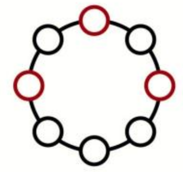
NCIS Annual Report 2012-13



Planning, Performance and Projects

TRIM ID: CD/13/308704*

State Government Victoria | Department of Justice

Contents

1 Directors Report 3

2 Benefits to the Community 4

3 Achievements and Challenges during 2012-13 6

4 Operational Statistics 8

5 Quality Assurance 13

6 Research and Publications 14

7 Staffing 17

8 Financial Reports 18

Appendix 1 Frequent NCIS Third Party Users in 2012-13 compared to 2011-12 20

Appendix 2 Governance Structure and Advisory Panels 22

Appendix 3 Status of NCIS Review Recommendations (as at 30 June 2013) 24

1 Directors Report

The implementation of new governance arrangements for the NCIS under the management of the Victorian Department of Justice commenced from 1 July 2012, and I am pleased to report the transition has all gone very smoothly. The newly comprised NCIS Board of Management and the newly established NCIS Advisory Committee each met three times during 2012-13, discussing a range of operational and strategic items.

Many of the recommendations arising from the NCIS Review conducted in 2011 were implemented during 2012-13 (Appendix 3) and several projects commenced which will strengthen the IT resilience of the NCIS. This includes a transition to a Java programming language, and the implementation of a backup remote offsite server which will permit system continuity in the event of primary server failure.

The NCIS Unit also developed a four year strategic plan for 2013-17 which was endorsed by the Board of Management. This will provide a clear direction for the NCIS over this period, and is available on the NCIS website (www.ncis.org.au).

During 2012-13 the NCIS Unit staff have continued to deliver high level support services to NCIS users including coroners and researchers. Two fact sheets about drug related deaths were produced by the NCIS Unit, and several high level reports were released by government agencies that were informed by data held on the NCIS (deaths in custody, police pursuits and driveway run-over deaths of children[1]).

I have found my first 12 months as the Director of the NCIS to be interesting and enjoyable, and I am proud to be associated with this international data resource which delivers quality coronial data to help prevent death and injury in our community.

NEIL TWIST
DIRECTOR NATIONAL CORONIAL INFORMATION SYSTEM
DIRECTOR PLANNING, PERFORMANCE AND PROJECTS
VICTORIAN DEPARTMENT OF JUSTICE

[1] See Section 6 for references to these reports

2 Benefits to the Community

2.1 Assisting in Death Investigations

- The NCIS Unit conducted 62 data searches for Death Investigators during 2012-13 and referred requesting parties to existing material on other numerous occasions.

- NCIS data was specifically referenced in a number of coronial findings made over this period, including determinations about children being crushed by heavy household items, children being run over in driveways, and scuba diving deaths.

- The Victorian and NSW Domestic Violence Teams at coronial offices both released reports based on their analysis of domestic violence related fatalities during 2012-13 which were informed by NCIS and local file access[1].

- The most frequent death investigation users of the NCIS during 2012-13 were ACT Clinical Forensic Medical Services, Domestic Violence Review Teams at coronial offices and the NSW Missing Persons Unit (see boxes below for information about how NCIS access benefits these organisations).

Box 1. ACT Clinical Forensic Medicine

Use the NCIS to provide cause of death findings as feedback to Forensic Medical Officers (FMO's) who attend death scenes.

"Having the cause of death findings adds to the medical staffs case learning and… provides them with some closure on some cases…it is beneficial for the medical staff to have the feedback so as they can reconcile their provisional thoughts on the cause of death and the pathologists findings."

Box 2. NSW Police, Missing Persons Unit

Use the NCIS to check if missing persons/unidentified body cases have been finalised.

"We are able to finalise files and locate missing persons off our databases."

2.2 Informing policy, awareness campaigns and practical change

A report about deaths and injury associated with child driveway run-over deaths was compiled by the Australian Department of Infrastructure and Transport during 2012-13 which relied heavily on fatality data from the NCIS. The report was released in August 2012, and in June 2013 the Federal Minister for Road Safety announced that Australia will be leading international research into the effectiveness of vehicle reversing cameras[2].

This research is noted to have the support of the European Commission, the United Kingdom, the United States of America and Germany and will collate data from participating countries about the effectiveness of such technologies. The Minister stated that "If the study finds that cameras are effective, Australia will consider seeking development of an international vehicle regulation through the United Nations.[3]"

[2] Bureau of Infrastructure, Transport and Regional Economics (BITRE), 2012, Child pedestrian safety: 'driveway deaths' and 'low-speed vehicle run-overs', Australia, 2001–10, Information Sheet 43, BITRE, Canberra

[3] Media Release by the Honourable Catherine King MP, Minister for Road Safety 16 June 2013 CK016/2013 "Australia heads international study on vehicle reversing cameras"

2.3 Identifying and alerting parties to mortality trends or concerns

In 2012-13, the NCIS Unit produced two publicly available Fact Sheets.

- Deaths related to Fentanyl Misuse (2000-2012)
- Opioid Deaths in Australia (2007-2009)

Data from these fact sheets were subsequently referenced in mainstream media articles[4].

2.4 Primary Data Source for Injury and Death Research

- Eighty-seven third party groups from 63 different agencies had access to the NCIS for research or monitoring purposes during 2012-13.
- Twenty-six academic journal articles were published during 2012-13 in which NCIS data was used as a data source. These publications covered a spectrum of topics such as deaths during recreation activities, deaths in the construction industry, deaths involving particular drugs, and deaths involving motorcycles.
- Several reports were released by the Australian Institute of Criminology which utilised NCIS data to examine the prevalence of deaths over a longitudinal period. This included an examination of motor vehicle police pursuit deaths over a twelve year period, and an analysis of deaths in custody over the past 20 years.
- Eight State, Federal or non-profit agencies used data from the NCIS to help inform annual reporting on specific types of deaths. This included topics such as drowning, work related deaths and child deaths, as well as the annual Cause of Death report produced by the Australian Bureau of Statistics.

See Section 6 for specific details of these publications.

[4] E.g. Dow, A. (2012). Spike in deaths from fentanyl overdoses, Sydney-Morning Herald, December 13 2012. http://www.smh.com.au/action/printArticle?id=3885273

3 Achievements and Challenges during 2012-13

3.1 Achievements

A combination of administrative and data related achievements are noted for the NCIS Unit during 2012-13.

- **Transition to new management and governance structure**
  - Successful first year of management of the NCIS Unit by the Victorian Department of Justice (‘the Department”)
  - Staff and budget for the NCIS Unit transferred to the Department
  - New composition and structure of NCIS Board of Management implemented and 3 meetings held (Appendix 2)
  - New NCIS Advisory Committee established and 3 meetings held (Appendix 2)
  - New processes for the management of media requests for coronial data (now referred to the Strategic Communications Unit within the Department)
  - Confirmed the operational structure for the assessment of any Freedom of Information requests

- **Implemented the majority of recommendations arising from the 2011 NCIS Review (Appendix 3)**

- **Four Year Strategic Plan prepared and endorsed by the NCIS Board of Management**

- **Progressed IT Risk mitigation strategies**
  - Commenced IT project for transition of NCIS programming language into Java
  - Commenced examination of remote offsite backup site

- **Launch of new NCIS public website**

- **Implemented additional validation rules for case management systems in Coronial Courts**
  - To assist with the quality and consistency of coronial data at the initial entry point (see Quality Assurance section for more detail)

- **Signed a three year intergovernmental agreement with the Australian Department of Health and Ageing to formalise funding support (2012-13, 2013-14 and 2014-15)**

- **Provided advice/assistance in relation to ICD-10 Cause of Death Unit Record File (COD URF) release**
  - Participated in National Data Management Framework Working Group
  - Developed an interim process for consideration of applications to access ICD-10 codes based on coronial data

3.2 Challenges

- **Various ethics committees/groups to consider data applications**

Over the past few years extra requirements have been put in place by some coronial offices in relation to the release of coronial data from the NCIS. This can often mean that numerous approvals are now required before coronial data can be provided. This is an ongoing concern due to the delays in data provision that can result, and the administrative impact of these processes at both the NCIS Unit and the coronial offices.

- **Increasing volume of closed cases to quality review**

An emphasis on closing completed cases on the NCIS at coronial offices has been a benefit for data completeness, but has also resulted in an increasing volume of cases that need to be quality checked by the NCIS Unit.

In 2012-13 more than 20,000 cases were closed on the NCIS by coronial offices.

During 2013-14 the NCIS Unit will be conducting an in-depth review of current NCIS Quality Assurance processes, with a view to streamlining processes where possible. Balancing the need for accuracy of data with available quality checking resources is an ongoing consideration.

- **Data release process for New Zealand**

Identifying an appropriate Ethics Committee to consider applications for New Zealand coronial data, and then customising the existing application forms to meet the NCIS requirements has proven more time consuming than originally anticipated.

As an interim measure, New Zealand applications for coronial data are initially being reviewed by the NCIS Unit and then approved by the Chief Coroner of New Zealand.

It is expected that review by a New Zealand Ethics Committee will support this process in the near future.

4 Operational Statistics

4.1 Usage Statistics

Death investigation users[5]

- There were over 13,000 searches of the NCIS conducted by death investigators during 2012-13 (Table 1).

  This is less than in previous years, however the majority of the reduction seems due to a decrease in use by a few NSW agencies which were extremely heavy users of the NCIS in previous years.
- The number of data reports produced the NCIS Unit for death investigators rose compared to 2011-12 levels (62 to 55, Table 1).
- During 2012-13 the most prevalent death investigation users of the NCIS were the NSW Domestic Violence Review Team; the NSW Police Missing Persons Unit, the Coroners Prevention Unit in Victoria and the ACT Clinical Forensic Medicine Service.

Table 1: System Use by Death Investigators

Type of search	2012-13	2011-12	2010-11
Query Design	1,631	3,530	4,304
Coroners Screen	1,885	1,681	3,101
Find Case screen	9,989	14,844	9,446
Externally Provided Codes screen	0	0	30
Requests made to NCIS staff	62	55	65
TOTAL	**13,537**	**20,110**	**16,946**

Third Party Users[6]

- Fourteen new third party applications were received in 2012-13, which is consistent with prior year application levels[7].
- Around three-quarters of these new applications came from universities or hospitals and were associated with specific research projects.
- Eighty-seven third party groups (from 63 different agencies) had approved access to the NCIS in 2012-13.
- Fifty-one of the 87 approved third party agencies (59%) with online access to the NCIS in 2012-13 were classed as “frequent third party users”.[8] (Appendix 1). This compares to 67% of third party users in 2011-12.

---

[5] 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.

[6] 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.

[7] An additional seven applications were received and processed for applicants who only wished to receive access to ICD-10 codes for coronial cases.

- Existing third party organisations which notably increased their use of the NCIS during 2012-13 included the National Drug and Alcohol Research Centre, the Queensland Child Death Review Team, the Australian Institute for Suicide Research and Prevention, Workplace Health and Safety Queensland, and the Monash University Department of Forensic Medicine.
- A decline in usage was seen for some organisations such as NSW Independent Transport Safety Regulator, National Critical Care and Trauma Response Centre, Vic Roads, Centre for Health Policy at Melbourne University and Queensland Police Drug and Alcohol Unit. This decline in usage is likely to be due to the completion of research or operational projects which required regular access to NCIS data.
- Approved third party users were also provided with NCIS data during 2012-13 via data extracts (n=4) and data reports (n=3).

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-eight searches for external parties were performed in 2012-13, which is consistent with 2011-12 levels (Table 2). In 30 additional instances, the NCIS Unit was able to refer a requesting party to existing material to meet their needs.

Table 2: De-identified data reports for external parties

Year	Searches performed for external parties
2012-13	38
2011-12	37
2010-11	45
2009-10	59

[8] "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.

4.2 Case Closure and Document Attachment

In most jurisdictions, the percentage of cases closed and reports available on the NCIS remained similar to 2011-12 levels (Table 3).

The proportion of Queensland cases with toxicology reports notably increased (up 11% from July 2012 levels) and the closed case percentages for NSW cases also increased slightly (from 79% to 84%).

As all New Zealand cases are closed before they are uploaded to the NCIS, the case closure rate for this jurisdiction was 100%, with high document attachment availability also a feature of the jurisdiction.

Unfortunately there are still very few autopsy reports available for South Australian cases.

Table 3: Case Closure and Document Attachment levels as at July 2013 compared to July 2012

State	Case Closure Average (%)		Finding Attachment (%)		Autopsy Attachment (%)		Toxicology Attachment (%)		Police Narrative Attachment (%)	
	July 13	July 12	July 13	July 12	July 13	July 12	July 13	July 12	July 13	July 12
ACT	95	94	99	99	92	92	67	67	100	100
NSW	84	79	60*	60*	69	72	71	74	56	55
NT	91	90	97	96	96	96	65	65	96	96
QLD	87	88	47	43	51	49	14	3	98	97
SA	95	96	99	98	1	1	9	10	100	100
TAS	92	93	92	90	77	77	91	91	100	100
VIC	87	87	97	99	92	92	98	98	94	93
WA	91	90	96	94	67	63	84	84	100	100
NZ	100	n/a	100	n/a	100	n/a	98	n/a	100	n/a

**Only of those cases that have gone to inquest.*

In order to examine the availability of documentation for cases most recently closed on the NCIS, Table 4 presents document attachment rates only for those cases closed during 2012-13 (compared to those closed during 2011-12).

The increased availability of toxicology reports for Queensland and South Australia is seen in Table 4 with around half of all cases closed in those jurisdictions during 2012-13 showing a toxicology report available. Conversely, the impact of a technical upload issue experienced in 2012-13 between the Coroners Court of Victoria and the NCIS is demonstrated by only 18% of Victorian cases closed during this period showing a coronial finding attached. The technical upload issue has been rectified, and the NCIS Unit is working with the court in an attempt to obtain a copy of these missing coronial findings where possible.

Table 4: Document Attachment levels (cases closed during 2012-13 as compared to those closed during 2011-12)

State	Finding Attachment (%)		Autopsy Attachment (%)		Toxicology Attachment (%)		Police Narrative Attachment (%)	
	July 13	July 12	July 13	July 12	July 13	July 12	July 13	July 12
ACT	99	95	92	91	87	84	93	100
NSW	46*	32*	45	56	42	59	35	45
NT	99	99	99	97	99	99	99	99
QLD	92	86	92	87	50	3	98	99
SA	100	100	0	0	49	1	99	99
TAS	100	99	99	100	99	83	98	98
VIC	18	91	97	95	94	98	95	88
WA	100	99	100	98	100	99	87	99
NZ	100	n/a	94	n/a	94	n/a	97	n/a

**Only of those cases that have gone to inquest.*

4.3 Timeliness of Case Closure

During 2012-13 case closure timeliness continued to show high levels in ACT, South Australia, the Northern Territory, 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 (Table 5).

The timeliness of case closure in Queensland increased by 14% from 2011-12 levels, yet Tasmania experienced a decline of 8%. Tasmania's decline was likely due to resourcing issues at the court during this period.

Case closure timeliness on the NCIS in Victoria and NSW during 2012-13 was low, although this is likely influenced in part by the fact that notable proportions of backlog data entry were conducted in these states during 2012-13[9].

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

State	% cases between 2012-13	% cases between 2011-12	% cases between 2010-11
ACT	99	98	98
NSW	27	20	23
NT	98	98	94
QLD	77	63	68
SA	99	99	98
TAS	82	90	90
WA	99	99	98
VIC	38	59	63

4.4 User Audits

During 2012-13 usage of the NCIS was audited for three randomly selected death investigation users and six randomly selected third party users. There were no concerns surrounding the use of the NCIS identified during these audits.

[9] In NSW and Victoria, 63% and 32% of all cases closed on the NCIS during 2012-13 respectively had been completed by the coroner prior to 2012-13. When only examining instances where the coroner completed the case in 2012-13, Victoria closed 50% on the NCIS within 60 days, and NSW closed 72% on the NCIS within 60 days.

5 Quality Assurance

During 2012-13 Quality Assurance activities included:

- the review of 17,400 Australian and New Zealand coronial cases that were closed on the NCIS
- the review and correction of 2,800 cases that had previously been submitted back to the jurisdictions for coding amendments to be made.

A significant project during 2012-13 was implementation of additional validation rules into local case management systems used in the Courts. These rules were implemented in jurisdictions where the court case management systems are supported by the NCIS Unit (ACT, Queensland, Tasmania, Northern Territory and Western Australia). These rules should prevent commonly made coding errors being accepted into the case management systems during data entry. Similar rules are expected to be implemented in the web based NCIS data entry interface used by Victoria and New South Wales[10].

Another project undertaken by the Quality Team in 2012-13 involved the development of two online e-training modules relating to NCIS coding. These modules (which relate to mechanism/ object coding and transport incident coding) will be released on the NCIS website in early 2013-14. These modules will enable new coders to engage in self-initiated training sessions when it is not possible for the NCIS Quality Manager to provide a face to face coder training session at the court. Further e-learning NCIS coding modules will be developed and released in 2013-14.

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

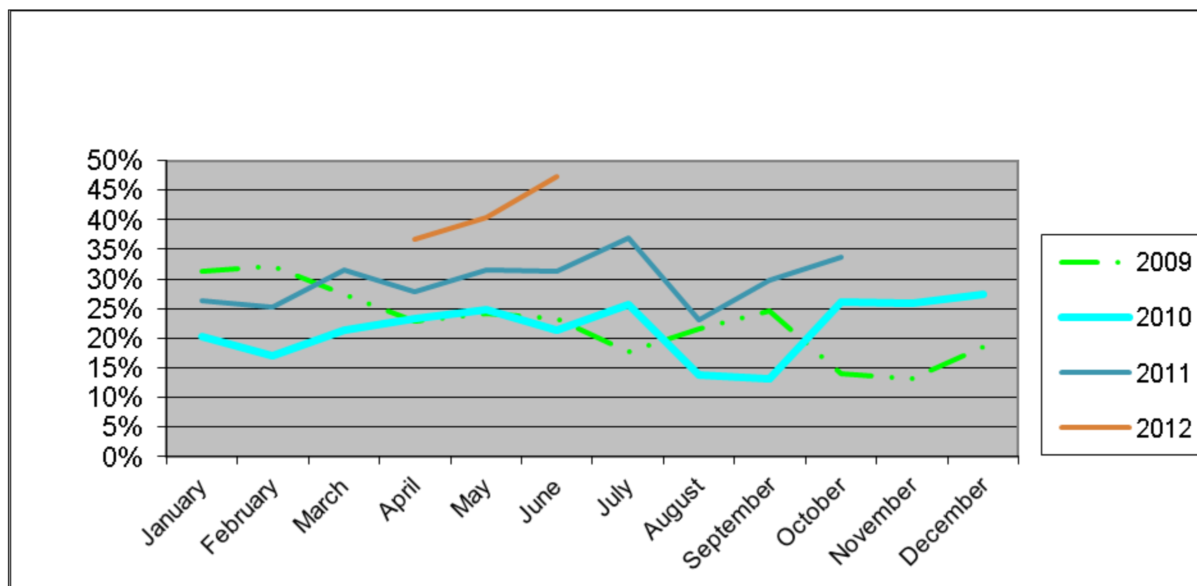


Figure 1 shows that while the percentage of cases with critical errors fluctuates quite regularly, a higher error percentage is seen for cases closed in 2012. It is suggested that this increase is a result of a large number of cases being coded and closed on the NCIS in two of the larger jurisdictions. While this volume of case closure was welcomed, it did mean that a higher number of errors were made as not all clerks in these jurisdictions had been trained on NCIS data entry.

[10] South Australia has not yet received the additional validation rules as the Coroners Court have recently commenced using new case management system.

6 Research and Publications

Academic Publications

Andrew, N. E., Gabbe, B. J., Wolfe, R. & Cameron, P. A. (2012). Trends in sport and active recreation injuries resulting in major trauma or death in adults in Victoria, Australia, 2001–2007. *Injury*, 43(9), 1527-1533.

Anthikkat, A., Page, A. & Barker, R. (2013). Low-speed vehicle run over fatalities in Australian children aged 0–5 years. *J Paediatr Child Health.* 49 (5), 388-393.

Bambach M., Grzebieta R. & McIntosh A. (2012). Injury typology of fatal motorcycle collisions with roadside barriers in Australia and New Zealand, *Accident Analysis and Prevention*. 49, 253-260.

Bambach, M., Grzebieta R. & McIntosh, A. (2013). The Crash Mechanics of Fatal Motorcycle–Barrier Collisions in Australasia, *Journal of Transportation Safety & Security*. 5:1, 66-77.

Bambach, M., Grzebieta, R., McIntosh, A. & Mattos, G. (2013). Cervical and Thoracic spine injury from interactions with vehicle roofs in pure rollover crashes. *Accident Analysis and Prevention*. 50, 34-43.

Brown, T. & Tyson, D. (2012). An Abominable Crime: Filicide in the Context of Parental Separation and Divorce. *Children Australia*. 37, 151-160.

Cheung, Y., Spittal, M., Williamson, M., Tung, S. & Pirkis, J. (2013). Application of scan statistics to detect suicide clusters in Australia. *PloS one*. 8(1), e54168.

Grzebieta, R., Mitchell, R., Zou, R. & Rechnitzer, G. (2013). Go-kart-related injuries and fatalities in Australia. *International Journal of Crashworthiness*, (ahead-of-print), 1-9.

Goeman, D., Abramson, M., McCathry, E., Zubrinich, C. & Douglas, J. (2013). Asthma mortality in Australia in the 21st century: a case series analysis. *BMJ Open*. 3:e002539 doi:10.1136.

Kitching, F., Jones, C., Ibrahim, J. & Ozanne-Smith, J.(2013). Pedestrian worker fatalities in workplace locations, Australia, 2000–2010. *International Journal of Injury Control and Safety Promotion.* (ahead-of-print), 1-7.

Kuipers, P., Appleton, J. & Pridmore, S. (2012). Thematic analysis of key factors associated with Indigenous and non-Indigenous suicide in the Northern Territory, Australia. *Rural and Remote Health.* 12(4), 2235.

Kuipers, P., Appleton, J. & Pridmore, S. (2013). Lexical analysis of coronial suicide reports: A useful foundation for theory building. *Advances in Mental Health*. 11(2), 197-203.

Lingard, H., Cooke, T. & Gharaie, E. (2013). A case study analysis of fatal incidents involving excavators in the Australian construction industry. *Engineering, Construction and Architectural Management.* 20(5), 5-5.

Lingard, H., Cooke, T. & Gharaie, E. (2013). The how and why of plant-related fatalities in the Australian construction industry. *Engineering, Construction and Architectural Management.*20(4), 365-380.

Lower, T. (2013), Quad bikes: tobacco on four wheels. *Australian and New Zealand Journal of Public Health.* 37, 105–107.

Lower, T., Pollock, K. & Herde, E. (2013), Australian quad bike fatalities: what is the economic cost? *Australian and New Zealand Journal of Public Health*. 37, 173–178.

Machlin, A., Pirkis, J., & Spittal, M. (2012). Which Suicides Are Reported in the Media–and What Makes Them “Newsworthy?” *Crisis: The Journal of Crisis Intervention and Suicide Prevention*. 1-9.

Mattos, G., Grzebieta, R., Bambach, M. & Mcintosh, A. (2012). Head Injuries to Restrained Occupants in Single-Vehicle Rollover Only Crashes, *Traffic Injury Prevention*. 14(4), 360-8.

Pilgrim, J. & Drummer, O. (2013). The toxicology and comorbidities of fatal cases involving quetiapine. *Forensic Science, Medicine, and Pathology*. 9(2), 170-176.

Pilgrim, J., Gerostomoulos, D. & Drummer, O. (2012). The role of toxicology interpretations in prevention of sudden death. *Forensic Science, Medicine, and Pathology*. 8 (3), 263-269.

Pilgrim, J., Gerostamoulos, D., Woodford, N. & Drummer, O. (2012). Serotonin toxicity involving MDMA (ecstasy) and moclobemide. *Forensic Science International.* 215(1), 184-188*.

Pilgrim, J., Woodford, N. & Drummer, O. (2013). Cocaine in sudden and unexpected death: A review of 49 post-mortem cases. *Forensic Science International*. 227 (1-3),52-59.

Porter, L. (2013). Indigenous deaths associated with police contact in Australia: Event stages and lessons for prevention. *Australian & New Zealand Journal of Criminology*. 46(2), 178-199.

Pridmore, S., Kuipers, P. & Appleton, J. (2013). The ‘Operationalized Predicaments of Suicide’ (OPS) applied to Northern Territory coroners’ reports. *Asian Journal of Psychiatry*. 6 (3), 214-217.

Roxburgh, A., Burns, L., Drummer, O., Pilgrim, J., Farrell, M. & Degenhardt, L. (2013). Trends in fentanyl prescriptions and fentanyl-related mortality in Australia. *Drug Alcohol Review.* 32(3), 269-275.

Walter, S., Bugeja, L, Spittala, M. & Studdert, D. (2012), Geographic variation in inquest rates in Australia. *Health and Place.* 18 (6), 1430-1435.

** Published in 2011-12 but not captured in NCIS 2011-12 annual report.*

Research reports

Bureau of Infrastructure, Transport and Regional Economics (BITRE) (2012). *Child pedestrian safety: ‘driveway deaths’ and ‘low-speed vehicle run-overs’,* Australia, 2001–10, Information Sheet 43, BITRE, Canberra.

Coroners Court of Victoria (2012). *Victorian Systematic Review of Family Violence Deaths –First Report.* Melbourne.

Lyneham, M. & Chan, A. (2013). *Deaths in Custody in Australia to 30 June 2011: Twenty years of monitoring by the National Deaths in Custody Program since the Royal Commission into Aboriginal Deaths in Custody.* Australian Institute of Criminology: Canberra.

Lyneham, M. & Hewitt-Rau, A. (2013). *Motor Vehicle Pursuit-related fatalities in Australia, 2000-2011.* Trends and Issues in Crime and Criminal Justice. No. 452. Australian Institute of Criminology: Canberra.

NSW Department of Attorney-General (2012). *NSW Domestic Violence Death Review Team Annual Report 2010-11.* Sydney.

NT Royal Life Saving Society (2012). *Northern Territory 9 Year Drowning Report.* Sydney.

QLD Commission for Children and Young People (2013). *Trends and Issues Paper: Child Deaths – Supervision of children under 5 around transport hazards.* (14). March 2013. Brisbane.

Royal Life Saving Society Australia (2012). *The Forgotten 50%: Analysis Of Drowning In Children Aged 5-19 Years In Australia.* RLSSA: Sydney.

Annual reports

Annual Report 2011-12, Queensland Child Death Case Review Committee.

Causes of Death Report 2011, Australian Bureau of Statistics.

Chief Psychiatrists Annual Report 2011-12, Victorian Department of Health.

National Coastal Safety Report 2011, Surf Life Saving Australia.

Victorian Drowning Report 2011/2012, Life Saving Victoria.

Victorian State Trauma Registry 2010-11 Summary Report.

Victorian State Trauma Registry 2011-12 Summary Report.

Work Related Traumatic Injury Fatalities, 2010-11, Safe Work Australia.

Presentations

Hanley, M. (2012*). "Choking, Coroners and Clinical Care."* Tasmanian Department of Health and Human Services.

Lower, T & Herde, E. (2013), *Australian quad bike deaths (2000-2010).* Are you remotely interested... in prevention; building a culture of safety Conference, 1-4 August 2012, Mt Isa Queensland.

Other publications

Barron, S. (2013). *Policing Organisation. Policing and the Mentally Ill: International Perspectives*, 247. (Book Chapter).

7 Staffing

Manager

Jessica Jackson (nee Pearse)

Quality Manager

Leanne Daking

Quality Assurance/IT Officer

Tony Chan

Quality Assistant

Jill Russell (0.6)

Access Officer

Jo Cotsonis

Coronial Liaison Officer

Lisa Crockett

Administration Officer

Catherine Daley (0.6) / Sharon Callaghan (0.2)*

Senior Research Officer

Steven Haas^ / Eva Saar**

* from October 2012

^^until March 2013

** from May 2013

8 Financial Reports

Statement of Receipts and Expenditure – NCIS

For the year ended 30 June 2013

	2013 $	2012 $
Opening balance (Cash in bank)	685,822	700,762
Add Receipts		
Income		
Government grants	1,047,048	1,011,994
User pays (1)	178,776	155,834
TOTAL	1,225,824	1,167,828
Less Expenses		
Audit services	0	3,000
Contractors, consultants and professional service expenses (2)	59,548	100,303
Depreciation	13,648	10,076
Employee related expenses	635,997	572,674
Information technology expenses	300,145	238,840
Other operating expenses	162	65
Postage and communication expenses	1,377	2,506
Printing, stationery and other office expenses	8,856	4,567
Staff training and development expenses (3)	11,773	2,444
Travel, entertainment and personal expenses	11,477	10,888
Utilities and services	119,951	189,996
TOTAL	1,162,934	1,135,359
Balance for the year	62,890	32,469
Capital expenditure	0	43,967
Accrued expenses	178	0
Depreciation	13,648	10,076
Grants paid in advance	122,503	0
Receivables	286,897	0
Movement in employee provisions (4)	6,589	(13,518)
Closing balance (Cash in bank)	604,733	685,822

Note: 2011-12 cash balance was overstated by $43,967, being assets purchased in 2011-12. An adjustment for movement in employee provisions of ($13,518) in 2011-12 has also been made. This has been reflected in the above comparatives.

Explanatory Notes for Statement of Receipts and Expenditure

(1) User Pays total includes New Zealand funding contribution ($91,609).

(2) The majority of contractor/consultant expenditure related to approved engagement of Java contractor ($56,305).

(3) The majority of staff training expenditure related to approved Java training ($10,000).

(4) Provisions for employee benefits consist of amounts for annual leave and long service leave accrued by employees. Provisions are recognised when NCIS has a present obligation, the future sacrifice of economic benefits is probable, and the amount of the provision can be measured reliably. The amount recognised as a provision is the best estimate of the consideration required to settle the present obligation at reporting period, taking into account the risks and uncertainties surrounding the obligation. The amount recognised as a provision is the best estimate of the consideration required to settle the present obligation at reporting period, taking into account the risks and uncertainties surrounding the obligation.

Government Contributions made in 2012-13 (Australia & New Zealand)

Table 6: Government Funding Contributions made in 2012-13

Agency	Amount contributed $AUD (GST Exclusive)
Australia	
Commonwealth	541,819
New South Wales	165,008
Victoria	125,196
Queensland	100,945
South Australia	37,892
Western Australia	51,028
Tasmania	11,822
ACT	8,185
NT	5,153
Australian Total	**1,047,048**
New Zealand	91,609
TOTAL (Aus & NZ)	**1,138,657**

Products Purchased in 2012-13

Type of Product	Number Purchased*
Online Subscriptions	27
Data Extracts	0
Data Reports	18
TOTAL	**45**

* There were an additional 60 online subscriptions, 10 data extracts and 20 data reports provided to external parties in 2012-13, 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.

Appendix 1 Frequent NCIS Third Party Users in 2012-13 compared to 2011-12

Organisation	Total Search Screen Accesses 2012-13	Total Search Screen Accesses 2011-12
Victorian Institute of Forensic Medicine/Monash Dept of Forensic Medicine	13,357	9,216
Royal Life Saving Society of Australia	10,988	11,931
Department of Health, South Australia	10,230	11,680
Australian Bureau of Statistics	10,190	11,182
Safe Work Australia	10,089	11,982
National Drug and Alcohol Research Council	7,055	1,673
Australian Institute for Suicide Research and Prevention, Griffith University	6,939	4,592
NSW Child Death Review Team	6,192	6,246
Surf Life Saving Australia	4,904	6,360
Workplace Health and Safety QLD	4,588	2,694
Department of Epidemiology, Monash University	4,484	3,805
NSW Road Traffic Authority	3,956	3,131
Australian Institute of Criminology	3,702	4,571
Consultative Council on Obstetric and Paediatric Mortality and Morbidity (CCOPMM)	3,007	2,959
Australian Centre for Agricultural Health and Safety, Uni of Sydney	2,548	1,741
School of Anthropology and Archaeology, Australian National University	2,444	1,770
Royal Australian College of Surgeons (including Vic Surgical Consultative Committee)	2,224	2,045
Australian Competition and Consumer Commission (ACCC)	2,023	1,132
QLD Children’s Commission for Children and Young People	1,894	357
Office of Correctional Services Review, Victoria	1,611	1,239
Centenary Institute	1,550	106
VicRoads	1,483	2,013
WA Drugs and Alcohol Authority	1,302	773
Centre for Forensic Behavioural Sciences, Monash University	1,248	482

NSW Independent Transport Safety Regulator	1,188	3,094
Office of the Federal Safety Commissioner	1,098	n/a
ACT Health	1,075	638
Griffith University	1,013	798
Department of Health, NSW (includes Epidemiology, Poisons Centre & Birth Defects Registry)	1,001	1,148
CARRS-Q, Queensland Uni of Technology	860	n/a
Centre for Health Policy, Melbourne University	790	1,565
NSW Risk Management Centre/NSW Transport	679	n/a
The McCaughey Centre, University of Melbourne	624	n/a
Life Saving Victoria	556	834
Divers Alert Network	437	672
NSW Injury Risk Management Research Centre	431	n/a
QLD Police - Drug & Alcohol Unit	385	1,317
NSW Institute of Trauma and Injury Management	366	706
Transport and Road Safety Research, University of NSW	357	n/a
National Injury Surveillance Unit, Flinders University	336	260
University of Sydney / Canberra Hospital	317	n/a
Family and Friends Missing Persons Unit, NSW Attorney-General's Department	307	n/a
Curtin University	307	n/a
National Critical Care and Trauma Response Centre	250	2,732
University of Tasmania	177	n/a
Epilepsy Australia	152	193
Public Transport Safety Victoria	147	128
The Alfred Hospital	135	213
Victorian Department of Health	125	269
Monash University Injury Research Institute (incorporating Monash University Accident Research Centre and VISAR)	110	393

Appendix 2 Governance Structure and Advisory Panels

NCIS Board of Management

Ms Penny Armytage/ Ms Claire Noone/ Mr Greg Shanahan (Chair)

Secretary/Acting Secretary, Victorian Department of Justice

Representative of Host Agency (VIC)

Mr Laurie Glanfield

Director-General, NSW Attorney-General's Department

Representative of Large Jurisdictions (NSW, QLD, NZ)

Ms Kathy Leigh

Director General, ACT Justice and Community Services Directorate

Representative of Smaller Jurisdictions (ACT, NT, SA, WA, TAS)

Professor James Harrison

Director National Injury Surveillance Unit

Representative of Public Health Researchers

Judge Jennifer Coate/ Judge Ian Gray

State Coroner of Victoria

Representative of State/Chief Coroners

Meetings held in October 2012, February 2013, and May 2013

NCIS Advisory Committee

Mr Neil Twist (Chair)
Director NCIS/Director PPP Unit
Victorian Department of Justice

Magistrate Michael Barnes
State Coroner
Queensland Coroners Court

Professor Stephen Cordner
Director
Victorian Institute of Forensic Medicine

A/Professor Tim Driscoll
School of Public Health
University of Sydney

Professor Olaf Drummer
Head of Scientific Services
Victorian Institute of Forensic Medicine

Mr James Eynestone-Hinkins
Director of Social and Demographic Statistics
Australian Bureau of Statistics

Professor James Harrison
Director
Research Centre of Injury Studies

Ms Jessica Jackson
Manager NCIS
Victorian Department of Justice

Professor Joan Ozanne-Smith
Head of Prevention Research
Department of Forensic Medicine, Monash University

Meetings held in September 2012, January 2013, and March 2013

Appendix 3 Status of NCIS Review Recommendations (as at 30 June 2013)

	Recommendation	Status
1	The Board consider 3 alternatives for the governance arrangement of the NCIS	Completed
2	NCIS seek advice in developing appropriate governance documentation which will succeed the current Heads of Agreement	Completed
3	NCIS Board Composition be reconsidered to ensure it has appropriate level of skills	Completed
4	The Governance Structure include an advisory group which would represent all relevant stakeholder views	Completed
5	Implementation of a risk management plan to identify, assess, monitor and manage risks to the NCIS (updated annually, monitored bi-annually)	In progress
6	During the next Strategic Planning process - ensure vision statement reflects broader aspirational role and purpose of NCIS	Completed
7	During the next Strategic Planning process - clarify strategies and actions involved in implementing goals	Completed
8	Revisit and further develop the Communications Strategy to incorporate strategies to engage with Coroners, the CPU and users	In progress
9	Enhance website functionalities, content relevance and currency to ensure congruence with information requirements of users and to maximise access	Yet to be commenced
10	Increase the frequency of user survey to annual, and expand survey to include questions on other services and products of NCIS	In progress
11	Identify opportunities to engage and collaborate with Coroners Prevention Unit (Victorian Coroners Court)	In progress
12	Out post an officer from the ABS to assist with the development of a data quality framework, revision of access agreements and development of new publications	Completed
13	The Board revise data access agreements to facilitate the release of de-identified statistics, reduce the number of requests to coroners, and increase the timeliness of providing data	In progress
14	Complete implementation of regular auditing of access by users and provide regular reporting of results to Board and in Annual report	Completed
15	Advise the Board on the technical feasibility of blocking users from access to cases that are not relevant to the reason for access	In progress
16	Increase proactive release of data through regular and ad hoc publications that do not compete with existing publications by other organisations such as ABS and AIHW	In progress
17	Increase the impact of NCIS publications through greater use of partnerships with appropriate organisations such as the AIHW, industry groups and the Coroners Prevention Unit	In progress
18	The NCIS Unit include standardised quality statements on all publications and summary statistics released advising users on the correct interpretation of the data and to reduce accidental misuse of the statistics	Yet to be commenced
19	Investigation the information available to third party users via Level 2 access to establish if changes can be made to meet more research needs without access to fully identified data	Yet to be commenced
20	Instigate a systematic review of data quality and develop a data quality framework for the evaluation and measurement of data quality to inform the management of the NCIS and decision making about data release policies	In progress
21	The Board consider establishing an implementation team	Completed
22	The NCIS Unit develop a communication strategy to clearly communicate the new governance structure to all stakeholders	Completed