



**NCIS**

# **National Coronial Information System (NCIS) Annual Report 2013-14**



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## 1 Director's forward

In 2012, the introduction of a new governance arrangement between the NCIS and the Victorian Department of Justice was reported as a smooth transition. I am pleased to report that the governance arrangement is continuing to prove positive for the NCIS with the completion of all recommendations from the 2011 NCIS Review and delivery of most items on the NCIS Business Plan. The NCIS has strong support from the Board of Management and from the NCIS Advisory Committee and each met three times during 2013-14, discussing a range of operational and strategic items.

All of the recommendations made in the NCIS Review in 2011 were implemented or incorporated into ongoing operational procedures. This included two significant IT developments; the implementation of an offsite backup sever to ensure system continuity in the event of primary server failure and the transition to a Java programming language for the NCIS website. The transition to Java was exceptionally well executed by our IT support and we are all seeing the benefits of this shift to Java.

The NCIS Unit completed ten of thirteen items in the 2013-14 Business Plan. Those items not completed were due to external delays and will be carried over to the 2014-15 Business Plan, which will also incorporate the second year items from our 2013-17 Strategic Plan. All documents are available on the NCIS website [www.ncis.org.au](http://www.ncis.org.au).

During 2013-14 the NCIS Unit staff have continued to deliver high level support services to NCIS users including coroners and researchers. Staff made presentations at three national conferences and maintained our commitment to contributing to the death investigation and research community with our participation in the National Committee for Standardised Reporting of Suicide (NCSRS). A report produced by the NCIS for the Australian Human Rights Commission into self-harm deaths among young people will be referenced in a Parliamentary Submission in November 2014. The NCIS has produced two publicly available fact sheets including an update to fentanyl misuse and thereby contributing data to the ongoing public discourse on misuse of prescription drugs.

The NCIS continued our commitment to stakeholder engagement and have plans to expand this in the 2014-15 year.

The NCIS continues to be an essential resource for death investigation and death and injury prevention. This report outlines activities undertaken in the past 12 months to ensure the continuity and ongoing value of the system.



**NEIL TWIST**  
**DIRECTOR NATIONAL CORONIAL INFORMATION SYSTEM**  
**DIRECTOR STRATEGIC PLANNING**  
**VICTORIAN DEPARTMENT OF JUSTICE**

## 2 Benefits to the community

### 2.1 Assisting in death investigations

In 2013-14 the NCIS continued to assist the research community in death investigation and prevention.

- ◆ The NCIS Unit conducted 42 data searches for external agencies during 2013-14 and referred requesting parties to existing material on numerous other occasions.
- ◆ NCIS data was specifically referenced in a number of coronial findings made over this period, including a determination about abuse of prescription drugs and 'Doctor Shopping'.
- ◆ Continuing our support of domestic violence research and data analysis, the NCIS introduced two new fields to identify cases of family domestic violence.
- ◆ Among the most frequent death investigation users of the NCIS during 2013-14 were the Victorian Coroners Court including the Coroner's Prevention Unit, the New South Wales Road Traffic Authority and the New South Wales Police Missing Persons Unit.
- ◆ The Royal Life Saving Society of Australia (RLSSA) is a long time user of the NCIS. Data contained in the NCIS has assisted the RLSSA in reporting on aquatic related fatalities and directing awareness campaigns for drowning prevention. In the box below the RLSSA has provided endorsement for the NCIS.

**Justin Scarr, CEO, The Royal Life Saving Society Australia**

*The RLSSA uses the NCIS to inform and support drowning prevention research and policy.*

The NCIS has been instrumental in the strengthening of the Royal Life Saving National Fatal Drowning Database, which holds valuable information on all unintentional fatal drowning across all aquatic locations and stretches back to 2002/03. The depth and quality of information, gathered through the NCIS, enhances the support Royal Life Saving provides to Government, Coroners and the community in terms of drowning prevention research and policy. The staff at NCIS are valuable and attentive partners, that assist Royal Life Saving research staff to maximise the potential of the NCIS & our drowning prevention and water safety efforts.

## 2.2 Identifying and alerting parties to mortality trends or concerns

In 2013-14, the NCIS Unit produced two publicly available Fact Sheets and one edition of Fatal Facts.

- ◆ *Fact Sheet* - Deaths related to Fentanyl Misuse – Updated
- ◆ *Fact Sheet* - Jetski Deaths (2000-2012)
- ◆ *Fatal Facts Edition 24* – Newsletter compilation of cases including coronial recommendation. Focus on deaths of children in care

## 2.3 Primary data source for injury and death research

Data sourced from the NCIS was used widely by injury and death researchers.

- ◆ Eighty-three third party groups had access to the NCIS at 30 June 2014 for ethically approved research projects. Fifteen of these were new projects which commenced during the 2013-14 financial year and eight were projects renewed during this period. Project topics included research into specific circumstances of death such as work related, drowning, product related and transport related death and death in care. Other projects involve longitudinal studies for the evaluation and identification of risk factors among particular groups in the population. Eleven applications were received and processed for researchers who only required access to ICD-10 codes for coronial cases.
- ◆ Sixty academic journal articles were published during 2013-14 which used NCIS data as a data source. Articles were published in a wide range of journals including both national and international publications. (See Section 6 for details about these publications).
- ◆ The Australian Human Rights Commission National Children's Commissioner requested a report on the instances of intentional self-harm resulting in death among children and youth age 17 years and under. Under the *Australian Human Rights Commission Act 1986* (Cth), the National Children's Commissioner has a statutory requirement to submit a report to Parliament, relating to the enjoyment and exercise of human rights by children in Australia. The data contained in this NCIS report will contribute to the Parliamentary report and promote discussion and awareness of matters relating to the human rights of children in Australia.

## 3 Achievements and challenges during 2013-14

### 3.1 Achievements

- ◆ **Completion of all recommendations from the 2011 NCIS Review**
  - The 2011 review identified 22 recommendations for the NCIS. All recommendations have now been implemented in full or form part of ongoing operational practice.
- ◆ **Completion of IT Java project**
  - Completion of IT project for the transition of NCIS programming language to Java
  - Implementation of Java to the NCIS production environment with limited downtime for users
  - Increased security through enhanced password protection
- ◆ **Progressed IT risk mitigation strategies**
  - Implementation of a remote backup site
- ◆ **Progressed strategies for increased data quality**
  - Implementation of data entry validation rules
  - Completion of an independent review of the quality assurance process to address the backlog of cases awaiting review. Four recommendations were made and will be responded to in the 2014-15 financial year
  - Implementation of two new fields to identify cases of family domestic violence
  - Delivery of 14 sessions of face-to-face coder training
  - Launch of seven online training modules for coding on the NCIS
  - Progression of project to geocode all NCIS cases. 19,000 cases were geocoded in the 2013-14 financial year resulting in a total of over 60,000 cases with geocoded residential and incident address coding available on the NCIS.
- ◆ **On-provision approval process established**
  - Established and implemented a process for approved agencies to on-provide the ICD-10 Cause of Death Unit Record File (COD URF) as required.
- ◆ **Conference presentations by NCIS staff at three national conferences**
  - Presentation at the Health Information Management Association of Australia (HIMAA) Conference in Adelaide in October 2013. The presentation focused using the NCIS for research.
  - Presentation at the 11<sup>th</sup> Australasian Injury Prevention and Safety Promotion Conference in November 2013 in Freemantle and at the Australian Mortality Interest Group (AMDIG) Conference in November 2013 in Canberra. Each presentation focused on the opportunity to use the NCIS to collect data on Family Domestic Violence
- ◆ **Delivery of all reporting requirements under the NCIS Commonwealth Funding Agreement**
- ◆ **Transfer of New Zealand closed cases and progression of the automated transfer of data**
  - Over 3000 NZ cases added to the NCIS in 2013-14
  - Automated transfer of data scheduled to commence in August 2014.

## 3.2 Challenges

### **Increasing volume of closed cases for quality assurance review.**

- ◆ In 2013-14 more than 19,000 cases were closed on the NCIS by coronial offices. The NCIS conducted a quality assurance review on more than 13,000 closed cases. Due to a four month gap in staffing resource and current procedures which ensure 100% quality assurance coverage, the backlog of cases that require quality checking has increased.
- ◆ During 2013-14 the NCIS Unit conducted an independent review of the quality assurance process with the aim to identify ways to reduce the backlog while balancing the need for accurate and timely data. The recommendations from this review will be implemented in 2014-15.

### **Access security breach**

- ◆ In October 2013, the NCIS Manager was alerted to an access breach by a staff member at the Australian Institute of Criminology (AIC). Investigations found the staff member had inadvertently supplied information to another NCIS user with a more limited level of access. The NCIS Board of Management were alerted to the breach and the subsequent course of action by the AIC. The Board were satisfied the matter was dealt with efficiently and professionally.

### **Staff resourcing**

- ◆ The NCIS Coronial Liaison Officer has been absent from the role since November 2013 due to a Workplace Injury. This absence has left a gap in the capacity to support coronial staff and significantly reduced our ability to seek new opportunities for the development of relationships.

### **Document attachment**

- ◆ The NCIS has continued to experience difficulty in securing autopsy reports from South Australia. Reports are not automatically transferred from the local case management system and we currently have no existing process for securing these reports, resulting in large gaps in the level of document attachment for South Australian cases. This incomplete data has a flow on effect to death investigators and researchers. The NCIS will look at options for solving this in 2014-15.

## 4 Operational statistics

### 4.1 Usage statistics

#### Death investigators<sup>1</sup>

- ◆ There were over 23,000 searches of the NCIS conducted by death investigators during 2013-14 (Table 1).
- ◆ This is less than in previous years, however there is an increase in the number of searches conducted using the Coroners Search Screen.

Table 1: NCIS searches launched by death investigators

Type of search <sup>2</sup>	2013-14	2012-13	2011-12
Query Design	528	920	1,741
Coroners Screen	1,039	814	883
Find Case screen	22,132	29,234	43,828
<b>TOTAL</b>	<b>23,699</b>	<b>30,968</b>	<b>46,452</b>

#### Third party users<sup>3</sup>

- ◆ There were over 61,000 searches of the NCIS executed by third party researchers during 2013-14 (Table 2). This is an increase from the previous two years.
- ◆ Eighty-three active third party groups had ethically approved access to the NCIS in 2013-14. This is a slight reduction (5 less) from the previous year.
- ◆ Fifteen new third party applications were received in 2013-14, which is consistent with previous application levels. An additional eight existing projects were renewed.
- ◆ Eleven applications were received and processed for applicants who only wished to receive access to ICD-10 codes for coronial cases.

Table 2: NCIS searches launched by third party researchers

Type of search	2013-14	2012-13	2011-12
Query Design	2,601	2,695	2,746
Coroners Screen	893	550	409
Find Case screen	57,745	56,783	54,747
<b>TOTAL</b>	<b>61,239</b>	<b>60,028</b>	<b>57,892</b>

<sup>1</sup> 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.

<sup>2</sup> The three types of searches, Query Design, Coroners Screen and Find Case Screen can be used interchangeably by all users. The Query Design is a narrow search and allows the user to create a specific query on any of the data collected. The Coroners Screen is a broad search utilising attached documentation. The Find Case search is a broad or narrow search dependent in the information the user inputs.

<sup>3</sup> 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.



### Usage by other groups<sup>4</sup>

- ◆ A variety of government, private and media organisations obtained aggregate data from the NCIS via data reports compiled by NCIS staff. In addition, the NCIS staff assist coronial death investigators in searching the NCIS as requested.
- ◆ Throughout 2013-14, 61 searches were conducted by the NCIS staff on behalf of users. The breakdown is detailed in Table 3.
- ◆ In several instances, the NCIS Unit was able to refer a requesting party to existing material to meet their needs

*Table 3: De-identified data reports for external parties and coronial death investigators*

Organisation type	Number of searches performed by NCIS staff
External Interest Groups	42
Media Organisations	8
Death Investigators	11
<b>TOTAL</b>	<b>61</b>

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<sup>4</sup> Other groups include the media, external interest groups and service providers. The NCIS prepares reports containing aggregate data on request. The NCIS also conducts searches to assist death investigators as required.

## 4.2 Document attachment

The NCIS reports on the level of supporting documentation attached to each case.

In addition to coded data, the NCIS attaches medico-legal documentation in the form of four different supporting documents to each case. These are: Coronial Finding, Autopsy Report, Toxicology Report and Police Narrative. Ideally, all four document types should be attached to each case though it will not always be possible as coronial jurisdictions operate differently and not all cases require all four reports.

Supporting documents are invaluable to researchers for the context and case detail they provide.

Table 4 lists the percentage of document attachment for all four document types by jurisdiction over the last three financial years (inclusion criteria is for cases closed on the NCIS in the specified reporting period).

In most jurisdictions, the percentage of reports attached to closed cases on the NCIS remained similar to previous levels, with a notable increase in the attachment of toxicology reports in Queensland and South Australia and for coronial findings in Victoria. For all four document types, New South Wales had a lower percentage of attachment from the previous year.

The absence of autopsy reports from South Australia will be addressed as part of an NCIS quality assurance review in 2014-15.

In 2014-15, as part of the NCIS Quality Assurance Review, the NCIS Unit will investigate the transfer process for document attachment in all jurisdictions, with particular focus on those jurisdictions with low or reduced attachment rates. Investigation will assess the technical and administrative processes and resource level for each jurisdiction with the aim to increase attachment rates where possible.

*Table 4: Document Attachment levels for cases closed during 2013-14 as compared to those closed during the two previous financial years.*

JURISDICTION	FINDING ATTACHMENT (%)			AUTOPSY ATTACHMENT (%)			TOXICOLOGY ATTACHMENT (%)			POLICE NARRATIVE ATTACHMENT (%)		
	13-14	12-13	11-12	13-14	12-13	11-12	13-14	12-13	11-12	13-14	12-13	11-12
<b>ACT</b>	99	99	92	96	92	91	96	87	84	94	93	100
<b>NSW</b>	46	46	32	44	45	56	34	42	59	29	35	45
<b>NT</b>	100	99	99	96	99	97	99	99	99	99	99	99
<b>QLD</b>	100	92	86	100	92	87	96	50	3	93	98	99
<b>SA</b>	100	100	100	0	0	0	88	49	1	100	99	99
<b>TAS</b>	100	100	99	99	99	100	100	99	83	99	98	98
<b>VIC</b>	61	18	91	97	97	95	98	94	98	93	95	88
<b>WA</b>	100	100	99	100	100	98	97	100	99	97	87	99
<b>NZ</b>	98	100	n/a	98	94	n/a	92	94	n/a	97	97	n/a

### 4.3 Timeliness of case closure

Timeliness of case closure is measured by the percentage of cases closed on the NCIS within 60 days of the coronial finding being finalised (Table 5). South Australia and Western Australia increased their timeliness of NCIS case closure from the previous year and continue to have the highest case closure rates. New South Wales still has a low level of timeliness of NCIS case closure at 47% but this is a significant increase on the previous year.

Tasmania, the Northern Territory and the Australian Capital Territory all saw a moderate drop in timeliness of NCIS case closure on the previous year, between 7% and 2%, but overall timeliness of case closure is very good.

Case closure timeliness on the NCIS in Victoria and Queensland during 2013-14 was low and shows a decrease on the previous year levels. This is likely due to a temporary loss of resource in Victoria and in Queensland.

New Zealand cases are transferred to the NCIS only once a case has been closed and therefore data is not relevant to table 5.

*Table 5: Percentage of cases closed on the NCIS within 60 days of completion of finding*

Jurisdiction	% cases between 2013-14	% cases between 2012-13	% cases between 2011-12
<b>ACT</b>	97	99	98
<b>NSW</b>	47	27	20
<b>NT</b>	91	98	98
<b>QLD</b>	23	77	63
<b>SA</b>	100	99	99
<b>TAS</b>	75	82	90
<b>WA</b>	99	99	99
<b>VIC</b>	22	38	59

Table 6 shows a breakdown of the total number of cases closed on the NCIS by jurisdiction. Case volume is generally commensurate to jurisdiction population.

The results show the Northern Territory and Tasmania saw a moderate rise in case closure volume on the previous year while Queensland and South Australia saw a significant rise. The Australian Capital Territory, Western Australia and New Zealand saw a moderate drop while New South Wales and Victoria saw a significant drop in case closure volume on the NCIS.

*Table 6: Total number of cases closed on the NCIS by Jurisdiction*

Jurisdiction	cases closed 2013-14	cases closed 2012-13	cases closed 2011-12
<b>ACT</b>	325	374	299
<b>NSW</b>	6057	8158	6074
<b>NT</b>	327	288	267
<b>QLD</b>	3197	2296	3977
<b>SA</b>	2038	1769	2339
<b>TAS</b>	445	303	446
<b>WA</b>	2062	2224	2183
<b>VIC</b>	1607	4279	4411
<b>NZ</b>	3149	3278	3104

## 5 Quality assurance

During 2013-14 quality assurance activities included:

- ◆ The review of 13,335 coronial cases that were closed on the NCIS. This is 4,065 fewer than in the previous financial year due to a five month vacancy in the role of Quality Assurance Assistant. The combination of increased productivity and staffing stability means that the next annual report should reflect an overall increase in the number of cases reviewed.
- ◆ The introduction of further data validation rules in addition to the rules implemented in 2012-13. The latest validation rules cover the quality input of time and date of incident, death and notification<sup>5</sup>. It is expected the validation rules will improve the quality and consistency of coding these fields.
- ◆ The implementation of seven online e-training modules to support the training needs of coders when in-person training is not available. The modules follow the same sequence and content as the in-person training sessions and allow coders to engage in self-initiated training sessions on NCIS coding. In-person training will be delivered as required and as capacity and budget allows. The modules ensure coders have access to immediate training or can be used as a follow up reference as required.

### 5.1 Quality assurance results

Results of the quality assurance assessments were good overall.

Of the cases reviewed, less than thirty percent contained errors (table 7). For the purposes of quality assessments, errors are categorised as either critical or non-critical. Critical errors are those which change the meaning of the case and are likely to impact the results of common NCIS searches due to erroneous inclusion or exclusion. Non-critical errors are less likely to influence search results.

Of the cases assessed, 21% were categorised as having critical errors, and 7% as non-critical errors.

Cases reviewed in 2013-14 were those cases closed between October 2011 and September 2012. This backlog will be addressed as part of the NCIS quality assurance process review in 2014-15

Table 8 shows the number cases reviewed for each jurisdiction.

*Table 7: Results of quality assurance assessment*

Quality Assurance Results 2013-14	Frequency	% of total cases reviewed
Cases reviewed with no error detected	9,615	72%
Cases reviewed with a critical error identified	2825	21%
Cases reviewed with a non-critical error identified	895	7%
<b>Total</b>	<b>13,335</b>	<b>100%</b>

<sup>5</sup> South Australia and New Zealand do not have the validation rules as they use local case management systems that are not managed by the NCIS.

Table 8: Total number of quality assurance assessments conducted in 2013-14 by jurisdiction.

Jurisdiction	Number of cases quality assessed	% of total cases quality assessed
ACT	233	2%
NSW	4024	30%
NT	137	1%
QLD	3074	23%
SA	1255	10%
TAS	265	2%
VIC	2675	20%
WA	1672	12%
NZ <sup>6</sup>	0	0%
<b>Total</b>	<b>13,355</b>	<b>100%</b>

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<sup>6</sup> NZ cases were not included in review in this period as these cases are not part of a regular data transfer but are uploaded in batches throughout the year. Now that we are receiving a regular transfer, these cases will be included in the routine QA process

## 6 Research and Publications

### Academic publications that cite data contained on the NCIS

Anthikkat, A., Page, A., & Barker, R. (2013). Low-speed vehicle run over fatalities in Australian children aged 0–5 years. *Journal of Paediatrics and Child Health*, 49, 388–393. doi:10.1111/jpc.12188

Goeman, D., Abramson, M., McCarthy, E., Zubrinich, C., & Douglass, J. (2013). Asthma mortality in Australia in the 21st century: a case series analysis. *British Medical Journal Open*, 3. doi:10.1136/bmjopen-2012-002539

AJ Clapperton, AJ., Herde, EL., Lower., T (2013) Quad bike-related injury in Victoria Australia, *Medical Journal of Australia* 199: 418-422

Arnautovska, U., McPhedran, S., & De Leo, D. (2014). A regional approach to understanding farmer suicide rates in Queensland. *Social Psychiatry and Psychiatric Epidemiology*, 49, 593–599. doi:10.1007/s00127-013-0777-9

Bambach, M. R., & Mattos, G. A. (2014). Head and spine injuries sustained by motorcyclists in head-leading collisions with fixed roadside objects. *Traffic injury prevention*, (just-accepted), 00-00.

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Cunningham, J., Williamson, D., Robinson, K., & Paul, L. (2013). A comparison of state and national Australian data on external cause of injury due to falls. *Health Information Management Journal*, 42(3), 1833-3583. doi:10.12826/18333575.2013

Depczynski, J., Herde, E., Fragar, L., & Lower, T. (2013). Safe play areas on farms in New South Wales. *Australian Journal of Rural Health*, 21, 220–224. doi:10.1111/ajr.12048

Dodds, L., Robinson, K. M., Daking, L., & Paul, L. (2014). The concept of 'intent' within Australian coronial data: factors affecting the National Coronial Information System's classification of mortality attributable to intentional self-harm. *Health Information Management Journal*.

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## 7 Staffing

### **Manager**

Jessica Jackson~ / Natalie Johnson\*

### **Quality Manager**

Leanne Daking

### **Quality Assurance/IT Officer**

Tony Chan

### **Quality Assistant**

Jill Russell^ (0.6) / Dannielle Murphy\*

### **Access Officer**

Joanna Cotsonis / Sharon Callaghan^^

### **Coronial Liaison Officer**

Lisa Crockett\*\* / Joanna Cotsonis^^

### **Administration Officer**

Catherine Daley (0.6)

### **Senior Research Officer**

Eva Saar

^ until July 2013

~until December 2013

\* from December 2013

\*\* until October 2013

^^ from March 2014

## 8 Financial Reports

### Statement of Receipts and Expenditure – NCIS

For the year ended 30 June 2014

	2014	2013
	\$	\$
<b>Opening balance (Cash in bank)</b>	618,251	685,822
<b>Income</b>		
Government Grants - AU	1,064,747	1,047,048
Government Grants - NZ	91,600	91,600
User pays (1)	106,083	87,176
<b>TOTAL</b>	<b>1,262,430</b>	<b>1,225,824</b>
<b>Less Expenses</b>		
Professional Services (2)	5,983	0
Contractors, consultants and professional service expenses (3)	87,311	59,548
Depreciation	10,992	13,648
Employee related expenses	679,025	635,997
Information technology expenses	305,286	300,145
Other operating expenses	51	162
Postage and communication expenses	1,544	1,377
Printing, stationery and other office expenses	1,299	8,856
Staff training and development expenses	3,730	11,773
Travel, entertainment and personal expenses	10,996	11,477
Utilities and services	121,672	119,951
<b>TOTAL</b>	<b>1,227,889</b>	<b>1,162,934</b>
<b>Balance for the year</b>	<b>34,541</b>	<b>62,890</b>
Capital expenditure	7,633	0
Accrued expenses	-178	178
Depreciation	10,992	13,648
Grants paid in advance	-72,503	122,503
Receivables	-265,978	286,897
Movement in employee provisions (4)	23,573	6,589
<b>Closing balance (Cash in bank)</b>	<b>888,287</b>	<b>604,733</b>

## Explanatory Notes for Statement of Receipts and Expenditure

- (1) User Pays total includes annual fees from third party researchers and fees from Data Requests.
- (2) The Professional Services were for advice from the Victorian Government Solicitor's Office about the On-Provision process and Access Agreements.
- (3) The majority of contractor/consultant expenditure related to approved engagement of Java contractor. This funding was not budgeted but was intended to be utilised from the cash balance.
- (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.

## Government Funding Contributions made in 2013-14

Table 3: Government Funding Contributions made in 2013-14

Agency	Amount contributed \$AUD (GST Exclusive)
Commonwealth	559,509
New South Wales	165,008
Victoria	125,196
Queensland	100,945
New Zealand	91,600
Western Australia	51,028
South Australia	37,892
Tasmania	11,822
ACT	8,185
NT	5,153
<b>TOTAL</b>	<b>1,156,338</b>

## Appendix 1 Governance Structure and Advisory Panels

### NCIS Board of Management

Mr Greg Wilson (Chair)

*Secretary Victorian Department of Justice*

Representative of Host Agency (VIC)

Mr Andrew Bridgman

*Secretary Ministry of Justice New Zealand*

Representative of Large Jurisdictions (NSW, QLD, NZ)

*Commenced April 2014*

Mr Laurie Glanfield

*Director-General, NSW Attorney-General's Department*

Representative of Large Jurisdictions (NSW, QLD, NZ)

*Ceased representation October 2013*

Mr Simon Overland

*Secretary Tasmanian Department of Justice*

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

*Commenced representation April 2014*

Ms Kathy Leigh

*Director General, ACT Justice and Community Services Directorate*

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

*Ceased representation April 2014*

Professor James Harrison

*Director National Injury Surveillance Unit*

Representative of Public Health Researchers

Judge Ian Gray

*State Coroner of Victoria*

Representative of State/Chief Coroners

Meetings held in October 2013, April 2014, and July 2014
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## NCIS Advisory Committee

Mr Neil Twist (Chair)  
Director NCIS/Director Strategic Planning  
*Victorian Department of Justice*

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

Magistrate Mark Johns  
State Coroner  
*South Australia Coroners Court*

Professor James Harrison  
Director  
Research Centre of Injury Studies

Professor Stephen Cordner  
Director  
*Victorian Institute of Forensic Medicine*

Ms Natalie Johnson  
Manager NCIS  
*Victorian Department of Justice*

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

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

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

Ms Leanne Daking  
NCIS Quality Manager  
*Victorian Department of Justice*

Meetings held in September 2012, January 2013, and March 2013
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## Appendix 2 Status of NCIS Review Recommendations at 30 June 2014

	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)	Ongoing
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	Completed
9	Enhance website functionalities, content relevance and currency to ensure congruence with information requirements of users and to maximise access	Completed
10	Increase the frequency of user survey to annual, and expand survey to include questions on other services and products of NCIS	Completed
11	Identify opportunities to engage and collaborate with Coroners Prevention Unit (Victorian Coroners Court)	Ongoing
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	Completed
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	Completed
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	Ongoing
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	Ongoing
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	Ongoing
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	Completed
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	Ongoing
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