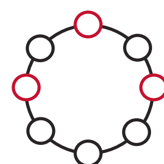
NATIONAL CORONERS INFORMATION SYSTEM

ANNUAL REPORT 2011-12



NCIS

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1. DIRECTOR'S REPORT

A main focus for the NCIS Unit during 2011-12 involved preparation for the transition of management from the Victorian Institute of Forensic Medicine ('VIFM', which has managed the NCIS since 2005) to the Victorian Department of Justice ('the Department') from 1 July 2012. Along with this change in management, a new governance structure was put in place, with adjustments made to the NCIS Board of Management composition and a newly formed Advisory Committee to be established.

These changes arose from a review of the NCIS, requested to be undertaken in 2010-11 by the NCIS Board of Management ('the Board') in order to examine the future governance and strategic direction for the NCIS. The significant contribution that the VIFM has made in developing, supporting and managing the NCIS was acknowledged by the Board, however it was considered that the future of the system would be strengthened if it was managed by a State Government Department. The composition of the NCIS Board of Management was also recommended for change, with the addition of a public health and State/Chief Coroner representative to the Board.

Legal, operational and support activities surrounding this transfer comprised a significant component of NCIS management time during 2011-12. I would like to extend my thanks to the Department's Planning, Performance, and Projects Unit which managed the implementation of the transfer, and the VIFM Executive which provided much assistance and support during the transfer process.

I am pleased to say that the transfer of NCIS management and governance proceeded smoothly on 1 July 2012, with no noticeable disruption to services provided to authorised NCIS users. The NCIS Unit staff remain in place to continue to manage and develop the system, and provide support to users under the new structure. The NCIS Unit also remains housed within the Coronial Services Complex at Southbank, in order to continue to be co-located in the hub of coronial, medical and scientific forensic activity in Victoria.

Despite the major focus of the governance transfer during 2011-12, the NCIS Unit was still involved in a number of activities designed to keep the system progressing. Technical work commenced on upgrading the local case management systems to ensure future stability, and the NCIS Unit worked with a number of stakeholder agencies to assist with data validation projects, to discuss issues associated with wider publication of mortality data, and to provide training and guidance to assist with case identification.

While the VIFM is still to be involved in providing IT support for the NCIS, the management change has required a new Director from within the Department to be appointed. Therefore while my official appointment to the NCIS ceased from 1 July 2012, I will continue to make a contribution to the system as a member of the new Advisory Committee. I am sure the newly appointed NCIS Director, Neil Twist, will bring new skills and perspectives to this unique data system to ensure, through strong governance, that it is well positioned to move securely into the next phase of its development.

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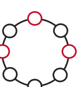


2. BENEFITS TO THE COMMUNITY

During 2011-12, data sourced from the NCIS contributed to improving the safety of the community in a number of ways. These included:

ASSISTING IN DEATH INVESTIGATIONS

During 2011-12 the NCIS Unit processed 55 data requests from coronial offices and other death investigators, and data from the NCIS was referenced in 15 coronial findings delivered during 2011-12.[1] In the majority of these findings the coroner made recommendations designed to prevent similar deaths and injury in future.

Use of coronial data to inform criminal investigations is a new but potentially important contribution the NCIS can make towards the community. In the case of Gilham v R [2012] NSW CCA 131 (25 June 2012) the NSW Court of Criminal Appeal made particular reference to NCIS data and the way it contributed to the evidence before the court. In its judgment, the Court referred on three occasions to the analysis, by a forensic pathologist, of data from NCIS, in relation to multiple homicidal deaths from stab wounds, and the numbers and locations of stab wounds in cases of homicides by stabbing. Such data was a central aspect of the conclusions relevant to the acquittal on appeal of an individual who had been previously convicted of a triple murder.

The death of Azaria Chamberlain has been subject to a number of legal proceedings in both criminal and coronial courts. In a finding handed down on the 12 June 2012, the Northern Territory Coroner specially referenced a report from the NCIS which outlined the numbers of deaths which were caused by animals, a matter of some particular significance to the coroner's deliberations.

1 Eight (8) coronial findings made direct reference to statistics from the NCIS in the coronial finding, an additional seven (7) findings made reference to statistics from the start of the NCIS data set (i.e. July 2000) indicating NCIS was the likely source.

INFORMING POLICY, AWARENESS CAMPAIGNS AND PRACTICAL CHANGE

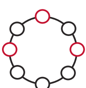
A number of practical research outcomes and government safety campaigns were directly influenced by access to NCIS data during 2011-12.

The University of NSW published findings from their examination of coronial data about injuries sustained by deceased involved in a vehicle rollover (see section 9). This research was able to determine a direct causal link between roof crush and spinal neck injuries, and that a majority of those injuries appear to be basil skull fractures. An Australian Research Council linkage grant to develop a Dynamic Rollover Occupant Protection was secured by UNSW as a direct result of this work, as was another grant to build a dynamic test rig which will be used to rate the crashworthiness of vehicles. Both these initiatives should result in an improved understanding of the relative safety of existing vehicles in terms of rollover protection, and inform future design developments to lessen the injuries sustained in rollover vehicle incidents.

A nation-wide safety campaign by the ACCC "Don't be a Jackass" was launched in October 2011 on the basis of data sourced from the NCIS which showed that at least 46 people have died whilst working under a vehicle over the past 10 years.

During 2011-12 the ACCC has also continued to facilitate working groups to address safety issues associated with the use of Motorised Mobility Scooters [MMS]. This includes working with Standards Australia to develop a voluntary Australian Standard surrounding these products. This concern about MMS was confirmed by a Monash University study using NCIS data in April 2011 which showed that at least 62 people had died while using Motorised Mobility Scooters over a 10 year period.

"This research was able to determine a direct causal link between roof crush and spinal neck injuries, and that a majority of those injuries appear to be basil skull fractures."



EXAMPLE REFERENCES TO NCIS DATA IN CORONIAL FINDINGS

In relation to a death involving an all-terrain vehicle:
"A review of the National Coroners Information System database would indicate that over the past 10 years, 141 all-terrain vehicle/quad bike deaths have been identified" (QLD finding, 2011).

In relation to a death involving a mobile elevating work platform:
"A search on the National Coroners Information System (NCIS) and news reports identified six interstate deaths...." (VIC finding, 2011)."

Data from an NCIS fact sheet produced in April 2011 about emergency lane deaths encouraged the formation of an industry "Roadside Breakdown Working Group", and an article in the motoring magazine "RACT Journeys" (Feb/Mar 2012) about safety issues relating to stopping a vehicle by the roadside.

During 2011-12 the NCIS conducted an internal 10 year analysis of suicide deaths in South Australia for the SA State Coroner's Office. The data was presented by year, mechanism, region and demographic variables and will be used to help inform suicide prevention activities in the State.

In light of a notification to death investigators by the NCIS Unit in 2011 about fentanyl overdose deaths (a prescription opioid), the VIFM has now added testing for this substance to its standard drug screen. This will provide a comprehensive picture of the influence played by fentanyl in deaths in the community, a factor which may otherwise have remained hidden.

IDENTIFYING AND ALERTING PARTIES TO MORTALITY TRENDS OR CONCERNS

The NCIS Unit published two fact sheets in 2011-12, one on electrocution deaths and another as an update about animal related deaths.

Ten State and Federal agencies used data from the NCIS to help inform annual reporting on specific types of deaths on topics such as drowning, work related injuries, and child deaths, as well as the annual Cause of Death report produced by the Australian Bureau of Statistics.

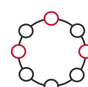
AS A PRIMARY DATA SOURCE FOR INJURY AND DEATH RESEARCH

During 2011-12 more than 60 organisations accessed the NCIS in order to understand critical factors associated with avoidable deaths and to assist with the development of policies and prevention strategies.

More than 20 medical and scientific publications arising from use of the NCIS were published in 2011-12 (see Section 9), which covered topics such as the value of coronial data for emergency medicine practice, identifying post-release deaths of prisoners, deaths of people aged under 50 in residential aged care homes, and harm that can be associated with a prescription opioid in Australia (oxycodone).

Several research reports were published which used data from the NCIS to examine issues such as recreational fishing deaths (Royal Life Saving Society of Australia) and suicide and the road toll (Monash University).[2]

2 See Section 9 for references for these reports.



3. ACHIEVEMENTS AND CHALLENGES DURING 2011-12

ACHIEVEMENTS DURING 2011-12

The last 12 months saw the NCIS Unit accomplish a number of goals.

Transition of NCIS Management and Governance

The largest of the 2011-12 achievements was arguably the successful transition of NCIS management Unit from the VIFM to the Victorian Department of Justice. This transfer was accomplished on time (by 1 July 2012) without disrupting service provision to NCIS users, while ensuring that stakeholders and NCIS staff were kept informed throughout the process.

A new Memorandum of Understanding to outline the new governance arrangements for the NCIS was signed by a representative from each of the Australian State and Territories and the New Zealand Ministry of Justice. Existing licence and access agreements were novated and additional Board members were nominated. A new NCIS Advisory Committee was established, with terms of reference drafted and approved. The transition of management, finance and human resources also occurred.

Assistance provided by both the VIFM and the Planning, Performance and Projects Unit of the Victorian Department of Justice during the management transfer period was a significant factor in the transfer occurring smoothly.

Strengthening risk management and system continuity

A detailed analysis of the risks and possible mitigation strategies surrounding IT support for the NCIS was undertaken in 2011-12. This included an assessment of risks such as a small number of IT staff with system knowledge, use of a proprietary programming language, and minimal system redundancy options. A plan which outlined these risks and proposed mitigation strategies was prepared and endorsed by the NCIS Board of Management. Details as to the activities and strategies put in place as part of this plan are outlined in the Business Plan Objectives section of this report.

Working with agencies to provide consistent and accurate mortality data

One of the objectives for the NCIS Unit in the last few years has been to increase the publication of mortality data statistics on the NCIS public website. During 2011-12, the NCIS Unit held discussions with the Australian Bureau of Statistics and the Australian Department of Health and Ageing in order to ensure that mortality data released by the NCIS Unit is consistent with data reporting best practice, does not replicate data that is already available, and will add value to the existing information. It is anticipated that these discussions will lead to aggregate data about intentional self harm deaths and drug related deaths being made publicly available in 2012-13, subject to coronial approval.

The NCIS also conducted a data validation project with the Australian Institute of Criminology, comparing the content of their internal deaths in custody database to that of the NCIS. Through this process 78 additional deaths in custody were identified on the NCIS which had occurred since July 2000 which were not within the AIC collection.

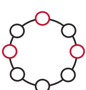
CHALLENGES DURING 2011-12

Delays in completing discrete projects

The need to invest time and resources in several unanticipated projects during 2011-12 (in combination with the transition to a new management and governance structure) led to a delay in the completion of certain projects.

Projects that were delayed included the launch of the new NCIS information website, publication of aggregate data on the NCIS website, and further implementation of the automatic upload of data from standard police forms to notify a death to a coroner.

Some of the activities that the NCIS Unit were instead involved in during 2011-12 included the Cause of Death Unit Record file project (being co-ordinated by the Queensland Registry of Births Death and Marriages); and facilitation activities with members of the National Committee for Standardised Reporting of Suicide with a view to securing funds for the improved identification and data collection of suicide deaths in Australia.



4. BUSINESS PLAN OBJECTIVES

The broad focus of the NCIS 2011-12 Business Plan was to ensure future service continuity for the NCIS, and to continue to increase data availability to users.

SERVICE CONTINUITY

Service continuity objectives were addressed by a number of activities and strategies. These included: commencement of migration of the Local Case Management Systems (LCMS) from Access to SQL Server, increasing the number of staff with IT knowledge of NCIS technical infrastructure and operations, increasing technical documentation, planning for system redundancy options, and consideration of migration from a proprietary programming language to an industry standard.

LCMS Upgrade

Migration of databases used for NCIS data entry and case management functions in the coronial offices (LCMS) from an Access platform to SQL Server will lead to increased system stability and performance.

This migration was completed for Queensland during 2011-12, with development work on the migration of the Western Australian and Tasmanian LCMS versions commenced.

Increasing staff knowledge of IT systems, system redundancy options and migration of programming language

Confirmation of the permanent appointment of an analyst programmer to the VIFM who will assist part-time with NCIS technical support has contributed towards the planned widening of NCIS IT support knowledge. There was also an increase in technical system documentation, and plans developed for an offsite mirrored server environment to be implemented in 2012-13.

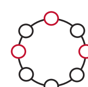
The cost and feasibility surrounding the migration of the programming language used by the NCIS from a proprietary language to an industry standard (Java) was examined during 2011-12, with this project also to be undertaken in 2012-13.

These activities should ensure the NCIS can continue to provide comprehensive and stable service delivery into the future.

DATA ACCESSIBILITY

With respect to increasing data accessibility, in addition to working on the publication of more aggregate data on the NCIS website (see earlier section), the NCIS Unit also further refined the methodology of a project to quantify the degree to which early coding on the NCIS changes once an investigation is complete ("Early coding project"). The outcomes from this project should inform the reliability of early coding for the production of preliminary statistics about types of deaths reported to a coroner.

The NCIS Unit continued to advocate for funding and implementation of the National Police Form for Notification of Death to a Coroner for the States and Territories which are yet to use this standard.



5. OPERATIONAL STATISTICS

5.1 USAGE STATISTICS

Death investigation users[3]

Death investigators increased the level of their use of the NCIS compared to the last 2 years (Table 1).

Of interest was the change of emphasis in the type of searches conducted on the NCIS by death investigators across the past few years. Searches conducted using the Coroners Screen have declined since 2009-10. While searches on the Coroners Screen allow a relatively quick method of identifying attached documentation which contain particular terms, it is not as reliable as the Query Design screen in identifying all relevant deaths (due to documentation not being attached or different terms used).

This may indicate that death investigation users are becoming more sophisticated in their use of the NCIS search options, although the use of the Query Design screen has fluctuated throughout this period.

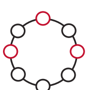
The Find Search screen remains the most utilised search mechanism by death investigators, who are often aware of certain deaths through other reporting methods and need to obtain additional information about these fatalities.

During 2011-12 the most prevalent death investigation users of the NCIS were the domestic violence researchers embedded within the Coronial Courts in South Australia and NSW; the NSW Crown Solicitors Office, the NSW Police Unsolved Homicide Squad, and the Coroners Prevention Unit in Victoria.

Table 1. System Use by Death Investigators

Type of search	2011-12	2010-11	2009-10
Query Design	3,530	4,304	3,677
Coroners Screen	1,681	3,101	4,782
Find Case screen	14,844	9,446	9,137
ABS Search Screen	0	30	50
Requests made to NCIS staff	55	65	75
TOTAL	**20,110**	**16,946**	**17,721**

3 Death investigators are those individuals who directly assist with the investigation of deaths reported to a coroner. They include coroners, coronial clerks, forensic scientists, pathologists and police assisting the coroner. Also included are police members who have access to the NCIS as death investigators such as the Victoria Police Arson Squad, and Missing Person Units around Australia.



Third Party Users[4]

Nineteen new third party applications were received in 2011-12, which is consistent with prior annual application levels. Around half of these new applications came from universities and were associated with specific research projects. The majority of remaining new applications involved agencies with a responsibility to review and/or monitor certain types of death (i.e. Victorian and West Australian Departments of Health, Transport Safety Victoria, Australian Institute of Health and Welfare). Appendix 3 details the 78 third party groups (from 61 different agencies) which had approved access to the NCIS in 2011-12.

Forty-seven of the 61 approved third party agencies (67%) with online access to the NCIS in 2011-12 were classed as "frequent third party users"[5]: This compares to 46 frequent third party users in 2010-11. The agencies, and the number of their logins to the system during 2011-12 are outlined in Appendix 4.

Existing third party organisations which notably increased their use of the NCIS during 2011-12 included the South Australian and NSW Departments of Health, the Royal Life Saving Society of Australia, Surf Lifesaving Australia and the NSW Child Death Review Team.

A decline in usage was seen for some organisations such as Monash University Accident Research Centre, WA Law Reform Commission, Austin Health, RMIT, University of Queensland, and NSW Maritime. This decline in usage is likely to be due to the completion of research projects which required NCIS data.

Approved third party users were also provided with NCIS data during 2011-12 via data extracts (n=6) and data reports (n=10). See Appendix 3 for these organisations.

4 Third Party users comprise researchers, university departments, policy makers or government departments who have a bona fide involvement in monitoring and preventing injury and death in the community. Third party users can only gain access to the NCIS once they have received approval from the relevant Ethics Committee.

5 "Frequent third party users" of the NCIS are those who have more than 104 logins into the online database in the 12 month period, equating to at least two logons per week.

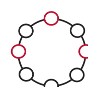
Usage by Other Groups

A variety of government, private and media organisations obtained aggregate data from the NCIS via data reports compiled by NCIS Unit staff.

Thirty-seven searches for external parties were performed in 2011-12, which was less than previous years (Table 2). However in approximately 30 additional instances, NCIS was able to refer a requesting party to existing material which would meet their needs. This made efficient use of NCIS Unit resources in that new searches were not required to be performed.

Table 2. De-identified data reports for external parties

Year	Number of searches performed for external parties
2011-12	37
2010-11	45
2009-10	59
2008-09	77



5. OPERATIONAL STATISTICS

5.2 CASE CLOSURE AND DOCUMENT ATTACHMENT

In most jurisdictions, the percentage of cases closed and reports available on the NCIS remained similar to 2010-11 levels (Table 3).

The proportion of Queensland cases with autopsy reports continued to increase (up 19% from July 2011 levels). A significant increase in attached findings for South Australia since July 2011 (up 51%) is a result of an addition of a standard template to all South Australian cases where the electronic finding is not available. This template indicates that an electronic version of the South Australian finding was not captured, however as it applies to non-inquest cases, these findings would not have contained any additional details other than deceased name, date of death and cause of death.

Closed case percentages for NSW cases also increased slightly from 73 to 79%.

Unfortunately as evidenced in Table 3, there are still very few toxicology reports available for Queensland and South Australian cases, and few autopsy reports for South Australian cases. The NCIS Unit is continuing to liaise within these jurisdictions in an attempt to obtain these reports for the system.

Table 3. Case Closure and Document Attachment levels as at July 2012 compared to July 2011

State	Case Closure Average (%)		Finding Attachment (%)		Autopsy Attachment (%)		Toxicology Attachment (%)		Police Narrative Attachment (%)	
	11-12	10-11	11-12	10-11	11-12	10-11	11-12	10-11	11-12	10-11
ACT	94	93	99	99	92	95	67	72	100	100
NSW	79	73	60*	70*	72	76	74	78	55	51
NT	90	91	96	95	96	94	65	63	96	96
QLD	88	84	43	51	49	30	3	1	97	96
SA	96	95	98	47	1	1	10	10	100	100
TAS	93	93	90	87	77	75	91	88	100	100
VIC	87	88	99	99	92	91	98	97	93	94
WA	90	87	94	95	63	60	84	82	100	100

*As coronial findings are only produced in NSW when a case has been investigated via Inquest, the total finding attachment percentage for all NSW cases is low. These statistics have therefore been produced to reflect the proportion of findings attached as a proportion of all inquest cases as at July 2012.

In order to examine the availability of documentation for the cases most recently closed on the NCIS, Table 4 presents document attachment rates for those cases closed during 2011-12 compared to those closed during 2010-11.

While still lower than other jurisdictions, Table 4 shows police narrative attachment for NSW cases closed during 2011-12 have improved (45% of cases closed in 2011-12 compared to 27% of NSW cases closed during 2010-11), while NSW autopsy report and toxicology attachment has declined. This decline is likely due to the NSW Court closing a number of older cases on the NCIS, where electronic copies of documentation are not available.

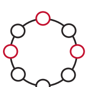


Table 4. Document Attachment levels (cases closed during 2011-12 as compared to those closed during 2010-11)

State	Finding Attachment (%)		Autopsy Attachment (%)		Toxicology Attachment (%)		Police Narrative Attachment (%)	
	11-12	10-11	11-12	10-11	11-12	10-11	11-12	10-11
ACT	95	100	91	100	84	84	100	100
NSW	32*	49*	56	76	59	74	45	27
NT	99	100	97	100	99	97	99	89
QLD	86	71	87	71	3	0	99	98
SA	100	99	0	0	1	1	99	99
TAS	99	100	100	98	83	97	98	99
VIC	91	97	95	92	98	93	88	90
WA	99	100	98	100	99	100	99	100

*As coronial findings are only produced in NSW when a case has been investigated via Inquest, the total finding attachment percentage for all NSW cases is low. These statistics have therefore been produced to reflect the proportion of findings attached as a proportion of all inquest cases that were closed during 2011-12.

5.3 TIMELINESS OF CASE CLOSURE

During 2011-12, case closure timeliness continued at high levels for ACT, South Australia, the Northern Territory, Tasmania and Western Australia, with most of these jurisdictions closing between 98-99% of cases on the NCIS within 60 days of the coronial finding being finalised.

Case closure timeliness for cases closed on the system in 2011-12 was low for Victoria and NSW, although this is likely influenced in part by the fact that notable proportions of backlog data entry were conducted in these states during 2011-12.[6]

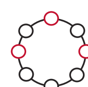
6 In NSW and Victoria, 69% and 31% respectively of all cases closed on the NCIS during 2011-12 had been closed by the coroner prior to 2011-12. When only examining instances where the coroner closed the case in 2011-12, Victoria closed 78% on the NCIS within 60 days, and NSW closed 61% on the NCIS within 60 days.

Table 5. Percentage of cases closed on local/NCIS systems within 60 days of completion of finding

	% cases closed 2011-12	% cases closed 2010-11	% cases closed 2009-10
ACT	98	98	94
NSW	20	23	39
NT	98	94	96
QLD	63	68	49
SA	99	98	100
TAS	90	90	92
WA	99	98	94
VIC	59	63	81

User Audits

During 2011-12, the usage of the NCIS was audited for six randomly selected death investigation users, and nine randomly selected third party users. There were no concerns surrounding the use of the NCIS identified during these audits.



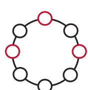
6. ADDITIONAL PROJECTS

FATAL ROAD CRASH DATABASE (FRCD)

The NCIS Unit received separate funding from the Road Safety Branch of the Federal Department of Infrastructure and Transport to manage the Fatal Road Crash Database, a national collection of detailed information about road crash fatalities. This funding is documented in the financial section of this report.

The coding of fatal road crash incidents that occurred in 2008 in Queensland, Tasmania, South Australia, the ACT and the Nothern Territory. was performed during 2011-12.

This was the final year that the NCIS Unit will be managing this project, due to the operational resources required to oversight the coding process. It is hoped that another organisation will be able to assume responsibility for the management of this project, so this data collection can continue to be maintained.



7. QUALITY ASSURANCE

During 2011-12, Quality Assurance activities included the review of 18,454 Australian coronial cases that were closed on the NCIS, and high level review of 15,000 New Zealand coronial cases that were closed with the coroner. The high level review of New Zealand cases was undertaken to ensure that NCIS coding principles were applied to coronial cases from this jurisdiction. This quality review identified a number of issues that were rapidly rectified within the New Zealand case management system, ensuring New Zealand cases will have coding standards comparable to the Australian cases. Data about deaths reported to a New Zealand coroner from 1 July 2007 will be made available via the NCIS in late 2012.

In order to strengthen the knowledge of coronial staff who are performing coding for New Zealand cases, the NCIS Quality Manager conducted a refresher coder training session in Auckland during 2011-12. A coder training session was also held at the Queanbeyan Magistrates Court in NSW to assist in the coding of deaths investigated in this region.

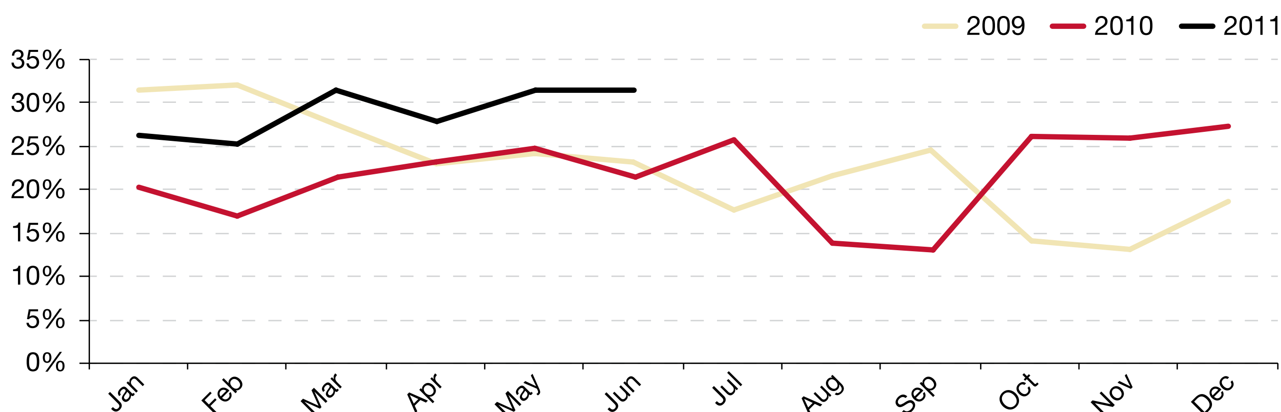
Further coder support was provided via three coding tips newsletters which were distributed to all coronial jurisdictions. These newsletters covered general coding related principles, how to code drug related deaths, and issues surrounding reported deaths that have subsequently received a medical certificate.

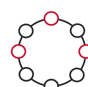
Figure 1 shows that while the percentage of cases with critical errors fluctuates quite regularly, a higher percentage is seen for cases closed in 2011 than in 2009 and 2010. It is suggested that this increase in errors was a result of a large number of NSW coronial staff closing cases throughout the past 12 months in preparation for the introduction of a new case management system in that jurisdiction. While this increase in case closure was welcomed, it did mean that a higher number of errors were identified as not all NSW clerks conducting the case closure had been trained on NCIS data entry.

A significant focus of the NCIS Quality team during 2011-12 involved the development of additional validation rules for the local case management systems used in the courts. The aim of these rules is to prevent commonly made coding errors being accepted into the system during data entry. These validation rules relate mostly to logical relationships between NCIS data fields (i.e. the date of death cannot occur before the date of birth, if the Mechanism of Injury is a Transport Incident, the corresponding object field should involve a vehicle). These rules should both improve the accuracy of case information in the local courts and on the NCIS, and reduce the number of errors identified by the NCIS Quality team. These validation rules will be incorporated into the Local Case Management Systems during 2012-13.

In order to provide a more timely feedback mechanism to the coders in the coronial offices, the Quality Unit also modified their processing of closed cases on the NCIS, alternating between cases that have been closed the longest, and those that have been closed in the preceding month. This allows coders to receive timely feedback about cases they have recently coded and closed, however it does not disregard the cases that have been closed for longer periods and are still in need of a quality review.

Figure 1. Percentage of Cases Reviewed with at least one critical error identified (by year closed)





8. TEACHING AND EDUCATION

The NCIS Unit attended and presented at several conferences related to mortality/coronial data during 2011-12. This included:

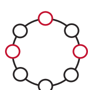
- Australian Mortality Data Interest Group (AMDIG) annual workshop
- Asia-Pacific Coroners Society Conference
- Australasian Road Safety, Research, Policing and Education Conference
- National Injury Prevention Conference
- Forensic and Clinical Toxicology Association Meeting

Presentations delivered by NCIS staff at these forums covered Emergency Lane Deaths, Quality Initiatives for the NCIS, and deaths involving the abuse of fentanyl patches.

Numerous training sessions were held with NCIS users during 2011-12 to enable them to use the system effectively, which included both death investigation and third party users.

The NCIS Unit hosted two Health Information Management students from La Trobe University as part of their placement program during 2011-12, who worked on projects involving the consistent coding of ecstasy related deaths, and a review of cases awaiting coding amendments to be made by the courts.

A delegation from the Central Institute of Forensic Science in Thailand visited the Coronial Services Centre in 2011-12 to examine Australian forensic practices, as did a delegation of government officials from China undertaking a study tour on road safety hosted by the Monash University Department of Forensic Medicine. During these visits, an information session about the NCIS was provided.



9. RESEARCH AND PUBLICATIONS

NCIS data continued to be referenced in academic and research papers during 2011-12, with twenty such academic papers published during this time.

ACADEMIC PUBLICATIONS

Andrews, J., Forsyth, S., Wade, J. & Kinner, S. (2011). Sensitivity of a national coronial database for monitoring unnatural deaths among ex-prisoners in Australia. *BMC Research Notes.* 4:450

Andrews, J. & Kinner, S. (2012). Understanding drug-related mortality in released prisoners: A review of national coronial records. *BMC Public Health*. 12: 270

Austin,A., Winskog, C., van den Heuvel, C. & Byard, R. (2011). Recent Trends in Suicides Utilizing Helium. *Journal of Forensic Sciences.* 56(3), 649-651

Bambach, M., Grzebieta R., Olivier, J. & McIntosh A. (2011). Fatality risk for motorcyclists in fixed object collisions. *Journal of Transportation Safety and Security*. 3: 232-235

Bambach, M., Grzebieta, R. & McIntosh, A (2012). Thoracic injuries to contained and restrained occupants in single vehicle pure rollover crashes. *Accident Analysis and Prevention*. http://dx.doi.org/10.1016/j.aap.2012.03.033.

Bugeja, L., Ibrahim, J., Ozanne-Smith, J., Brodie. L. & McClure, R. (2011). Application of a public health framework to examine the characteristics of coroners' recommendations for injury prevention. *Injury Prevention.* 18(5), 326-333

Curran, J. & Taylor, D. (2012). The National Coroners Information System: A valuable source of lessons for emergency medicine. *Emergency Medicine Australasia.* 24(4), 442-450

Dearn, L. (2011). Permanent discharge: Deaths of people under 50 years of age in residential aged care in Victoria. *Journal of Law and Medicine.* 19:53-68

Deasy, C., Bray, J., Smith, K., Hall, D., Morrison, C., Bernard, S. & Cameron, P. (2012).Paediatric traumatic out-of-hospital cardiac arrests in Melbourne, Australia. *Resuscitation*. 83(4), 471-475

Freestone, D., Williamson, D. & Wollersheim, D. (2012). Geocoding coronial data: tools and techniques to improve data quality. *Health Information Management Journal.* 41(3), 4

Guiney, R. (2012). Farming suicides during the Victorian drought: 2001–2007. *Australian Journal of Rural Health*, 20: 11–15.

Jones, C., Routley, V., Trytell, G., Ibrahim, J, & Ozanne-Smith, J. (2012). A descriptive analysis of work-related fatal injury in older workers in Australia 2000-2009. *International Journal of Injury Control and Safety Promotion.* Published online 27 April 2012

Judd, F., Jackson, H., Komiti, A., Bell, R. & Fraser, C. (2012). The profile of suicide: changing or changeable? *Social Psychiatry and Psychiatric Epidemiology*, 47(1),1-9

Lippmann, J. & Pearn, J. (2012). Snorkelling-related deaths in Australia 1994–2006. *Med J Aust*; 197(4), 230-232

Lower, T. & Herde, E. (2012). Non-intentional farm injury fatalities in Australia, 2003–2006. *NSW Public Health Bulletin*. 23(2), 21-26

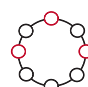
Pilgrim, J., Ruiz, Y., Gesteira, A., Cruz, R., Gerostamoulos, D., Carracedo, A. & Drummer, O. (2012). Characterization of Single Nucleotide Polymorphisms of Cytochrome P450 in an Australian Deceased Sample. *Current Drug Metabolism*, 13(5), 679-692

Rintoul, A., Dobbin, M., Drummer, O. & Ozanne-Smith, J. [Abstract] (2011). Drug toxicity deaths involving oxycodone, Victoria. *Drug and Alcohol Review.* 30 (Supp 1): 76

Routley, V. & Ozanne-Smith, J. (2012) Work-related suicide in Victoria, Australia: a broad perspective. *International Journal of Injury Control and Safety Promotion*. 19(2), 131-134

Roxburgh, A., Bruno, R., Larance, B. & Burns, L. (2011). Prescription of opioid analgesics and related harms in Australia. *MJA.* 195 (5). 280-284.

Walter, S., Bugeja, L., Spittal, M. & Studdert, D. (2011). Factors predicting coroners' decisions to hold discretionary inquests. *Canadian Medical Association Journal*. 184:521-528.



9. RESEARCH AND PUBLICATIONS

The number of research and annual reports relying on NCIS data also remained consistent with fifteen such reports produced.

RESEARCH REPORTS

Boufous, S., Gabbe, B., Elkington, J., Bohensky, M., Cameron, P. & de Rome, L. (2012). *Investigation of the potential to enhance emergency response to motorcyclists involved in crashes.* George Institute and Monash University: VicRoads.

Cassell, E., Reid, N., Clapperton, A., Houy-Pang, K. & Kerr, E. (2011). Assault Related Injury among young people aged 15-34 that occurred in public places: deaths and hospital treated injury, *Hazard. Edition 73.*

Cooke, T. & Lingard, H. (2011). A retrospective analysis of work-related deaths in the Australian construction industry, in Charles Egbu and Eric Choen Weng Lou (ed.) *Proceedings of the ARCOM Twenty-seventh Annual Conference*, University of Reading, Reading UK, 5-7 September, 2011, 279-288.

National Drug and Alcohol Research Centre (2012). *A Review of Opioid Prescribing in Tasmania, A Blueprint for the future*. University of NSW: Sydney.

Piliskic C., Franklin, R. & Vasica, C. (2011). *Recreational Fishing in NSW: An Overview of Drowning Related Fatalities and Current Practices.* Royal Life Saving Society – NSW: Sydney.

Routley, V., Trytell, G. & Davis, M. (2011). *Suicide and the Road Toll.* Monash University: Victoria.

ANNUAL REPORTS

Causes of Death Report 2010, Australian Bureau of Statistics.

Victorian Drowning Report 2010/2011, Life Saving Victoria, Melbourne.

National Coastal Safety Report 2011, Surf Life Saving Australia.

National Drowning Report 2011, Royal Life Saving Society of Australia.

National Drowning Report 2012, Royal Life Saving Society of Australia.

Annual Report 2010, NSW Child Death Review Team.

Review of Government Services - Chapter 9: Fire, road rescue and ambulance. Australian Productivity Commission.

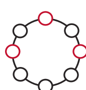
Victorian State Trauma Registry 2009-10 Summary Report.

Work Related Traumatic Injury Fatalities, 2009-10, Safe Work Australia.

OTHER PUBLICATIONS

Warner M & Chen, L (2012). “Surveillance of Injury Mortality” in Gouhua Li & Susan Baker (Ed.) *Injury Research Theories, Methods, and Approaches.* Springer. 3-12.

Dickson, T. (2012) “The real physical risks: Putting it in Perspective” in Tracey Dickson & Tonia Gray (Ed). *Risk management in the outdoors.* Cambridge University Press. 91-115.



10. STAFFING

The NCIS Administration Officer Catherine Daley was on maternity leave during 2011-12, and was replaced by Andrea Gallo during this time. Andrea fitted into the team well, and was a great help in supporting the NCIS team with administration functions during this period. We wish Andrea all the best, as we welcome Catherine back from maternity leave in July 2012.

Fatal Road Crash Database (FRCD) staff members Jennifer To and Tracey Caulfield moved onto other opportunities during 2011-12, and were replaced by Jessica Majerczak and Chebi Kipsaina in order to complete the FRCD coding.

As from 1 July 2012 the NCIS Unit will no longer be managing the FRCD, we take the opportunity to thank Bronwyn Hewitt (FRCD senior coder) and all other previous staff members who have worked on the FRCD for their dedication and efforts on this project.

See Appendix 2 for training and development activities undertaken by staff during 2011-12.

STAFF IN 2011-12

Manager
Jessica Pearse/Chris Jones (Acting)

Quality Assurance Manager
Leanne Daking

Coronial Liaison Officer
Lisa Crockett

Access Officer
Jo Cotsonis

Quality Assurance/IT Officer
Tony Chan

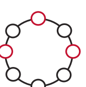
Administrative Officer
Andrea Gallo (0.8) / Catherine Daley (on leave)

Senior Research Officer
Steven Haas

Senior Coder, Fatal Road Crash Database
Bronwyn Hewitt (0.5)

Coder, Fatal Road Crash Database
Jennifer To (to November 2011)
Tracey Caulfield (to November 2011)
Chebi Kipsaina (from April 2012)
Jessica Majerczak (from April 2012)

Quality Assistant
Jill Russell (0.6)



VAGO
Victorian Auditor-General's Office

Level 24, 35 Collins Street
Melbourne VIC 3000
Telephone 61 3 8601 7000
Facsimile 61 3 8601 7010
Email comments@audit.vic.gov.au
Website www.audit.vic.gov.au

INDEPENDENT AUDITOR'S REPORT

To the Director of Victorian Institute of Forensic Medicine

The Statement of Receipts and Expenditure

The accompanying statement of receipts and expenditure for the year ended 30 June 2012 relating to the National Coroners Information System of the Victorian Institute of Forensic Medicine (the Institute) has been audited. The statement has been prepared for the Secretary of the Commonwealth Department of Health and Ageing to certify that the amount reported as expended during the year was used solely on the purpose described in the funding agreement with the Commonwealth Department of Health and Ageing.

The Director's Responsibility for the Statement of Receipts and Expenditure

The Director of the Victorian Institute of Forensic Medicine is responsible for the preparation of the statement of receipts and expenditure, and has determined that the statement is appropriate to the needs of the Commonwealth Department of Health and Ageing, based upon the reporting requirements of the funding agreement with the Commonwealth Department of Health and Ageing.

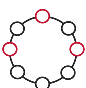
The Director is responsible for such internal control as the Director determines is necessary to enable the preparation of the statement of receipts and expenditure that is free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

My responsibility is to express an opinion on the statement of receipts and expenditure based on the audit, which has been conducted in accordance with Australian Auditing Standards. Those standards require compliance with relevant ethical requirements relating to audit engagements and that the audit be planned and performed to obtain reasonable assurance about whether the statement of receipts and expenditure is free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the statement of receipts and expenditure. The audit procedures selected depend on judgement, including the assessment of the risks of material misstatement of the statement or receipts and expenditure, whether due to fraud or error. In making those risk assessments, consideration is given to the internal control relevant to the Institutes's preparation of the statement of receipts and expenditure in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Institute's internal control.

I believe that the audit evidence I have obtained is sufficient and appropriate to provide a basis for my audit opinion.



Independent Auditor's Report (continued)

Independence

The Auditor-General's independence is established by the *Constitution Act 1975*. The Auditor-General is not subject to direction by any person about the way in which his powers and responsibilities are to be exercised. In conducting the audit, the Auditor-General, his staff and delegates complied with all applicable independence requirements of the Australian accounting profession.

Opinion

In my opinion:

(a) the statement of receipts and expenditure is based on proper accounts and records

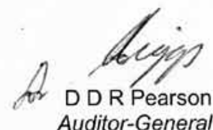
(b) the amount reported as expended during the year was used solely for the purpose described in the funding agreement with the Commonwelath Department of Health and Ageing.

Emphasis of Matter

Without modifying my opinion, I draw attention to the special purpose nature of the statement of receipts and expenditure which is prepared to meet the requirements of the Director of the Victorian Institute of Forensic Medicine and the Department of Health and Ageing to certify that the amount reported as expended during the year was used solely for the purpose described in the funding agreement with the Commonwealth Department of Health and Ageing. As a result, the financial statement may not be suitable for another purpose.

Matters Relating to the Electronic Publication of the Audited Statement of Receipts and Expenditure

This auditor's report relates to the statement of receipts and expenditure of the National Coroners Information System for the year ended 30 June 2012 included both in the National Coroners Information System's annual report and on the website. The Directors of National Coroners Information System are responsible for the integrity of the National Coroners Information System's website. I have not been engaged to report on the integrity of the National Coroners Information System's website. The auditor's report refers only to the subject matter described above. It does not provide an opinion on any other information which may have been hyperlinked to/from these statements. If users of the statement of receipts and expenditure are concerned with the inherent risks arising from publication on a website, they are advised to refer to the hard copy of the audited statement of receipts and expenditure to confirm the information contained in the website version of the statement of receipts and expenditure.



MELBOURNE
5 September 2012

D D R Pearson
Auditor-General

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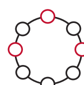
Auditing in the Public Interest



11. FINANCIAL REPORTS

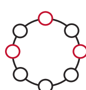
CORE OPERATIONAL FUNDING

Statement of Receipts of Expenditure

NCIS Activity 176 - Normal Operating

For the year ended 30 June 2012

	2012 $	2011 $
Opening balance (Cash in Bank)	**700,762**	658,275
Income		
Government grants	**1,011,994**	990,660
User pays	**155,834**	174,791
TOTAL	**1,167,828**	1,165,451
Less Expenses		
Audit services	**3,000**	3,000
Contractors, consultants and professional service expenses	**100,303**	57,601
Depreciation	**10,076**	-
Employee related expenses	**572,674**	601,634
Information Technology expenses	**238,840**	237,172
Other operating expenses	**65**	32
Postage and communication expenses	**2,506**	4,117
Printing, stationery and other office expenses	**4,567**	12,282
Staff training and development expenses	**2,444**	7,746
Travel, entertainment and personal expenses	**10,888**	13,224
Utilities and services	**189,996**	186,096
TOTAL	**1,135,359**	1,122,964
Balance for the year	**32,469**	42,487
Capital Expenditure	**-**	-
Accrued expenses	**-**	-
Depreciation	**10,076**	-
Closing balance (Cash in Bank)	**743,306**	700,762



EXPLANATORY INFORMATION ABOUT INCOME AND EXPENSESO ON PAGE 18

The User Pays line item of revenue includes revenue from NCIS subscriptions and data reports ($64,225) and the funding contribution provided from the NZ Ministry of Justice ($91,609).

The increase in contractor/consultancy expenses in 2011-12 related to the engagement of contracted staff to cover for Long Service Leave of the NCIS Manager for 4 months. These costs are offset in part by a reduction in salary expenses.

Depreciation relates to NCIS servers.

Utilities and service expenses are charged at approved levels by the Victorian Institute of Forensic Medicine for costs associated with managing and housing the NCIS Unit.

IT expenses include amounts for NCIS maintenance and support, equipment replacement and external software licences and services.

The closing balance reflects the agreement by the NCIS Board of Management that around six months operational funding should be retained in accrued NCIS funds in the event of any future system funding shortfalls.

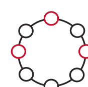
GOVERNMENT CONTRIBUTIONS MADE IN 2011-12 (AUST & NZ) *

Agency	Amount contributed $AUD (GST Exclusive)
Australia	
Commonwealth	506,766
New South Wales	165,008
Victoria	125,196
Queensland	100,945
South Australia	37,891
Western Australia	51,028
Tasmania	11,822
ACT	8,185
NT	5,153
Australian Total	**1,011,994**
New Zealand	91,609
TOTAL (Aus & NZ)	**1,103,603**

PRODUCTS PURCHASED IN 2011-12

Type of Product	Number Purchased*
Online Subscriptions	14
Data Extracts	1
Data Reports	14
TOTAL	**29**

* There were an additional 47 online subscriptions, 4 data extracts and 23 data reports provided to external parties in 2011-12, however these services were not invoiced due to the fact the recipients of these products either provide core funding to the NCIS, had obtained fee relief or had access through other agreements. See Appendix 5 for organisations which were granted fee relief for Online Subscriptions during 2011-12.



11. FINANCIAL REPORTS

OTHER PROJECT FUNDING

Fatal Road Crash Database

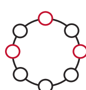
This funding relates to the management and coding of detailed information about every fatal road crash in Australia. This project is funded by the Road Safety Branch of the Australian Department of Infrastructure and Transport (which was previously located within the Australian Transport Safety Bureau).

Statement of Receipts of Expenditure

NCIS Activity 165 ATSB

For the year ended 30 June 2012

	2012 $	2011 $
Opening balance (Cash in bank)	**26,522**	37,840
Income		
Government grants	**65,700**	74,128
User pays	**-**	-
TOTAL	**65,700**	74,128
Less Expenses		
Contractors, consultants and professional service expenses	**(664)**	-
Employee related expenses	**62,549**	50,037
Information Technology expenses	**1,195**	12,217
Other operating expenses	**-**	5,985
Staff training and development expenses	**-**	-
Travel, entertainment and personal expenses	**-**	-
Utilities and services	**13,632**	17,207
TOTAL	**76.712**	85,446
Balance for the year	**(11,012)**	(11,318)
Capital Expenditure	**-**	-
Accrued expenses	**-**	-
Depreciation	**-**	-
Closing balance (Cash in Bank)	**15,510**	26,522



Automated Extraction of Data from ACT Police Notification of Death Form & AMDIG Conference

The opening balance for this Activity related to remaining funds for the ACT electronic police notification of death form project (during 2010-11 this account was also used to hold funds for the Australasian Mortality Data Interest Group Conference).

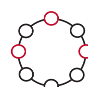
In 2011-12 the remaining funds from this account were expended on IT programming services for the ACT police form project.

Statement of Receipts of Expenditure

NCIS Activity 157

For the year ended 30 June 2012

	2012 $	2011 $
Opening balance (Cash in Bank)	**7,610**	8,074
Income		
Government grants	-	-
User pays – AMDIG Conference Fees	-	21,395
TOTAL	**0**	21,395
Less Expenses		
Employee related expenses	-	2,981
Information Technology expenses	**7,610**	-
Postage and communication expenses	-	68
Printing, stationery and other office expenses	-	7,270
Staff training and development expenses	-	5,773
Travel, entertainment and personal expenses	-	5,767
TOTAL	**7,610**	21,859
Balance for the year	**(7,610)**	(464)
Capital Expenditure	-	-
Accrued expenses	-	-
Depreciation	-	-
Closing balance (Cash in Bank)	**0**	7,610



APPENDIX 1 - GOVERNANCE STRUCTURE AND ADVISORY PANELS

NCIS COMMITTEE

Judge Jennifer Coate,
Victorian State Coroner (Chair)

Prof Olaf Drummer,
Head of Scientific Services, VIFM

Magistrate Mary Jerram,
NSW State Coroner

A/Prof James Harrison,
Director National Injury Surveillance Unit

Prof Joan Ozanne-Smith,
Director NCIS

Ms Jessica Pearse,
Manager NCIS

** Due to the review of NCIS governance during 2011-12, no meetings of the NCIS Committee were held over this period.*

VIFM COUNCIL

The composition of the VIFM Council can be accessed from the VIFM Annual Report 2011-12

NCIS BOARD OF MANAGEMENT

Ms Penny Armytage (Chair)
Secretary,
Victorian Department of Justice

Mr Laurie Glanfield (Deputy Chair)
Director-General,
NSW Attorney-General's Department

Ms Cheryl Gwilliam
Director General,
WA Department of the Attorney-General

Ms Lisa Hutton/ Mr Michael Stevens
Secretary/Acting Secretary,
Tasmanian Department of Justice

Ms Kathy Leigh
Director General,
ACT Justice and Community Services Directorate

Mr Jerome Maguire/ Mr Paul White
Chief Executive/Acting Chief Executive,
SA Attorney General's Department &
Department of Justice

Mr Chris Milton
Director, Research, International & Policy Section
Drug Strategy Branch,
Australian Department of Health and Ageing

Mr Terry Ryan
Deputy Director General Justice Services,
Dept Justice and Attorney-General, QLD

Mr Greg Shanahan
Chief Executive Officer,
NT Department of Justice

Ms Heather Baggott
General Manager Special Jurisdictions,
Ministry of Justice NZ

*** Meetings held in July 2011, November 2011, April 2012, June 2012*

TECHNICAL AND METHODS ADVISORY PANEL

Mr Michael Barnes
State Coroner
Office of the Queensland State Coroner

Ms Leanne Daking
Quality Manager
National Coroners Information System

A/Professor Tim Driscoll
Lecturer
University of Sydney

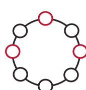
Professor James Harrison
Director
National Injury Surveillance Unit

Professor Joan Ozanne-Smith
Director
National Coroners Information System

Ms Jessica Pearse
Manager
National Coroners Information System

Mr James Eynstone-Hinkins
Assistant Director, Social and Demographic Statistics
Australian Bureau of Statistics

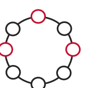
*** Meetings held in July 2011, March 2012*



APPENDIX 2 - STAFF PROFESSIONAL DEVELOPMENT

Lisa Crockett
- Continuing "Certificate IV in Workplace Training & Assessment" (online).

Jessica Pearse
- The Impact of Government 2.0 on Information Managers
- Graeme Schofield VIFM Oration, "Hell's Kitchen: Post Conflict Recovery and Justice



APPENDIX 3 - AGENCIES WITH ACCESS TO NCIS DATA AS AT 30 JUNE 2012

DIRECT SYSTEM ACCESS

Child Deaths

Centre for Forensic Behavioural Sciences, Monash University

NSW Child Death Review Team

Queensland Commission for Children and Young People and Child Guardian

SIDS and KIDS (new)

University of NSW, through the School of Women and Children's Health (new)

Consumer Product Safety

Australian Competition and Consumer Commission (ACCC)

Consumer Affairs Victoria

QLD Office of Fair Trading

Drug Related Deaths

Department of Forensic Medicine, Monash University x 3 (one new)

Drug and Alcohol Strategy Unit, Victoria Police

National Drug and Alcohol Research Centre (NDARC)

NSW Poisons Information Centre, NSW Health

Western Australian Drug and Alcohol Authority

General Mortality

Australian Bureau of Statistics

Department of Forensic Medicine, Monash University x 2

National Injury Surveillance Unit, Flinders University

NSW Injury Risk Management Research Centre x 2

NSW Institute of Trauma and Injury Management

Health

Austin Health

Centre for Rural Emergency Medicine, Deakin University (new)

Centenary Institute (new)

Department of Allergy, Immunology & Respiratory Medicine, The Alfred Hospital

Department of Health and Families, Northern Territory

Department of Health, Victoria x 2 (including VCCAMM, CCOPMM, and VSCC)

Department of Health, South Australia

Department of Health, New South Wales

Department of Health, ACT

Department of Health and Human Services, Tasmania

Department of Epidemiology and Preventive Medicine, Monash University x 3 (one new)

Epilepsy Australia

National Critical Care Trauma Response Centre, Royal Darwin Hospital

NSW Department of Forensic Medicine

Queensland Injury Surveillance Unit

Royal Australasian College of Surgeons

School of Population Health, University of Melbourne x 4

School of Population Health, University of Queensland

Justice

Australian Institute of Criminology

Office of Correctional Services Review, Victoria

Other

Department of Veterans' Affairs (new)

Griffith University

School of Anthropology and Archeology, Australian National University

School of Property Construction and Project Management, RMIT

Victorian Injury Surveillance Unit, Monash University Accident Research Centre

Work Related Deaths

Australian Centre for Agricultural Health and Safety, Sydney University

Curtin University of Technology, Western Australia x 2

Department of Forensic Medicine, Monash University

Office of the Federal Safety Commissioner (new)

Safe Work Australia

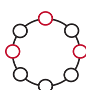
Workplace Health and Safety, Queensland

Suicide

Australian Institute for Suicide Research and Prevention, Griffith University

Department of Forensic Medicine, Monash University

Flinders University Centre for Remote Health, Alice Springs



Transport related Deaths

Department of Forensic Medicine, Monash University (new)

NSW Roads and Traffic Authority x 2

QLD University of Technology (new)

Transport Accident Commission, Victoria

Transport Safety Victoria (previously Public Transport Safety Victoria)

Transport Workers Union

VicRoads

Water/Fire/Emergency Service Agencies

Australian Fire & Emergency Services Authority Council, AFAC

Divers Alert Network Asia-Pacific

Monash University, Injury Surveillance Unit (new)

Office of the Emergency Services Commissioner, Victoria

Queensland Fire and Rescue Service

Royal Life Saving Society of Australia

Surf Life Saving Australia

RMIT University

DATA EXTRACTS FOR THIRD PARTY USERS

- Australian Institute of Health and Welfare (COD URF) (new)
- Western Australia Department of Health (COD URF) (new)
- LifeSaving Victoria
- Curtin University
- Department of Forensic Medicine, Monash University (x2)

Note: Data extracts are only performed for existing users of the NCIS within their approved level of access.

COD URF refers to organisations which obtained coronial data about the cause of death from the Cause of Death Unit Record File, released by the Registry of Births, Deaths and Marriages Queensland on behalf of all State/Territory registries.

DATA REPORTS

ABC (x2)

Aust Dept Infrastructure and Transport (x2)

Australian Dept of Health and Ageing

ACCC* (x5)

Bus Industry Confederation (x2)

Crime and Misconduct Commission (x2)

Department of Defence

Eastern Health

Illawarra Mercury Newspaper

King & Wood Mallesons

Knox City Council

Masters/PhD Students (x2)

MP Office

Mental Health Professionals Network

Monash University, Dept Forensic Medicine

National Motor Vehicle Theft Reduction Council

NPS Pharmaceutical Decision Support

NT Department of Housing

Select Committee on Youth Suicides in the NT

SA Police (x2)

Swan Hill Local Council

SIDS and KIDS NT*

Sunday Herald Sun

Sydney Morning Herald

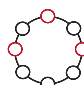
University of South Australia

Victorian Building Commission

Yea and District Memorial Hospital

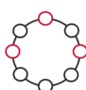
* Authorised NCIS third party organisation with access to NCIS

Note: Data reports can contain statistical data and/or de-identified case summaries

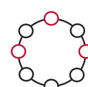


APPENDIX 4 - FREQUENT NCIS THIRD PARTY USERS IN 2011-12 COMPARED TO 2010-11

Organisation	Total Search Screen Accesses 2011-12	Total Search Screen Accesses 2010-11
Safe Work Australia	11,982	13,692
Royal Life Saving Society of Australia	11,931	6,788
Department of Health, South Australia	11,680	2,728
Australian Bureau of Statistics	11,182	27,796
Victorian Institute of Forensic Medicine/Monash Dept of Forensic Medicine	9,216	15,921
Surf Life Saving Australia	6,360	3,649
NSW Child Death Review Team	6,246	4,933
Australian Institute for Suicide Research and Prevention, Griffith University	4,592	7,676
Australian Institute of Criminology	4,571	3,146
Department of Epidemiology, Monash University	3,805	4,003
Transport Workers Union	3,447	-
NSW Road Traffic Authority	3,131	2,465
NSW Independent Transport Safety Regulator	3094	-
Consultative Council on Obstetric and Paediatric Mortality and Morbidity (CCOPMM)	2,959	2,919
National Critical Care and Trauma Response Centre	2,732	-
Workplace Health and Safety QLD	2,694	78
Royal Australian College of Surgeons (including Vic Surgical Consultative Committee)	2,045	1,806
VicRoads	2,013	6,983
School of Anthropology and Archaeology, Australian National University	1,770	2,906
Australian Centre for Agricultural Health and Safety, Uni of Sydney	1,741	3,231
National Drug and Alcohol Research Council	1,673	1,408
Centre for Health Policy, Melbourne University	1,565	3,656
RMIT – School of Mathematics and Geospaitial Science	1,347	1,008
QLD Police - Drug & Alcohol Unit	1317	-
Office of Correctional Services Review, Victoria	1,239	1,962
Department of Health, NSW (includes Epidemiology, Poisons Centre & Birth Defects Registry)	1,148	537
Australian Competition and Consumer Commission (ACCC)	1,132	1,103
Life Saving Victoria	834	722
Griffith University	798	3,427
WA Drugs and Alcohol Authority	773	1,396



Organisation	Total Search Screen Accesses 2011-12	Total Search Screen Accesses 2010-11
NSW Institute of Trauma and Injury Management	706	429
Divers Alert Network	672	539
Department of Health and Human Services, Tasmania	671	493
ACT Health	638	1,171
Centre for Forensic Behavioural Sciences, Monash University	482	-
Monash University Accident Research Centre	393	3,739
QLD Children's Commission for Young People and Young People	357	448
Office of the Emergency Services Commissioner	312	-
Victorian Department of Health	269	165
National Injury Surveillance Unit, Flinders University	260	751
The Alfred Hospital	213	775
Aust Fire and Emergency Services Authority Council	200	190
Epilepsy Australia	193	632
Flinders Uni Remote Health	188	-
Royal Prince Alfred/NSW Dept Forensic Medicine	133	281
Public Transport Safety Victoria	128	88
Centenary Institute	106	-

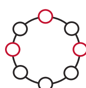


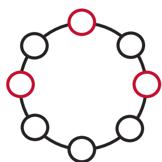
APPENDIX 5 - APPLICANTS GRANTED FEE RELIEF DURING 2011-12

FULL FEE RELIEF

Post Graduate Students

- University of Tasmania
- Department of Epidemiology and Preventive Medicine Monash University, and Ambulance Victoria
- Centre for Rural Emergency Medicine, Deakin University
- Monash University, Department of Forensic Medicine (Toxicology)
- Monash University, School of Psychology and Psychiatry (data extract fee waived)





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