcomes of data completeness efforts include:

- South Australian Autopsy and Toxicology reports are now available on the NCIS, improving the contextual information about SA deaths.
- Increased number of WA and SA finding documents on the system, improving user access to contextual information, the final coronial determination concerning cause and circumstances of death, and any coronial recommendations made about these deaths.
- The majority of contributing jurisdictions have police narratives attached to more than 90% of their cases, increasing the contextual information available about deaths stored on the system.

Other areas where NCIS data has been enhanced include:

- The development and implementation of an upload reporting system. This system will allow immediate notification of any technical issues concerning the upload of case information or documentation to the NCIS.
- Initial investigations undertaken to obtain Tasmanian autopsy reports from Launceston General Hospital; NSW toxicology reports; WA autopsy cover sheets and QLD autopsy, toxicology and coronial findings.

03 | NCIS Business Plan Objectives continued

- ABS coded data fields obtained for geographical areas of deceased's residence (ASGC); occupation codes (ASCO) and injury classification (ICD-10). Additional interfaces to store ABS data designed and implemented. This will enhance researchers' use of the NCIS by allowing identification of relevant NCIS cases using standard ABS coding structures.

3.3. System Awareness and Usage

Strategies implemented to promote system awareness and usage have proven successful, as there was a significant increase in the amount and frequency of death investigators who have access to the system in 2004/05 (260 compared to 207 in 2003/04), the number of information requests that were received from external organisations (25 compared to 9 in 2003/04), and the number of third party applications received (remaining steady with 11 new applications made, the same number as in 2003/04).

Other strategies included:

- The redesign of the Fatal Facts publication
- NCIS information included in the coroners bench book.
- Coronial awareness sessions held
- Production of Broadsheets of Interest

3.4. Stakeholder Relationships and Communication

Achievements in this priority area during 2004/05 included:

- Regular reports provided to NCIS governance bodies
- Implementation of regular teleconferences with coronial managers and coders
- Creation of NCIS advisory group
- Agreements made with funding agencies as to NCIS access levels

The number of third party users subscribing to the system remained steady for the period, even after the first year of implementation of the user pays system. Testimonials made about the NCIS (see Appendix 3); and the responses made about the value of the NCIS within submissions to the Victorian Parliamentary Review (see Appendix 4) have been extremely positive. The range of third party users who have agreed to participate in the NCIS Advisory Group Committee is also an indication of widespread third party usage and support (see Appendix 5).

3.5. Administration

The new governance structure for the NCIS has been smoothly implemented, and the NCIS Board accepted and endorsed NCIS financial information presented to them concerning the 2004/05 year.

The NCIS operated within budget and finalised the legal transfer of NCIS Management to VIFM.

04 | Staffing outline

4.1. NCIS staff during 2004/05

During 2004/05, NCIS staffing levels were returned to optimum capacity, with 6 team members (equivalent to 5.4 full time staff) employed at 30 June 2005.

4.1.1. NCIS Staff Composition

- Jessica Pearse was appointed NCIS Manager in July 2004 replacing Vicky Winship who was the acting project manager. This position involves managing the NCIS team, reporting to and liaising with NCIS stakeholders and funding agencies, and preparing NCIS budgets and strategic plans. Jessica was previously the Senior Project Officer at the NCIS.
- Leanne Daking was appointed NCIS Quality Manager in August 2004. This position involves managing the NCIS Quality Assurance processes and providing training and support to the data entry clerks in each of the coronial offices who perform NCIS coding. Leanne has a background in Health Information Management and previously worked for the Victorian Department of Human Services. Leanne replaced Sue Wood who departed the NCIS in July 2004.
- Rebecca Thornton was appointed NCIS Coronial Liaison Officer in November 2004. This position involves liaison with the coronial offices on a variety of matters including: obtaining documents not currently available on the NCIS, encouraging increased coronial usage of the system, and providing a help desk facility for NCIS and local system queries. Rebecca has a background in Health Information Management and previously worked for the Victorian Department of Human Services. Rebecca replaced Jessica Pearse, who was promoted to NCIS Manager.
- Karen Holley was appointed as a part time Administrative Officer in November 2004. This position involves assisting the NCIS team in organising meetings, taking, compiling, and distributing minutes, manual document attachment and general administrative duties. Karen has a background in Science, and is also working at the Royal Children's Hospital as a records officer.
- Marde Hoy continued in her role as Applications Officer. This position involves liaising with death investigation and third party users regarding their applications to access to the system, and liaison with the various Ethics Committees which assess NCIS access applications.
- Tony Chan continued in his role as Quality Assurance Assistant. This role involves assisting the QA Manager in performing the regular quality reviews of the coded data available on the NCIS.

Some of the NCIS Team - L-R Jessica Pearse, Tony Chan, Marde Hoy (absent from the photo: Leanne Daking, Rebecca Thornton, Karen Holley)



05 | Governance Structure

The revised NCIS Governance Structure had its first year of implementation during 2004/05, with the official commencement of the new governance model taking effect in March 2005. Prior to this official commencement date, the Governing Committees were established, and some held initial meetings to formulate and confirm terms of reference and other administrative details.

The new Governance Structure is outlined in Appendix 1.

The members of the various Committees and Boards which comprise the NCIS Governance Structure (and the meetings held throughout 2004/05) are outlined below.

5.1. NCIS Committee (VIFM Council sub-committee)

Composition:

- Graeme Johnstone, Victorian State Coroner (chair)
- Arnold Shott, Tasmanian Chief Magistrate
- A/Professor David Ranson, Director NCIS
- Professor Stephen Cordner, Director VIFM
- A/Professor James Harrison, Director National Injury Surveillance Unit

NCIS Committee Meeting Dates:

- 1 October 2004
- 15 November 2004
- 24 January 2005
- 12 April 2005

5.2. Victorian Institute of Forensic Medicine Council

Composition:

The composition of the VIFM Council in 2004/05 can be accessed from the VIFM 2004/05 Annual Report.

VIFM Council Meeting Dates:

- 15 March 2005
- 3 May 2005
- 14 June 2005

Please note the dates above only refer to VIFM Council Meetings (or VIFM Executive and Finance meetings) where NCIS material was considered by the Council.

5.3. NCIS Board of Management

Composition

Ms Penny Armytage (Chair)

Secretary, Victorian Department of Justice

Mr Laurie Glanfield (Deputy Chair)

Director General, NSW Attorney-Generals Department

Mr Colin Murphy

Acting Director General, WA Department of Justice

Mr Richard Coates

Chief Executive Officer, NT Department of Justice

Ms Elizabeth Kelly

Acting Chief Executive, ACT Department of Justice and Community Safety

Mr Mark Johns

Chief Executive Officer, SA Attorney Generals Department and Department of Justice

Ms Rachel Hunter

Director General, QLD Department of Justice and Attorney-General

Mr Peter Hout

Secretary, Tasmanian Department of Justice

Ms Jenny Hefford

Assistant Secretary, Drug Strategy Branch, Australian Department of Health and Ageing

NCIS Board of Management Meeting Dates:

- 8th April 2005 Canberra

Note: An NCIS Board Meeting was also held on 28th July 2005

5.4. Outcomes from NCIS Governance Meetings in 2004/05

In 2004/05, the NCIS Committee and the NCIS Board of Management endorsed the following:

- Terms of reference for each governing group
- Existing policies and procedures of the NCIS
- The 2004-2006 NCIS Business Plan
- The process for the triennial review of NCIS funding

The NCIS Committee also assessed 5 applications for Exceptional Circumstance Fee Relief in relation to the NCIS User Pays System.

06 | Teaching and Education

6.1. Presentations

A number of presentations concerning the NCIS were made to various groups throughout the 2004/05 year. Some of these are outlined below.

6.1.1. Magistrates Coronial Training Session

Introductory sessions about the NCIS were held at the 2 day magistrates training course in May 2005. A number of magistrates from around Australia who act as coroners in their jurisdictions were introduced to the NCIS. A number of new applications for access to the system resulted from these sessions (including coroners from New Zealand and Norfolk Island).

6.1.2. Parliamentary Review Committee

A review of the *Victorian Coroners Act 1985* commenced in 2004/05, with the Parliamentary Review Committee assigned to this task visiting the VIFM in April 2005. NCIS conducted a presentation to the Review Committee, highlighting current uses of the NCIS, and how some amendments to the Victorian Coroners Act may encourage further adoption of the system.

6.1.3. Victorian Country Pathologists

In March 2005, a presentation was made to Pathologists from Country Victoria. This presentation addressed possible benefits they could obtain from using the NCIS, and examined the possibility of the electronic transfer of country autopsy reports to the VIFM, for attachment to the NCIS. The outcome of this meeting is also referenced in section 10, Document Attachment and Case Closure.

6.1.4. International visitors

Throughout 2004/05, a number of international visitors attended the VIFM. During their visit, they were provided with a presentation about the NCIS.

These visitors included:

- a Delegation from the University Hospital Medical Information Network, University of Tokyo Hospital, JAPAN
- a Professor from the Department of Forensic Medicine, University of Tokyo, JAPAN
- a delegation from the National Institute of Public Health, JAPAN.
- a delegation from the Faculty of Forensic Medicine, CHINA
- The retired medical examiner of Los Angeles, USA
- HM Coroner in Sheffield, UNITED KINGDOM

6.2. Training/Awareness sessions for Coroners

In February 2005, two awareness sessions were held. The sessions provided coroners with information about how the NCIS could be used to assist their death investigation work, different ways of accessing the information, promotion of NCIS experts, and some demonstrations of the NCIS.

Feedback was positive from a number of Coroners who attended the session.

Further training and awareness sessions for coroners are planned for 2005/06

6.3. Student Supervision

The NCIS supervised the placement of a number of students over the 2004/05 year. These included:

- Claire Rowan –Melbourne University, criminology Honours Placement Program (full year placement)
- Hannah Lane – LaTrobe University. Health Information Management, 3rd year placement (four week placement)
- Laura Mascitti - LaTrobe University, Health Information Management, 3rd year placement (five week placement)

Claire Rowan investigated the quality and quantity of coronial information on the NCIS concerning drug fatalities (examining ecstasy and amphetamine deaths), with her report to be produced in 2005/06.

Laura Mascitti and Hannah Lane conducted short projects investigating the coding of adverse medical events on the NCIS; and the use of the product related field on the NCIS respectively.

07 | NCIS Quality Assurance

The NCIS Quality Assurance team made a number of significant advances in terms of improving and maintaining the data quality and consistency of coding on the NCIS during 2004/05.

These achievements included:

- Conducting refresher coder training sessions for NCIS coders in every state around Australia. This ensured that all NCIS coders were up to date and trained in a consistent manner, as the initial coder training delivered was in a staggered format, and conducted almost five years ago.
- Providing increased support for NCIS Coders. This included;
 - implementing and conducting regular coder teleconferences
 - producing regular coding tips newsletters
 - the NCIS Coding Manual to incorporate more detailed guidelines, definitions and examples
 - establishing a coder queries help desk.
- Developing a more automated quality checking procedure using SQL which resulted in improved and more efficient quality checking processes; and
- The implementation of a new Quality Flagging Process, which allows the QA team to obtain more details concerning the quality status of cases, and prevents quality assurance activities being over written during local system uploads.

Other quality assurance activities involved:

- Reviewing coding for 14,329 cases between the period of 30 August 2004 to 30 June 2005. 4629 cases were identified as containing at least one critical error, indicating an error percentage of 32.30% (this compares to a critical error target of 15%).
- Disseminating four Quality Feedback Reports to jurisdictions.
- Reviewing the “product related” field in terms of current usage and suggested recommendations for change to be implemented in 2005/06.
- Recording outstanding causes of deaths for over 100 NSW cases.

All the efforts outlined above were intended to improve and maintain the accuracy, completeness and consistency of coding on the NCIS. Accuracy levels for each jurisdiction will be monitored over 2005/06 to determine the impact of the quality assurance activities listed above. The impact of such activities were unable to be accurately measured at the end of the 2004/05 financial year, as certain states had only recently received refresher coder training and updated manuals. The cases being reviewed by the NCIS QA team also largely still pre-dated the

implementation of coder training initiatives. However it is expected that an improvement in the coding accuracy of NCIS will be detected over the 2005/06 year, and will be reported in the 2005/06 Annual Report. A quality target of less than 15% error rates detected for each month’s data has been agreed as an initial goal by each coroner’s office.

The figures below in Table 1 indicate the number of cases quality reviewed as at 30 June 2005.

Table 1. NCIS Quality Assurance Statistics as at 30 June 2005

Total Cases on NCIS	92,559
Total Cases Closed	72,667
% Cases Closed	78.51
Total Cases Quality Reviewed	55,213
% Cases Quality Reviewed	59.65%

08 | Research and publications

8.1. Publications produced

8.1.1. Fatal Facts redesigned

The Fatal Facts publication was redesigned in 2005/06 to improve user friendliness and show more targeted content. The new Fatal Facts focuses on findings where recommendations were made, as well as providing search tips for coroners, case studies and recent information requests. The first edition under this new design was sent to State/Chief Coroners in January 2005, and is now available for public access on the NCIS website, along with the June 2005 edition.

8.1.2. Production of NCIS Broadsheet of Interest – Home Maintenance Deaths

To continue to encourage coronial awareness of the type and potential of data on the NCIS, the first edition of NCIS Broadsheets was produced in late June 2005. A publication which features patterns or trends on particular topics of interest, the first edition about home maintenance deaths was disseminated to all coroners. An Issue of Concern in relation to the number of individuals falling through roofs/skylights was generated on the basis of this first publication. The topics for future editions will be based upon coronial feedback and suggestion.

8.2. Use of the NCIS by researchers

There are a number of ways in which the NCIS can contribute to research. The NCIS can provide statistical information for individuals who require one-off figures about the frequency and demographics surrounding

certain types of fatalities, or provide direct system access to researchers who need to conduct in-depth analyses of deaths reported to a coroner. A indication of the types of contributions made by the NCIS along these lines throughout 2004/05 is provided below.

8.2.1 Information searches conducted for clients

During the 2004/05 year, there was a significant increase in the number and type of organisations requesting statistical data from the NCIS. Organisations requesting statistical data from the NCIS included researchers, government departments, private organisations and media outlets. The purposes for which this information was requested included submissions to Parliament, briefing papers for Government Ministers, grant applications, research proposals, academic publications and media articles.

25 information searches for external fee paying clients were provided in 2004/05. The types of information requests made are listed in Appendix 6.

8.2.2. Direct access to the NCIS by third party organisations

In 2004/05, 11 new organisations or groups applied to gain direct access to the NCIS system. These organisations included government departments (e.g. A section within NSW Police; a State Road Traffic Authority), Research Organisations (e.g. Child Death Review Team; various schools within Universities; Injury Centres), and Non-Profit Organisations (Patient Safety Group; Building Codes Board). The breakdown of new user applications is indicated in Table 2.



Table 2. Type of new NCIS third party applicants in 2004/05

User Type	Number of Applicants
Government Departments	2
Academic/research centres	4
Non-Profit research agencies	2
PhD Students	3
TOTAL	11

The type of research or monitoring that these organisations are undertaking includes: child death; suicide; road traffic accidents; structural building safety issues, amphetamine related deaths; deaths in custody; patient safety; ischaemic heart disease; psychiatric illness; injury surveillance systems; and toxicological involvement in deaths.

This number of new applications in 2004/05 is consistent with the level of applications received in 2003/04, where 10 new third party applications were received.

13 existing NCIS subscribers also applied to extend their period of access to the NCIS during 2004/05, which is a similar number to 2003/04 (13).

At 30 June 2005, there were 36 third party organisations who had direct access to the NCIS, which equates to over 100 individual users. These statistics seem a little lower when compared to 2003/04 usage figures (40 third party organizations, with 123 individual users) however the reduced usage numbers are a result of a number of separate access agreements held by one organization being consolidated in 2004/05.

8.3. Research Reports/Papers which used NCIS data as a primary source

A number of significant reports concerning death and injury monitoring and/or prevention were published during 2004/05 which used the NCIS as one of their primary data sources. These reports included:

- Bugeja, L. Fire, contact burn and scald injury fatalities among children (0-9 years) and seniors (70+ years) in Victoria, 2000-2003. Victorian State Coroners Office & Department of Human Services: October 2004
- Bugeja, L. Farm related fatalities in Victoria: July 2000 – June 2003. Victorian State Coroners Office, October 2004.

- Cameron PA, Finch CF, Gabbe BJ, Collins LJ, Smith KL, McNeil JJ. Developing Australia's first statewide trauma registry: what are the lessons? ANZ Journal of Surgery. 2004 Jun;74(6):424-8.
- Driscoll TR, Harrison JE, Steenkamp M. Alcohol and drowning in Australia. Injury Control and Safety Promotion. 2004 Sep;11(3):175-81.
- Eastman, P. Homicide on the NCIS: An analysis of the current level and status of information regarding homicide deaths in Victoria stored on the National Coroners Information System (NCIS). University of Melbourne: November 2004
- Gabbe BJ, Finch CF, Cameron PA, Williamson OD. Incidence of serious injury and death during sport and recreation activities in Victoria, Australia. British Journal of Sports Medicine. 2005 Aug;39(8):573-7.
- Monash University Accident Research Centre (MUARC) Annual Report 2004
- Ranson, D.L. & Freckleton, I.R. (In Press) Death Investigation and the Coroners Inquest. Oxford University Press.
- Victorian Trauma State Registry (VSTORM) Annual Report 2003/04

8.4. Conference abstracts (and other submissions)

An abstract was submitted for the following national conferences during the 2004/05 year:

Australian Injury Prevention Conference (Sept 2004)

Paper submitted: The NCIS: Contributions to Death and Injury Prevention

Victorian Parliament Law Reform Committee Review of the Coroners Act 1985 (June 2005)

Paper submitted: NCIS (submission made within the overall VIFM submission about issues raised in the Law Reform Committee Discussion Paper.)

09 | NCIS Contribution to death investigation research or analysis

The NCIS can contribute to death investigation research or analysis by providing coroners and other death investigators with access to information about the frequency and circumstances of deaths reported to a coroner within Australia.

There are numerous ways to measure how the NCIS has assisted in the investigation of reportable deaths. These include measurement of the number of death investigators who have access to the system, the number of NCIS searches conducted by coroners or their staff, the number of references to NCIS data within coronial findings, and an examination of the practical death and injury prevention initiatives which have arisen from coronial searches of the NCIS.

Outlined below are details of these various ways of measuring the application of the NCIS by coroners and death investigators to assist in the prevention of death and injury.

9.1. Number of death investigation users who have access to the NCIS

In 2004/05, 55 new death investigators were provided with access to the NCIS. A fifth (or 20%) of these were coronial clerks; 28% were coroners; 13% were police assisting the coroner; 11% were pathologists, 3% were personal assistants to a coroner; and 4% were coronial office managers.

These new users brought the total number of individual death investigation users having access to the NCIS to 260 at 30 June 2005. Table 3 indicates the proportionate breakdown of the types of death investigation users within this total.

Table 3. Percentage of death investigation users by user type

User Category	Proportion of Total Death Investigation Users
Coroners/Magistrates	28%
Coronial Officer Managers	4%
Police assisting the Coroner	13%
Coronial Clerks	20%
Coronial Researchers	2%
Coroner's Personal Assistant	3%
Pathologists	11%
Forensic Scientists/Medical Staff	19%
TOTAL	100%

9.2. Information requests from coroners/death investigators

During 2004/05, the NCIS received 46 requests from coroners and death investigators around Australia to perform searches of the NCIS on their behalf. The topics requested ranged from the number of drownings which occur in spas and baths; to deaths involving particular types of medical equipment. A list of the topics requested by coroners and death investigators is presented in Appendix 7. 31 or 66% of these information requests were made by coroners (or coronial staff on behalf of coroners), while 15 or 33% of requests were made by other death investigators (police assisting the coroner; forensic pathologists, forensic scientists, coroners research assistants). One of the information requests made from a coroner, came from an overseas coroner (New Zealand).

Table 4. Number of information requests from coroners/death investigators direct to NCIS staff during 2004/05

User Category	Number of Requests
Coroners or Coronial Staff	31
Other Death Investigators*	15
TOTAL	46

* Other death investigators include: police assisting the coroner; forensic pathologists, forensic scientists, coroners research assistants

9.3. Direct access by coroners/death investigators (or coronial staff) to the NCIS

NCIS users can search the database using the query design screen, or the coroners screen. The frequency of use of these screens by coroners or death investigators directly in 2004/05 is outlined in Table 5.

Table 5. Number of direct system searches conducted by coroners/death investigators during 2004/05¹

User Category	Query Design Screen	Coroners Screen	Total Searches conducted
Coroners/Magistrates	49	200	249
Coronial Clerks or NCIS Expert Users [#]	368	848	1216
Other Death Investigation Users [*]	279	149	428
TOTAL	696	1197	1893

The counts presented in Table 5 represent the number of times a particular user selected that search screen option (e.g. coroners screen or query design screen) from the NCIS search menu.

[#] An NCIS expert user is an individual who has been nominated by each State/Chief coroner to be given increased access permissions so they can conduct searches of the NCIS on behalf of coroners in that state/territory. These expert users are given additional NCIS search training to assist them in this role.

^{*} Other death investigators include: police assisting the coroner; forensic pathologists, forensic scientists, coroners research assistants

As indicated in Table 5, death investigation users tended to prefer to conduct direct searches using the coroners search screen. This is especially true of coroners/magistrates, with 75% of their NCIS searching done using this screen.

It is also demonstrated that there are relatively few coroners who conduct searches of the system themselves, in most cases requesting that the NCIS users or coronial clerks conduct the search.

The increased use of the NCIS as a search tool for direct death investigation purposes is highlighted by the fact that there were over 1,800 online searches conducted by coroners and other death investigation users in 2004/05, with an additional 46 search requests being made directly to the NCIS team. These figures have been collected for the first time in 2004/05, and will be used as a comparison figure for future years to determine the degree to which coroners are continuing to access information from the NCIS.

9.4. Impact and Influence of NCIS data on coronial / death prevention initiatives

While the impact and influence of the searches conducted above can be difficult to quantify, some measures such as the number of references to NCIS data made within coronial findings; and practical death prevention initiatives launched or supported by NCIS data can be made. These are outlined on the following page.

09 | NCIS Contribution to death investigation research or analysis continued

9.4.1 References to NCIS data within coronial findings

During 2004/05, there were at least six (6) coronial findings which referenced NCIS data. They included coronial findings that reported on the following:

- the number of national motor sport racing fatalities (Vic case number 353/02);
- the number of national deaths in relation to mechanical drilling equipment (Vic case number 3678/02)
- the number of national deaths in relation to pedestrians being hit by moving trucks, vans or plant equipment at a construction site or equivalent (Vic case number 551/03)
- the number of national deaths in relation to taxi drivers not wearing seat belts (Vic case number 2231/03)
- the number of national deaths of children strangled by blind cords (Vic case number 3774/03)
- the number of hang-gliding deaths (Vic case number 505/04)

In all but one of these six coronial findings, the coroner made a formal recommendation to prevent future deaths. In the one case in which a formal recommendation was not made, the coroner made a comment in relation to safety issues.

This is a significant increase from 2003/04, when only one coronial finding made during the period mentioned NCIS data.

9.4.2 Practical impacts of NCIS usage during 2004/05

In 2004/05, there were a number of safety or prevention initiatives that were developed or supported by NCIS data. These included:

- In February 2005, a national safety campaign concerning working under vehicles was launched by the ACCC and the Australian Department of Health and Ageing on the basis of NCIS data (see Appendix 2 for more information).
- In July 2004, an accredited TAFE training program on ATV safety for farmers was announced by the Tasmanian Farmers and Graziers Association. This program was approved by the government in light of NCIS data indicating the number of ATV fatalities around Australia.
- In July 2004, the national conference of Blind Manufacturers Association of Australia heard of the need to comply with new NSW blind manufacturing regulations, due to the presentation of NCIS de-identified case scenarios concerning child deaths due to accidental strangulation by blind or curtain cords.
- Since the completion of a study using NCIS data (which identified design issues contributing to fatalities in industrial workplaces), the National Occupational Health and Safety Commission (NOHSC) has been working with industry, unions and government agencies to develop a Safe Design Guideline. In addition, a series of seminars on safe design are being planned for presentation in various forums around the country.

10 | Document attachment/case closure statistics

During 2004/05, there was substantial progress made in terms of increasing the proportion of cases which are closed on the NCIS (allowing third party users to access detailed information about cases) and the number of full text documents attached to the system.

The percentage of open/closed cases on the NCIS and the percentage of full text documents attached to the NCIS at 30 June 2005 are detailed in Appendix 8.

Some summary items of interest arising from these figures are outlined below.

Achievements relating to the proportion of cases closed on the NCIS at 30 June 2005:

- There has been a significant increase in the percentage of cases reported in 2003 and 2004 which are closed as compared to June 2004 (from 64% to 85%, and 28% to 64% respectively).
- Half of the jurisdictions have a total case closure percentage of over 80%
- All states have an average of over 80% closure for all cases reported to a coroner prior to 2004.
- All Jurisdictions have > 95% closure rates for cases reported to a coroner in 2000
- All Jurisdictions have > 80% closure rates for 2001 & 2002 cases with the majority having > 90%
- All Jurisdictions have > 70% closure rates for 2003 cases
- Half of the jurisdictions have a case closure percentage of over 50% for cases reported in 2004.

It should also be noted that targets for the timeliness of data entry for case closure were agreed between NCIS and the managers of the coroners courts around Australia during 2004/5 (a target of no more than 60 days between finalisation of the case by the coroner, and case closure on the NCIS was agreed).

Achievements relating to the proportion of documents available on the NCIS at 30 June 2005:

- South Australian Autopsy and Toxicology reports are now available on the NCIS.
- Increased number of WA finding documents on the system (from 36% in June 2004 to 88% in June 2005).
- Increased number of SA finding documents on the system (from 7% in June 2004 to 50% in June 2005).
- Six of the eight jurisdictions which submit data to the NCIS have a police narratives attached to more than 90% of their cases.
- Victoria and the Northern Territory have the highest percentage of documents attached to cases.

It should also be noted that ABS codes have been added to the NCIS data set. These comprise of Australian Standard Geographical Codes (ASGC); Australian Standard for Classification of Occupation Codes (ASCO), and International Classification of Disease Codes (ICD-10).

10.1. Efforts to obtain additional reports for the NCIS during 2004/05

The NCIS Coronial Liaison Officer was engaged in discussions throughout the year with various coronial and forensic or health organisations to investigate the possibility of obtaining the following full text reports for the NCIS:

- Queensland Coronial Findings – Due to the relatively recent establishment of a State Coroners Office in Queensland, the central co-ordination and collection of coronial findings electronically is still in its infancy. NCIS has liaised with the Queensland Coroners Office to enable coronial findings from Brisbane to start being attached to the NCIS in early 2005/06.
- Queensland Autopsy and Toxicology reports – The NCIS has been liaising with the John Tonge Centre in Queensland to organise the transfer of autopsy and toxicology reports relevant to Queensland Coronial Cases to the national coroners database. The case management system at the John Tonge Centre has only recently been upgraded, which will allow the secure electronic transfer of these documents. It is expected these reports will become available on the NCIS in 2005/06.
- Autopsy reports from Tasmania's Launceston General Hospital – Discussions with Launceston General Hospital have also been undertaken to facilitate the electronic transfer of the autopsy reports produced by the Hospital to the NCIS. Pathologists from Launceston General Hospital agreed to transfer autopsy reports to the Tasmanian Coroners Office for attachment to the NCIS, and the technical issues concerning this process are currently being investigated.
- NSW Toxicology Reports - The implementation of a new case management system for the NSW Toxicology Laboratory during 2004/05 means it is likely that NSW Toxicology reports will be available on the NCIS during 2005/06.
- WA Autopsy Report cover sheets – A request for the attachment of the WA Autopsy Report cover sheets (which provide an overview as to the medical cause of death) has been made by the NCIS to the WA Coroners Ethics Committee. NCIS are currently awaiting the outcome of this application.

10 | Document attachment/case closure statistics continued

- Victorian Country autopsy reports – A presentation to Pathologists from Country Victoria (see section 6.1.3) concerning the transfer of country autopsy reports for attachment to the NCIS received a positive response, with agreement from those in attendance that reports will be electronically transferred to allow attachment to the NCIS.

10.2. Other related developments during 2004/05

The introduction of the Health Records and Information Privacy Act in NSW resulted in the NSW Department of Forensic Medicine ceasing the transfer of NSW Autopsy reports to the NCIS in February 2004. Consequently during the 2004/05 year, no NSW autopsy reports were received from the NSW Department of Forensic Medicine. Efforts by NCIS staff were made to resolve this issue, involving liaison with the NSW Department of Health, the NSW Privacy Commission and the NSW Attorney-Generals Department. In July 2005, this issue was resolved and the transfer of autopsy reports from the NSW Department of Forensic Medicine recommenced.

NSW Police narratives – Since March 2004, NSW police indicated they would no longer extract police narrative information from the COPS system. As such, no police narratives from NSW have been attached to the NCIS since March 2004. During 2004/05 the NCIS provided assistance to the NSW Attorney-Generals Department to encourage the adoption of an electronic police form for reporting death to the coroner within NSW Police. Whilst this possibility is investigated, the NCIS undertook several other activities during the financial year in order to process

the backlog of NSW police documents. These included extracting police narrative information from NSW Autopsy reports, and manual attachment of previously extracted COPS narratives onto the database.

New South Wales coding of country cases – In December 2004, coder training was provided to various NSW country coroners courts to allow them to perform their own data entry for NCIS rather than sending the files to Glebe for NCIS processing. Since this time, there has been a noticeable improvement in case closure rates for these regions. This improvement has contributed to an overall increase in the number of NSW cases being closed on the NCIS each month by over 50% (from an average of 162 per month preceding the training to 389 per month after the training).

Endnote

2 Does not include Qld data for 2000



The NCIS Quality Assurance team; Leanne Daking (left) and Tony Chan

11 | Local Case Management System Updates and Enhancements

During 2004/05, the Local Case Management Systems (which all states and territories excepting NSW and VIC enter NCIS data onto), were updated to include several new fields. These new fields included a flag to identify medical certificate cases, fields to identify cases that have been transferred from other states, and fields to clarify the date the coroner completed the investigation. These changes should allow better identification and removal of medical certificate and duplicate cases from the NCIS. It will also allow improved monitoring of the timeliness of data entry once a coroner has finalised a case.

Specialised enhancements were also made upon request to the South Australian Local Case Management System and an upgrade of the Western Australia database copy utility was made.

12 | International Relationships/ Usage of the NCIS

A number of requests to access the NCIS were received in 2004/05 from international coroners.

UK Coroner Chris Dorries was granted access to the NCIS for the purposes of increasing international awareness of the system in 2003/04, and HM Dorries provided a demonstration of the NCIS to the UK Home Office in late January 2005.

In May 2005, the NCIS received direct access applications from New Zealand and Norfolk Island coroners.

Ongoing discussions and information exchange continued during 2004/05 with the Canadian Bureau of Statistics (who are developing a Coroners/Medical Examiners Database) and the Centre for Disease Control in the United States (who are developing a National Violent Death Reporting System).

13 | Drugs Module Project Update⁴

A pilot project for the collection of additional information about drug related fatalities for the NCIS is to be undertaken in Victoria during 2005/06. Upon review of this pilot project, it is likely a new proposal to the Australian Department of Health and Ageing will be made concerning the funding of a similar collection process for additional drug information on a national basis. It is expected that all toxicology laboratories should now have the functionality to be able to contribute such information to the NCIS.

Endnote

⁴ The implementation of an additional module about drug related fatalities was a project separately funded by the Australian Department of Health and Ageing in 1999/2000. Due to technical limitations in toxicology laboratories at the time of the project, full implementation of the specifications for the project was not possible. In 2004/05, the Australian Department of Health and Ageing instructed that the remaining funds allocated to the Drugs Module Project (\$130,997) were to be incorporated into the NCIS core funding revenue, as this amount would comprise part of the Commonwealths funding contribution to the NCIS for 2004/05.

14 | National Police Form Project Update⁵

As at 30 June 2005, five out of the eight states/territories around Australia were using a version of the National Police Form to Report a Death to a Coroner. These states /territories are: South Australia, Tasmania, ACT, Queensland, and the Northern Territory. Victoria and NSW are considering full implementation and a pilot of the form respectively.

This standardisation of the police reporting of death form should allow for improved comparability and consistency of the information collected by police and provided to the coroner about reportable deaths.

In 2005/06, the remaining funds allocated to this project by the Department of Health and Ageing (\$14,160) are to be expended on a pilot program to determine the feasibility of automated extraction of the information on the electronic police forms into new fields on the NCIS. This would allow NCIS users to search upon the extra variables that are now being collected by police about certain types of fatalities.

Endnote

5 This project has been funded by the Commonwealth Department of Health and Ageing, and involved the development of a standard form for police around Australia to use when reporting a death to the coroner. Previously, each state and territory had their own individual forms, which collected varying levels and types of information about each death. A standard template form was developed in consultation with pathologists, coroners, researchers, police and other stakeholders in 2002/03. The development of a national police form should hopefully result in collection of extra information by the police at the initial investigation of a fatality, which will benefit pathologists and coroners. At a later stage, this additional information will also benefit researchers and policy makers. A national data set will also result in the standardisation of information that is provided to a coroner by police.

15 | Preparation of future enhancements paper

A paper concerning a number of possible future enhancements for the NCIS was developed in 2004/05 by the NCIS Manager. Possible system enhancements addressed in the paper included geo-coding address information; graphing and mapping the trends and location information on the NCIS; natural language querying; trend analysis tools; automatic case notification, and the capture of responses to coronial recommendations.

This paper was presented to the NCIS Committee, VIFM Council and NCIS Board of Management for review and consideration in July 2005. These enhancements have been subsequently endorsed.

16 | Financial reports

In 2004/05 the NCIS continued to receive the majority of its income from government funding. Government funding in 2004/05 was received from each State and Territory Government, and four Commonwealth government agencies (being the Australian Department of Health and Ageing, the Australian Department of Employment and Workplace Relations, the Australian Institute of Criminology, and the Australian Competition and Consumer Commission).

The government funding provided to the NCIS in 2004/05 was based upon the three year funding agreement made with the Victorian Institute of Forensic Medicine from 2003/04.

In its second year of operation, income from the user pays system was also received in 2004/05. Fees received covered third party NCIS users purchasing online subscriptions, data extracts, and information request services.

The largest areas of expenditure for the NCIS during 2004/05 continued to be for the purchase of IT services (\$280,880) and employee salaries and entitlements (\$218,389 and \$45,648 respectively).

16.1. Core operational funding

NCIS expenditure and revenue are included as part of the Victorian Institute of Forensic Medicine audit.

NCIS Core Operational Funding and Expenditure for 2004/05 is detailed in Table 6.

Of the \$1,058,296 income received by the NCIS in 2004/05, detailed statements concerning the source of government contributions and user pays income are presented in Tables 7 & 8.

Table 6. NCIS Core Operational Funding and Expenditure

Balance Bought Forward 2003/04	\$158,957#
Revenue	
Government Funding	\$967,696
User Pays income	\$90,600
TOTAL REVENUE	\$1,058,296
Expenditure	
Salaries	\$218,389
Employment Related Expenses	\$45,648
Travel, Entertainment & Personal Expenses	\$11,368
Printing, Stationery & Other Office Expenses	\$7,187
Postage & Communication	\$1,332
Contractors & Consultants	\$19,535
Staff Training & Development	\$2,180
Other Operating Expenses	\$1,115
Information Technology	\$280,880
Depreciation	\$5,625
Utilities & Services ¹	\$32,700
TOTAL EXPENDITURE	\$625,959
NET OPERATING OUTCOME	\$432,337
BALANCE CARRIED FORWARD	\$591,294²

Notes for table 6

Funding contributions for the 04/05 year from NSW, VIC, and QLD were reduced by \$77,000 in total from the original contribution totals outlined in the 'Evaluation of the Funding Requirements of the NCIS' paper prepared by Vic DOJ in 2003, to recompense them for user pays income derived in 2003/04 from specified government agencies within their jurisdiction. Therefore the amount in brackets indicates the originally agreed contribution amount from each agency for 2004/05.

¹ Note: Utilities and services consists of funds provided to VIFM to cater for NCIS expenses in relation to maintenance, rent and property services, property utilities, audit services and HR and accounting services

² The NCIS Board of Management approved the expenditure of \$265,000 of the Balance Carried Forward funds at the July 2005 Board Meeting for system enhancement projects, assistance to coroners offices with data entry of backlog cases, and the costs of the triennial finding review.

Table 7. Government Contributions made in 2004/05

Agency	Amounts Received	Original Amount agreed#
Commonwealth*	\$593,940	\$374,040
Victoria**	\$145,126	\$92,505
New South Wales	\$85,660	\$126,580
Queensland	\$60,270	\$69,270
South Australia	\$26,960	\$29,690
Western Australia	\$36,240	\$36,240
Tasmania	\$9,580	\$9,580
ACT	\$6,250	\$6,250
NT	\$3,670	\$3,670
TOTAL	\$967,696	\$748,095

Notes for table 7

* Commonwealth Government agencies are: Department of Health and Ageing; Department of Employment and Workplace Relations; the ACCC, and the Australian Institute of Criminology. The amount received by the Commonwealth in 2004/05 includes \$219,900 from the Department of Health and Ageing for the 2003/04 contribution which was received in June 2005.

**The Victorian contribution received in 2004/05 includes \$76,621 for the 2003/04 contribution which was received in July 2004.

In its second full year of implementation, the NCIS User Pays system generated \$90,600 in 2004/05. Table 8 outlines the types of services purchased. Appendix 9 provides a list of those agencies which purchased services during 2004/05. It should be noted that the figures represented here are only those services purchased under the user pays system, and as such, do not include services provided to coroners or death investigators.

Table 8. Products purchased in 2004/05

Type of Product Purchased	Number Purchased	Income Generated
Online subscription	21	\$86,750
Data extract	-	-
Information Search	25	\$3,850
TOTAL	46	\$90,600

16.2. Other projects funding

Drugs Module

The total remaining balance allocated to the Drugs Module Project of \$130,997 was transferred in July 2005 to NCIS core revenue, as directed by the Australian Department of Health and Ageing. This amount will comprise a proportion of the Commonwealth 2004/05 core funding contribution. Further discussions as to future funding for a national drugs module enhancement for the NCIS are to be held after 2005/06.

Table 9. National Minimum Dataset Project (including water related deaths)

Income	\$
Bought forward 2003/04	\$14,160
Expenses	Nil
BALANCE	\$14,160

Note: the remaining balance allocated to the National Minimum Data Set project will be expended in 2005/06 on a pilot program to assess the feasibility of automatic data extraction from the electronic police form for reporting of death to a coroner, into additional fields on the NCIS.

Appendix 1 – Governance structure

National Coroners Information System Governance Framework

Governance Arrangements

The new governance arrangements for NCIS are detailed in Figure 1. The bodies referred to in Figure 1 will perform the roles and responsibilities detailed in this document.

Definitions

Commonwealth Users Group means the Commonwealth Department of Health and Ageing; the Commonwealth Department of Employment and Workplace Relations; the Australian Institute of Criminology; the Australian Competition and Consumer Commission.

NCIS means the National Coroners Information System.

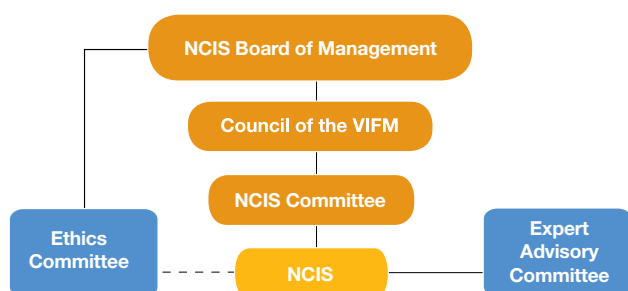
National Justice CEO's means the Chief Executive Officers of the Attorney General or Justice Departments in each State and Territory, as appropriate.

Participating Jurisdictions means Victoria; Australian Capital Territory; South Australia; Queensland; New South Wales; Western Australia; Northern Territory; Tasmania.

SCAG means the Standing Committee of Attorneys-General

VIFM means the Victorian Institute of Forensic Medicine

Figure 1. Revised Governance Arrangements for the NCIS



The VIFM Council will create the NCIS Committee to assist in the management of the NCIS and to provide high level support to the NCIS Manager. The NCIS Committee will be subject to oversight by the VIFM Council. The VIFM Council will report to the NCIS Board of Management.

NCIS Board of Management

The NCIS Board of Management ('NCIS Board') will oversee the operations of the NCIS, ensure the effective and efficient management of funds, monitor the strategic direction of the NCIS, and assess the policies and performance of the NCIS.

It is expected that the NCIS Board will meet face to face twice a year, and meet as required by teleconference during the course of the year.

The NCIS Board comprise representatives of the Commonwealth and each State and Territory in the following manner:

- One representative from the Participating Jurisdictions as nominated by each of the National Justice CEO's.
- One representative from the Commonwealth Users Group.

The NCIS Board will undertake the following functions:

- Determine by agreement with the VIFM, the work program and priorities of the NCIS on an annual basis.
- Monitor the progress and output of the NCIS and the allocation of resources in achieving the objectives of the work program.
- Approve the policies and strategic direction of the NCIS.
- Report annually to SCAG on the operation of the NCIS and to furnish to SCAG such reports as may be required relating to the operations and achievements of the NCIS.
- Coordinate an independent review and evaluation of the NCIS on a triennial basis, to be completed at least six months prior to the end of each three year funding period. The terms of the review and the engagement of an independent reviewer will be determined by the NCIS Board.

The NCIS will be funded on a triennial basis, and at least three months prior to the end of each three year funding period (or at whatever time required by SCAG to fit in with funding cycles) the NCIS Board will report to SCAG on the results of the independent review, and its recommendations on a further three year funding agreement.

NCIS Committee

The NCIS Committee will provide high level advice and support to the NCIS Manager concerning operational, strategic, financial, and human resource aspects of the NCIS.

The NCIS Committee will be composed of representatives from:

- VIFM (two representatives)
- Australasian Coroners Society (two representatives)

- Injury Prevention community (one representative)
- NCIS (the NCIS Manager)

The NCIS Committee will meet on a quarterly basis and provide quarterly reports to the VIFM Council.

VIFM Council

The VIFM Council will furnish to the NCIS Board the following reports:

- An annual report on the administration, functioning and achievements of the NCIS;
- A biannual report on expenditure against budget, progress of the business plan, any proposed changes to the strategic direction of the NCIS, or proposed enhancements to the NCIS;
- Any such other report or reports as the NCIS Board may request from time to time.

Expert Advisory Group

This group will be created to provide a forum for NCIS users and interested parties. Its role will be to provide feedback on technical and usage issues associated with the NCIS and make any recommendations as to the further development of the system. This group however will not be involved in the governance of the NCIS.

Ethics Committee

A formal ethics committee is an essential part of the management of the NCIS for the following reasons:

- All research projects that relate to humans must be considered by an ethics committee governed by NHMRC (National Health and Medical Research Committee) guidelines.
- The government will be protected by having controls in place that are in line with the NHMRC guidelines pertaining to third party access to sensitive government information about deceased individuals.
- State and Territory Coroners confidence in the independence and transparency of processes in determining access of third parties to coronial data will be maintained.
- Any appearance of a potential conflict of interest will be reduced, in that the body that obtains revenue from the authorisation of new users does not have sole decision making responsibility as to who can receive access.
- The likelihood of complaints from next of kin or other interested parties with regard to information about their loved ones will be reduced as access has been governed by standard nationally approved controls.

NCIS applications under the revised governance framework will be considered by either the VIFM Ethics committee, or the Victorian Department of Justice Ethics Committee.

Appendix 2 Launch of a national safety campaign on working under vehicles

A national safety campaign concerning working under vehicles was launched on February 18 2005 by the Federal Minister for Ageing, Julie Bishop. This joint campaign by the Australian Department of Health and Ageing and the ACCC was prompted by new figures from the NCIS which showed that 19 home mechanics died in Australia over the past four years as a result of incidents associated with the incorrect use of jacks. As part of this campaign, a safety alert brochure has been produced and can be downloaded from the ACCC website at www.accc.gov.au

Appendix 3 Third party testimonials

Social and Demographic Statistics, Australian Bureau of Statistics

"The NCIS system is an effective and efficient access point to data the ABS requires for coding external causes of death across the State and Territory jurisdictions. It has proven to be an invaluable aid with regard to mortality coding undertaken by the ABS, saving significant time and staff resources both in the Health and Vitals Statistics Unit in Queensland, and in other ABS locations. Prior to the availability of NCIS, ABS staff had to physically obtain the information from files at Coroners' offices in each State/Territory

The quality of national cause of death data produced by the ABS has been enhanced by the consistent use of one database across all jurisdictions. There has also been a definite decrease in the number unresolved queries in the previous processing years. Just one example where there was significant improvement was in the clear up rate for fractures in the elderly."

Tara Pritchard

Director, Social and Demographic Statistics
Australian Bureau of Statistics, June 2005.

Drugs Policy and Services, Victorian Department of Human Services

"...thanks for the fantastic service you all provide. We're getting a lot of use out of this data, and hopefully it will lead to preventing some of these tragic and unnecessary deaths."

Dr Malcolm Dobbin

Senior Medical Advisor, Drugs Policy and Services,
Victorian Department of Human Services, December 2004

Blind Makers Association of Australia

"In January 2003, the Office of Fair Trading in NSW imposed on the window furnishing industry a regulation to prevent children strangling themselves in looped operating cords.

The industry had no knowledge of any such tragedies and as such were unaware of the background to these incidents.

Using information from the NCIS, I was able to tell the principals of some of the largest blind manufacturers in Australia that children had in fact died, and was able to relate the circumstances of some of the cases in such a way that we could all be motivated to do our best to minimise risks in the future.

It has made our job of selling the need for a safety first approach to blind loops to our members, and they in turn to their staff and customers, much easier."

Peter Schweinsberg

Safety Officer, Blind Makers Association of Australia,
September 2004

Elmatom Pty Ltd.

"The National Coroners Information System is the most innovative and comprehensive initiative anywhere in the world to make use of Coroners' information, and should underpin all major research initiatives into fatal injury in Australia."

Dr Tim Driscoll

Elmatom Pty Ltd, November 2003

Senior Deputy State Coroner, New South Wales

"Just Brilliant! Thank you so much for taking the time to do that [search on deaths involving logging incidents] for me.....absolutely invaluable!"

It's great to see the worth of your wonderful program in action. Well done!

Jacqueline Milledge

Senior Deputy State Coroner, New South Wales,
April 2003

Epidemiology and Surveillance Branch, NSW Health Department

"Currently the NSW Department of Health relies on data from the Australian Bureau of Statistics for information on the number of deaths and their causes. The National Coronial Information System has the potential to provide richer and more timely information than is currently available, and will improve the Department's ability to monitor the occurrence of unnatural deaths, implement programs targeting relevant risk factors and evaluate prevention programs."

Lee Taylor

Manager, Surveillance Methods, Epidemiology and Surveillance Branch, NSW Health Department,
November 2002

Appendix 3 Third party testimonials continued

Accident Research Centre, Monash University

“NCIS is unique and Australia is the envy of every country where I have presented injury data and research in recent years, including the United States, Canada, the United Kingdom, Sweden, The Netherlands, New Zealand and other Asian Pacific countries.”

Professor Joan Ozanne-Smith

Chair of Injury Prevention, Accident Research Centre,
Monash University, November 2002

Research Centre for Injury Studies, Flinders University, South Australia

“I am writing to let you know that we are finding the information from the NCIS to be very useful. We are able to study the topic of interest (alcohol and water safety) in ways that go beyond what we could do with any other practicable source. We have been able to undertake this part of our project quickly (ie within a few weeks), once we obtained access to the relevant set of NCIS records.”

Professor James Harrison

Research Centre for Injury Studies, Flinders University,
South Australia, November 2002

Victorian Attorney-General

“The NCIS represents a world first in providing an Internet accessible database of coronial information across Australia. Coronial data is a rich source of information about the causes of preventable deaths in this country. (The NCIS) will provide a means of accessing data in a timely way and will increase the potential for coronial information to contribute to a reduction in preventable death and injury in Australia and in doing so, it will reduce both the emotional and financial burden of lost life in our community. The NCIS will revolutionise the way we investigate and respond to preventable deaths in Australia”.

The Honourable Rob Hulls

Victorian Attorney-General, NCIS Launch, August 2000

Appendix 4 Comments from Vic Parliamentary Review Submissions

Comments made about the NCIS in submissions to the review of the Victorian Coroner's Act

Attendees were impressed in regards to the establishment of the National Coroners Information System (NCIS). It was considered an important tool for identifying similar deaths and perhaps could be strengthened. This could be done by extending it to cover areas as previously discussed to strengthen the death certification process.

Ms Emilia Arnus

Convenor, Representing Constituents of East Yarra
Provence

The discussion paper raises the issues of how effective the current systems for identifying similar kinds of deaths are, such as the National Coroners Information System and whether there are resource issues in relation to this System.

It would be advisable that current systems for identifying similar kinds of death be given as much resources as possible by Government and that such information be available on line or disseminated on a regular basis to interested groups such as the Australian Nursing Federation. For nurses, this information may be used because if they are able to readily identify similar kinds of deaths occurring in certain circumstances through a central database or information system which is readily accessible, then extra care can be taken in their duties whilst at work.

In this regard, the information system should be easily accessible and all Coroners should use this system when investigating deaths so that previous cases can be easily traced and identified by researchers. There is no requirement presently under the Act which will obligate Coroners identifying cases of similar kinds of death in similar circumstances. If this occurred, researchers would then be able to examine those past cases and identify the most common risk factors leading to certain deaths. This may be useful in professional perspective for the ANF and its member nurses.

Jill Clutterbuck

Senior Professional Officer, Australian Nursing Federation
(ANF) – Victorian Branch

We are aware that deaths in similar settings are reported to our office. We believe that a system for identifying similar kinds of deaths such as the National Coroners Information System is very important.

Ms Kathryn Booth

Principal, Maurice Blackburn Cashman Lawyers

Unfortunately, the current systems offer insufficient information for health care providers. Industry would benefit from the provision of timely, readily accessible de-identified data. Information, such as data examining the frequency of particular events and the associated learnings, would greatly assist organisations with the development and implementation of systems changes to improve patient safety. This would provide a platform for organisations to share their experiences and subsequent outcomes from implementing Coronial recommendations.

Dr Mark Garwood

Chief Medical Officer, Austin Health

Overall the current systems for identifying similar kinds of death on the National Coroners Information System (NCIS) are very effective. The information provided is highly useful for Life Saving Victoria to establish preventative strategies for drowning incidents. The up-loading of relevant documents and insertion of key information for identification of similar deaths onto the NCIS in Victoria is very efficient. Comparatively, documents up-loaded and information on relevant cases in other states is less timely, most probably due to a lack of staffing and resources. The timely identification of deaths Nationwide is imperative to allow organisations such as Life Saving Victoria to identify emerging trends and thus instigate preventative actions promptly. In particular, prompt addition onto the NCIS of information contained in Police Reports for the Coroner (Form 83s) would be most useful for flagging relevant cases that may require follow-up to help prevent further unnecessary deaths. The intended addition of certain coded fields to NCIS provided by the ABS, for example, ICD-10 Cause of Death codes would also be most beneficial to more clearly identify similar kinds of death.

The ability to consistently retrieve all relevant cases on the NCIS may be hindered, not only by the lack of coded data entered onto the system in a timely manner but also by variations in the coding of data. While there is an extensive coding system providing detailed information to users, there is a lack of consistency in the coding of similar cases and from State to State. This may be due to variations in the interpretation of information provided which may in turn be a resource issue due to a lack of continual training of staff, and/or due to the variation in the nature and level of detail in reports.

The inclusion of additional documents on the NCIS pertinent to the identification of similar kinds of deaths and further information relating to the circumstances and contributing factors relating to such deaths (e.g., Work Cover reports) would also be useful. This would allow clearer trends to be determined for the prevention of deaths or injuries under similar circumstances based on all available evidence.

Appendix 4 Comments from Vic Parliamentary Review Submissions continued

Additional resources are required to improve the timeliness of the input of information and up-loading of documents onto the NCIS. As discussed above, such early identification of similar cases would allow organisations to respond in a timely fashion to initiate preventative measures.

Of the Victorian deaths examined by Life Saving Victoria it is evident that as the amount of information on the system increases so too has the referral by Coroners to similar kinds of deaths. Coroners are also reiterating and reinforcing where necessary any previous recommendations or comments made by other Coroners.

Dr Bernadette Matthews
Manager Research, Injury Prevention and Health Promotion, Life Saving Victoria – Royal Life Saving

The Federation supports the use of a database as an essential tool to assist coroners with their work.

The database provides coroners with information about deaths occurring in other parts of the country. It allows coroners to identify patterns in preventable deaths which, on the bases of the limited information within an individual coroner's jurisdiction, might otherwise go unnoticed. The database also reduces repetition of work. For example, one coroner might not hold an inquest into a particular type of death if s/he knows that a coroner in another state has already investigated that type of death in detail and that the lessons in terms of death prevention have already been learned.

The Federation notes the following concerns that have been raised with NCIS:

- NCIS has had teething problems.
- Wrong codes have been applied to variables, so that results are not entirely accurate.
- Short comings relating to analyses of suicides involving drugs – no codes relating to specific drugs used.
- Topics for general overview of injury surveillance do not include deaths in custody.
- Proper authorisation is required in order to access the database. Does a legal practitioner fit into the category of authorised bodies?
- NCIS does not include: transcripts of inquests, photographic evidence or statements by witnesses.
- How effective is the data collected when the definition of 'reportable deaths' differs from jurisdiction?

In order that the database is used to its full extent, the Federation supports comprehensive training for coroners about the database and the development of mandatory guidelines about its use. The federation also supports the database being made available online to parties involved

in an inquest and more generally to the public for research purposes.

Pauline Spencer
Executive Officer, Federation of Community Legal Centres (Vic) Inc

The National Coronial Information System (NCIS) is a national database of coronial information extracted from all coronial files of all Australian States and Territories – generally dating back to July 2000. The NCIS facilitates the role of coroners around Australia and other third party users in obtaining access to coronial data. It was developed by the Monash University National Centre for Coronial Information (MUNCCI) – a consortium of three bodies: the Monash University Department of Epidemiology and Preventative Medicine, the Victorian Institute of Forensic Medicine and the Monash University Accident Research Centre.

It appears that changes to the governance and management of the NCIS have recently resulted in the Victorian Institute of Forensic Medicine assuming responsibility for the management of the NCIS in 2005.

The IPA applies to the Victorian Institute of Forensic Medicine and to other Victorian agencies involved in the NCIS as bodies established for a public purpose by or under an Act.

The NCIS includes a signification amount of personal information, mainly, but not exclusively about deceased persons, including:

- Name, age, sex, date of birth, place of usual residence, marital status, indigenous identification of deceased;
- Date of notification of death;
- Period of residence in Australia, country of birth, employment status, usual occupation;
- Details of incident where work-related, time and location of incident, activity and time of incident, intent and mechanism of injury, object or substance involved, medical cause of death, vehicle type where motor vehicle-related, whether driver or passenger, and context;
- Full text reports including police narrative of circumstances, autopsy report, toxicology report, and finding.

Access to identifiable data and full text reports is available to 'level 1 users' – namely, coroners' officers, and any forensic scientists, pathologists or police officers assisting in coronial investigations. 'Level 2 users', e.g., media, private organisations, and other research agencies, are able to access non-identifying data sets.

State and Territory public sector agencies provide personal information to the NCIS under Licence and Access Agreements. These determine how the information is used by MUNCCI and accessed by third parties.

While some of the organisations participating in NCIS may be bound to comply with the IPA or similar laws in other jurisdictions, other recipient organisations may not be regulated by privacy laws. This may affect or make uncertain Victorian agencies' compliance with IPP9, which governs the sharing of personal information across state/territory and international borders.

New South Wales resolved this issue in 2002 by the New South Wales Privacy Commissioner making several public interest directions authorizing the disclosure of information by NCIS under section 41 of the Privacy and Personal Information Protection Act 1998. The current Direction authorises disclosures of personal information by NSW public sector agencies to the NCIS which would otherwise breach the Act. The authorised disclosures are subject to the condition that each public sector agency disclosing information is satisfied that the use and disclosure by MUNCCI is consistent with the Licence and Access Agreement, or similar agreement entered into between the agency and Monash University.

Under the Information Privacy Act 2000 the Victorian Privacy Commissioner does not have a function to make public interest directions. In this context, as in many others, it would be better if it did.

In the interest of ensuring coronial data (as it relates to living persons or, under the HRA, to deceased persons) is handled in accordance with appropriate privacy standards, I recommend that the NCIS project be given detailed, transparent and accountable legislative backing (in either the Coroners Act or other appropriate law). The IPA, which contains internationally applied standards for data quality and data security as well as access/disclosure standards, should apply, together with Privacy Commissioner (and Health Services Commissioner) oversight, augmented by a public interest directions power (a code of practice under Part 4 of the IPA may also be apt for NCIS).

Paul Chadwick
Privacy Commissioner, Office of the Victorian Privacy Commissioner

The National Coroners Information System has a very important role to play. This information should be widely available.

Beth Wilson
Health Services Commissioner

All information systems are only as good as the accuracy of the data fed into it and the processes for ensuring currency of its database. If all coroners are not updating information it will be problematic.

RCNA recommends that there be an auditing function in the Act to maintain the National Coroners Information System.

All information systems require resources – human and physical, to maintain such a system. Adequate resources to maintain the National Coroners Information System are necessary.

Rosemary Bryant
Executive Director, Royal College of Nursing Australia

The National Coroners Information System (NCIS) is managed by the Institute on behalf of the various State/Territory Departments of Justice and Australian Coroners. NCIS provides timely data on all coroners' cases in Australia to help coroners in investigations and to identify trends and patterns in problem areas. The database was established in July 2000 and there were about 95,000 cases recorded by July 2005. Researchers and government agencies also have access to the data for research and prevention purposes.

Graeme Johnstone
State Coroner, State Coroner's Office

Appendix 5 List of NCIS advisory group members

As at June 2005

Angela Clapperton - Monash University Accident Research Centre
Paul Halliday - Commonwealth Department of Employment & Workplace Relations
Maria Bachelor - State Coroner's Office (VIC)
Jacqueline Joudo - Australian Institute of Criminology
Rebecca Scott-Bray - State Coroners Office (VIC)
Mandy Keating - Department of Human Services (VIC)
Rebecca Mitchell - Injury Risk Management Centre (NSW)
Gary Shapcott - Australian Transport Safety Bureau
Richard Franklin - Royal Life Saving Society of Australia (National branch)
Steven Young - Australian Transport Safety Bureau
Dean Bloom - Australian Bureau of Statistics
Penny Irvine - NSW Child Death Review
Geoff Henley - National Injury Surveillance Unit
James Harrison - Flinders University (SA)
Ros Higgins - Australian Bureau of Statistics
Lyndal Bugeja - Royal Life Saving Society of Australia (VIC)
Tim Driscoll - Elmatom Pty Ltd. / University of Sydney
Jenny Mouzous - Australian Institute of Criminology

Appendix 6

Information Request topics

- All deaths in a certain Local Government Association (LGA)
- Brisbane falls from Buildings
- Child deaths from blind cord strangulation
- Child deaths from choking on toy parts
- Coronial deaths for Residents of Stonnington, Banyule, Hume LGA's
- Dairy related deaths
- Deaths originating from fires caused by cigarettes
- Ecstasy
- Electrical fatalities in NSW
- Heroin related deaths in a certain LGA
- Home safety/disability related fires
- Intentional Self Harm deaths associated with antihistamines
- Intentional Self Harm (Grampians)
- NSW electrical fatalities
- NSW rock fishing deaths
- Potassium Chloride
- Product related deaths
- Queensland drowning cases
- Recommendations concerning paediatric deaths in hospitals
- Rockfishing (including fatalities update)
- SA Opioid deaths
- SA opioid fatalities
- Sporting related deaths
- Stolen Vehicles
- Suicides by Fall in Brisbane City
- Suicide deaths in over 16 yrs olds
- Suicide deaths in Vic 16-30yr males
- Suicide deaths within a certain LGA
- Suicides of patients on leave from care
- Swimming Pool drownings
- Timber/tree hazards
- Victorian suicides
- Workplace related deaths

Appendix 7 List of coroners/death investigators request topics

- Anaphalactic reaction to Voltarin
- Aviation – mechanical problems
- Baby bath deaths
- Buprenorphine
- Child Falls from a height
- Deaths involving Clozapine
- Deaths involving pulmonary thrombo-embolisams in young or downs syndrome cases
- Distracted drivers
- Drowning in Spas and Baths
- Elderly residents absconding from secure facilities
- Farm Deaths
- Faulty pool gates
- Free Dive Drowning
- Hang gliding fatalities
- Hanging deaths (identification of lung weights of deceased).
- Hypo-plastic adrenal glands
- Infant overlay deaths
- Intentional Self Harm
- Intentional Self Harm deaths in a particular region
- Learner driver MVA's
- Logging
- MVA's between car and bicycle
- MVA's involving mobile phone use
- MVA's where driver was epileptic
- Natural cause truck driver fatalities
- Neck fractures due to hangings
- Overhead Powerlines
- Percutaneous Endoscopic Gastronomy (PEG) Tube
- Perforation by swann ganz catheter
- Police shootings
- Police use of capsicum spray
- Probationary drivers and MVA's
- Rockfishing
- Restraint deaths
- SIDS and IVF
- Suicides
- Suicides soon after refusal to admit into medical care
- Taxi drivers & seat belts
- Trees falling on caravans
- Ultralight aircraft deaths
- Update of ATV/Quad bike deaths
- Update of deaths involving augers
- Unidentified remains
- Vioxx or Celebrex related deaths
- Work related runovers

Appendix 9 Organisations invoiced under User Pays System in 2004/05

Organisation	Product Purchased
VICTORIA	
Support After Suicide	Information Search
Maribynong City Council	Information Search
VicRoads	Online subscription
University of Melbourne	Information Search
Victoria Police (Drug and Alcohol Strategy Unit)	Online subscription
Transport Accident Commission	Online subscription
Individual member of public	Information search
University of Ballarat (School of Behavioural and Social Sciences and Humanities)	Information search
Insight Social & Health Research	Information search
InteRisk	Information search
Victorian Farm Safety Centre	Information Search
Department of Sustainability and Environment (Vic)	Information search
Russell Kennedy Solicitors	Information Search
Blake Dawson Waldron	Information Search
NEW SOUTH WALES	
Northern Sydney Health	Information Search
NSW Dept of Sports and Recreation	Information Search
NSW Maritime Authority	Information Search
NSW Institute of Trauma and Injury Management	Online subscription
NSW Office of Fair Trading	Information Search
University of Sydney (School of Public Health)	Information Search
SOUTH AUSTRALIA	
Drug and Alcohol Services Council (SA)	Online subscription
Department of Health, SA	Information Search
AUSTRALIAN CAPITAL TERRITORY	
The Canberra Times	Information Search
ACT Health (Alcohol and Other Drugs Unit)	Online subscription
ACT WorkCover (OHS Inspectorate)	Online subscription
ACT Health (Office of the Chief Health Officer)	Online subscription

Appendix 9 Organisations invoiced under User Pays System in 2004/05 continued

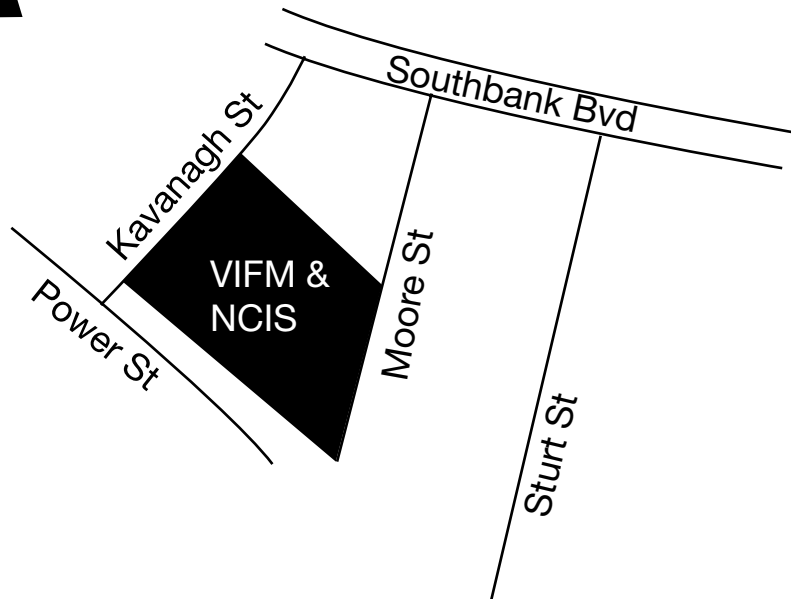
QUEENSLAND

Product Safety Unit, Department of Tourism, Racing and Fair Trading	Online subscription
Queensland Alcohol and Drug Research and Education Centre	Information Search

NATIONAL

BlindMakers Association of Aust	Information Search
Royal Life Saving Society of Australia	Online subscription
Australian Nursing Federation	Information Search
Motor Vehicle Theft Reduction Council	Information Search
Australian Transport & Safety Bureau	Online Subscription
National Drug and Alcohol Research Centre	Online Subscription
The Royal Australian and New Zealand College of Psychiatrists	Information Search
Surf Life Saving Australia	Online subscription
Divers Alert Network S.E. Asia-Pacific	Online subscription
Australian Centre for Agricultural Health and Safety	Online subscription
National Drug and Alcohol Research Centre	Online subscription
Woolworths Risk and Safety Department	Information Search
Productivity Commission	Information Search

Where to find the NCIS



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