NCIS

National Coronial Information System (NCIS) Annual Report 2014-15

TRIM ID:

VICTORIA State Government | Justice and Regulation

Contents

1 Director's Foreword

The 2014-15 financial year was both challenging and highly productive for the NCIS and overall I am very pleased with the outcomes.

Throughout the year, the NCIS increased stakeholder engagement. Stakeholders include Coroners and death investigators, external researchers, other data custodians and public and private agencies with an interest in injury and death prevention. The results of this dedicated engagement are evident in the increased usage of the NCIS by death investigators and researchers and increased output of NCIS data reports for both coroners and external parties.

In addition, our presence at conferences and workshops over the past year has cemented our standing as an essential national statistical data collector. The increase in usage and presence in the data community is a very pleasing result and a validation of the efforts from the team. The NCIS will continue on this strategic course of stakeholder engagement in the coming year.

Other highlights from the year include working very closely with the Australian Human Rights Commissioner for Children to prepare a comprehensive report on self-harm among children and youth. We have established a firm relationship with Suicide Prevention Australia and continue to collaborate on mutually beneficial initiatives such a national minimum dataset for suicide reporting.

In January 2015, we commenced the IT Risk Mitigation Oracle Project to migrate our database operating system to *Oracle* to ensure it continues to meet industry security and technical standards. As part of this project we have purchased a new server and completed staff training and the project is running on schedule.

Throughout the year there were several staff changes. Four staff members left the team and were replaced by three new team members; two roles were changed and a new position of Deputy Manager was created. The former Manager, Jessica Jackson commenced this role upon her return from maternity leave. The staff changes made for a challenging time operationally and socially as the team re-formed. During the year the management team has restructured roles to ensure that NCIS continues to provide a high quality service as efficiently as possible. Changes that we have made to quality assurances processes in 2014-15 should start to bear fruit in 2015-16 The team has worked hard to ensure a high level of productivity throughout all of the changes and are in a good position to continue that growth and further increase our output.

I am very happy with the way the NCIS is tracking. The significant changes over the past year have put us in good stead to expand on the developments from 2014-15. This report outlines the activities undertaken in the past twelve months to deliver on our goal to provide *comprehensive coronial data to those who need it.*

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

2 Benefits to the community

2.1 Assisting in death investigations

In 2014-15 the NCIS continued to assist the research community in death investigation and prevention.

- The NCIS Unit produced 90 data reports for external parties, coronial investigators and the media during 2014-15. This is an increase of 48% on the previous year. The majority of reports were focused on intentional self-harm, drugs and alcohol, youth and child deaths and traffic related deaths. Forty-one of these reports directly informed coronial investigations.
- In July 2014, the NCIS introduced two new data fields to assist with the identification of possible family domestic violence related deaths. Over 3,000 assault cases have been retrospectively coded to indicate the relationship between the perpetrator and the deceased. Liaison with Domestic Violence Review Committees in each jurisdiction is ongoing to appropriately populate the Family/Domestic Violence flag on the NCIS.
- In October 2014, the Australian Human Rights Commission released the Children's Rights Report 2014 which contained data provided by the NCIS. The NCIS was able to provide a level of detail about youth suicide that has not previously been published and directly informed actions to be taken for the prevention of youth suicide. The full report can be accessed at https://www.humanrights.gov.au/our-work/childrens-rights/projects/childrens-rights-report-2014.

  An endorsement from the Children's Commissioner is contained in the box below.

Megan Mitchel, Children's Commissioner for the Australian Human Rights Commission

The Australian Human Rights Commission used data provided by the NCIS in its Children's Rights Report 2014, tabled to federal parliament in October 2014.

As National Children's Commissioner, I would sincerely like to thank the National Coronial Information System (NCIS) for generously working with me to provide previously unpublished data about the deaths of children and young people aged 0-17 years as part of my statutory report to parliament in 2014. The assistance of the NCIS and its efforts to deliver an unprecedented level of detail in the data was commendable. The detailed data provided by the NCIS in its ongoing role is of vital value for researchers and policy makers to better support the rights of children and young people engaging in intentional self-harm and suicidal behaviour.

2.2 Identifying and alerting parties to mortality trends or concerns

In 2014-15, the NCIS Unit produced two publicly available Fact Sheets.

- *Fact Sheet* – Intentional Self-Harm Among Emergency Services Personnel
- *Fact Sheet* – Opioid Related Deaths in Australia 2007-2011

In addition to the publication of Fact Sheets, the NCIS launched *Fatal Facts Search*, a public search tool to enable users to search *Fatal Facts* publication by category of death.

Fatal Facts is a publication periodically produced by the NCIS unit which summarises all coronial recommendations that have been uploaded to the NCIS over the relevant period.

Fatal Facts Search allows users to search by pre-defined case categories to identify all coronial recommendations relevant to a selected category. A list of the case categories is available within the tool.

Cases currently included in the search tool are cases closed between 1st July 2000 and 31st March 2010. The tool contains a total of 1,148 cases and this figure will continue to increase with the publication of further issues of *Fatal Facts*.

Fatal Facts Search is accessible via the NCIS website http://www.ncis.org.au/mortality-data-from-the-ncis/fatal-facts/

2.3 Primary data source for injury and death research

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

- At 30 June 2015 there were 80 external groups with access to the NCIS for ethically approved research projects. Twenty-eight of these were new projects which received ethical approval in 2014-15 and eight were projects that were renewed in this period. Ten projects concluded. Project topics include research into several specific aspects of intentional self-harm, injury deaths, the monitoring of drug and alcohol deaths, fall related deaths and 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.
- Seventeen academic journal articles were published during 2014-15 which used NCIS as a primary 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 NCIS provides data reports on request from Coroners and external parties. There was a significant increase in the number of Coroners utilising this service, up from 11 in 2013-14 to 41 in 2014-15. The increase in utilisation of this service and the positive feedback about the quality and timeliness of the reports is very pleasing.

3 Achievements and challenges during 2014-15

3.1 Achievements

Research Publication and Community Engagement

- **Conference presentations by NCIS staff at national and international conferences**
  - The International Association of Forensic Toxicologists (TIAFT), hosted its annual meeting in Buenos Aires, Argentina in November 2014. The NCIS Research and Engagement Manager presented on the increasing trend of oxycodone poisonings and how data collection on the NCIS can assist in capturing a comprehensive picture of the national situation.
  - Australian Mortality Data interest Group (AMDIG), November 2014 – The NCIS Manager gave a presentation about data accessibility and a data visualisation tool currently in development.
  - National Drowning Prevention Summit, August 2014 – The NCIS Research and Engagement Manager was invited to present on the challenges associated with the collection of accurate alcohol and drug related drowning data. Goal 7 of the Australian Water Safety Council Strategy targets the reduction of alcohol and drug related drowning in Australia.
  - Suicide Prevention Australia (SPA) hosted a workshop in December 2014 to discuss the development of a national minimum dataset for the capture of suicide deaths. The NCIS Manager was asked to make a presentation about suicide data capture on the NCIS.
  - National Child Death Review Committee, March 2015 – The NCIS Manager was invited to present on the challenges and benefits of national data collection.
  - Asia Pacific Coroners Meeting, April 2015 – The NCIS Manager gave an informal update on the activities of the NCIS. Topics discussed were data quality and the issue of consistency in the capture of suicide cases on the NCIS.
- **Increased engagement with stakeholders**
  - The NCIS has been working closely with Suicide Prevention Australia (SPA) to engage with stakeholders and develop a national minimum dataset for the reporting of suicide and a national suicide register to contain this information. This work is ongoing.
  - The NCIS has commenced discussion with the Australian Bureau of Statistics (ABS) and the Australian Co-ordinating Registry for all Births, Deaths and Marriages (ACR) to investigate the opportunity to share demographic data such as country of birth and indigenous status to enhance the completeness of the NCIS data set in these areas.
  - The NCIS produced 41 data reports for coroners and death investigators in the 2014-15 financial year. This was a significant increase from the previous year and was a result of dedicated consultation and engagement with death investigators resulting in valuable reports.
  - The NCIS commenced discussion with the Australian Domestic & Family Violence Review Network to ensure consistency of coding family violence assault cases on the NCIS. This work is ongoing.
- **Delivery of all reporting requirements under the NCIS Commonwealth Funding Agreement**
  - Delivery of three mortality reports to the Commonwealth Department of Health: *NCIS Drug Mortality Data Report 2012, NCIS Injury Mortality Data Report 2012* and *NCIS Intentional Self-Harm Mortality Report 2012.*
- **Media coverage of publications produced by the NCIS**
  - NCIS Fact Sheet – Opioid Deaths in Australia was released to coincide with National Overdose Awareness Day and received print media coverage.
  - NCIS Fact Sheet – Intentional Self-Harm Among Emergency Services Personnel was widely covered by the ABC including coverage on national television news, radio and online.
- **Launch of Fatal Facts Search**
  - Increased accessibility to publicly available coronial recommendations in a searchable format.

Data Quality Improvement

- **Data Quality improvement strategies progressed**
  - The NCIS has made several changes to its quality assurance process with the aim of completing more timely data updates and reducing the backlog of cases awaiting quality review. This includes correcting errors at the point of review, prioritising external cause cases and an overhaul of the error report provided to jurisdictions to ensure it is focused on training and education for an overall reduction in errors at the point of entry.
  - Quality review of over 2,500 cases from New Zealand. Cases from New Zealand has now been incorporated into the standard quality review process.
  - Review and implementation of error categories to focus on the impact of the error.
  - Retrospective coding of over 3,000 assault cases to include perpetrator relationship to the deceased with the intention to identify domestic violence cases.
  - Second round implementation of data entry validation rules
  - Delivery of four face-to-face coder training sessions in Northern Territory, Western Australia, Tasmania and Victoria.
  - Progression of the initiative to geocode all NCIS residential and incident addresses. In the 2014-15 financial year, 15,906 addresses were geocoded - 9,648 residential addresses and 6,258 incident addresses. In total, 148,912 addresses have been geocoded in the NCIS. Geocoding enables researchers to analyse data using geospatial boundaries.
  - Transcription and upload of over 800 police narratives to the NCIS for NSW cases.

Information Technology and Security

- **Commencement of IT Risk Mitigation Project**
  - Commencement of a project to migrate the NCIS backend operating system from Informix to Oracle.
  - Purchase and installation of a new dedicated server.
  - Training for three staff in Oracle programming.
- **Commencement of automated weekly transfer of New Zealand closed cases.**
  - Automated transfer of New Zealand closed cases began in October 2014 and is conducted on a weekly basis.

3.2 Challenges

Increasing volume of closed cases for quality assurance review.

- In 2014-15 over 23,000 cases were closed on the NCIS by Coronial offices and are now awaiting quality review by the NCIS. The NCIS quality assurance process had to change to keep pace with this demand. In 2014-15, the NCIS conducted quality reviews on over 17,500 cases. This was 4,244 more cases than the previous year but the backlog of cases awaiting review continued to increase.
- During 2013-14 the department's consulting team reviewed the quality assurance process with the aim of identifying ways to reduce the backlog while balancing the need for accurate and timely data.
- The recommendations from this report are being implemented and we expect to see a reduction in the backlog during the 2015-16 year. Section five contains more information about these changes.
- The backlog of cases for review was further impacted by the inclusion of New Zealand cases in the quality assurance review process. Due to the irregular nature of data uploads from New Zealand up until October 2014, New Zealand cases were not previously part of the usual quality review process but were reviewed separately. These cases will now be added to the standard review process and as such will result in an overall increase in the volume of closed cases for quality review.

Staff Changes

- Throughout 2014-15 there were several staff and position changes. Four staff members left to pursue other career goals and three new staff members joined the team. One staff member, Jessica Jackson, returned to the NCIS from maternity leave in a newly created position of NCIS Deputy Manager.
- The role of NCIS Coronial Liaison Officer, which had been vacant for some time, was replaced with a new position, NCIS Research and Engagement Manager, supported by the NCIS Senior Research and Support Officer. These two positions are responsible for producing research and supporting both external researchers and death investigators.
- While the significant number of staff changes in a small team has been challenging, it has also resulted in a renewed focus on knowledge sharing and cooperation with the team. From January 2015, the team has been in a learning and rebuilding phase. Productivity has not suffered from the changes but rather has increased. This is a testament to the dedicated staff and the clear communal goals of the NCIS Unit.

Timeliness of Case Closure

- In 2014-15, the Victorian Coroners Court had the lowest timeliness of case closure on the NCIS at just 12% closed on the NCIS within 60 days of case completion. This is the lowest nationally and affects the ability of the NCIS to release national data. In 2015-16 the NCIS will work with the Victorian court to try and prioritise cases for closure on the NCIS and assist where possible.

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 2015-16.

4 Operational statistics

4.1 Usage statistics

Death investigators[1]

- There were over 23,000 searches of the NCIS conducted by death investigators during 2014-15 (Table 1).
- This is a 94% increase from the previous year, with an increase in each type of search available to death investigators.

Table 1: NCIS searches launched by death investigators

Type of search[2]	2014-15	2013-14	2012-13
Query Design	1,365	528	920
Coroners Screen	1,234	1,039	814
Find Case screen	21,154	10,653	15,164
TOTAL	**23,753**	**12,202**	**16,898**

Third party users[3]

- There were over 95,000 searches of the NCIS conducted by third party researchers during 2014-15 (Table 2). This is a 56% increase in usage from the previous year.
- At 30 June 2015, there were 80 active research projects with approved access to the NCIS. This is three less than at 30 June 2014. Ten projects came to completion throughout the year. The total number of active projects remains consistent.
- Twenty-eight new third party applications were received in 2014-15 (Table 3). This is a significant increase from the previous year. An additional eight existing projects were renewed.

Table 2: NCIS searches launched by third party researchers

Type of search	2014-15	2013-14	2012-13
Query Design	3,983	2,601	2,695
Coroners Screen	816	893	550
Find Case screen	90,954	57,745	56,783
TOTAL	**95,753**	**61,239**	**60,028**

[1] 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.

[2] The three types of searches, Query Design, Coroners Screen and Find Case Screen can be used interchangeably by all users. The Query Design is based on coded data and allows the user to create a specific query on any of the data collected. The Coroners Screen is a broad text based search utilising attached documentation. The Find Case search is a used to identify a specific known case.

[3] 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 Victorian Department of Justice and Regulation Human Research Ethics Committee, and any other required coronial bodies.

Table 3: Number of new and renewed 3rd party projects utilising the NCIS

External Research Projects	2014-15	2013-14
New project	28	15
Renewed project	8	8
TOTAL	**36**	**23**

Usage by other groups[4]

- 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 assisted coronial death investigators in searching the NCIS as requested.
- Throughout 2014-15, the NCIS team produced 90 data reports for external parties, the media and coroners. The breakdown is detailed in Table 4.
- This is a 48% increase in output from the previous financial year, due to the significant increase in the number of reports produced at the request of Coroners.

Table 4: Data reports for external parties and coronial death investigators

Organisation type	Number NCIS Data Reports Produced 2014-15	Number NCIS Data Reports Produced 2013-14
External Interest Groups	44	42
Media Organisations	5	8
Death Investigators	41	11
TOTAL	**90**	**61**

[4] 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.

Document attachment

Cases on the NCIS contain coded data and medico-legal documentation in the form of up to four supporting documents for each case. These four documents are; Coronial Finding, Autopsy Report, Toxicology Report and Police Narrative. Ideally, all four documents will be attached to each case though this will not always be possible as coronial jurisdictions operate differently and not all cases require each examination.

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

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

Table 5 displays 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 where it is known the reports have been produced as part of the investigation).

In most jurisdictions, the percentage of reports attached to closed cases on the NCIS remained similar to previous years, with some notable changes:

Finding documents were attached at much the same level as previous years for most jurisdictions; with a significant increase in both Victoria and New South Wales. However both are still below the national average.

Autopsy documents – New South Wales saw an increase in autopsy report attachment levels but at 55% this is still relatively low. Victoria saw a significant reduction in the attachment level of autopsy reports and South Australia still does not have autopsy reports available. The upload of autopsy documents from South Australia will be an item to be addressed in this coming year.

Toxicology reports – New South Wales increased the attachment level of toxicology reports compared to 2013-14, however this is still low overall. South Australia increased the attachment of autopsy reports with 92% of cases closed in 2014-15 having an attached report. The New Zealand attachment of toxicology reports is low due to a data transfer issue which has since been rectified. This is demonstrated by the fact that New Zealand cases closed between April and June 2015 had an attachment rate of 94%. The NCIS will work with New Zealand to obtain any missed toxicology reports and will closely monitor all future document transfers.

Police narrative – New South Wales still have a low attachment rate of police narratives, while Victoria saw a slight reduction in the proportion of cases with attached police narratives.

In 2015-16, the NCIS aim to work closely with jurisdictions with the lowest attachment rates. These are identified to be: Autopsy reports from South Australia and New South Wales, Coronial Findings from Victoria and New South Wales and Toxicology and Police Reports from New South Wales. As part of our strategic focus on the quality and comprehensiveness of data contained on the NCIS, we will aim to increase the overall level of document attachment.

Table 5: Document Attachment levels for cases closed during 2014-15 as compared to those closed during the two previous financial years.

JURISDICTION	FINDING ATTACHMENT (%)			AUTOPSY ATTACHMENT (%)			TOXICOLOGY ATTACHMENT (%)			POLICE NARRATIVE ATTACHMENT (%)		
	14-15	**13-14**	**12-13**	**14-15**	**13-14**	**12-13**	**14-15**	**13-14**	**12-13**	**14-15**	**13-14**	**12-13**
ACT	100	99	99	96	96	92	97	96	87	95	94	93
NSW	66	46	46	55	44	45	39	34	42	28	29	35
NT	100	100	99	97	96	99	100	99	99	99	99	99
QLD	100	100	92	99	100	92	98	96	50	95	93	98
SA	100	100	100	0	0	0	92	88	49	99	100	99
TAS	99	100	100	100	99	99	100	100	99	95	99	98
VIC	82	61	18	82	97	97	99	98	94	87	93	95
WA	100	100	100	99	100	100	98	97	100	97	97	87
NZ	97	98	100	96	98	94	57	92	94	94	97	97

4.2 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 6). South Australia and Western Australia maintained their consistently high timeliness rate. The Australian Capital Territory saw a slight drop but overall the timeliness rate is still high.

Queensland saw a significant increase from 23% in 2013-14 to 68% in 2014-15. This is still not as high as in previous years but it is a notable increase from last year. New South Wales saw an increase but overall the rate of 55% is still low.

The Northern Territory and Tasmania saw a drop in timeliness in case closure in 2014-15 which is of concern as the three previous years in these jurisdictions have been relatively constant.

Victoria has the lowest rate of timeliness of case closure at 12%. This has progressively reduced each year over the past four years. The significant delay in case closure has a negative impact on research capabilities. The NCIS are working with Victoria to address the issue of timeliness of case closure.

Table 6: Percentage of cases closed on the NCIS within 60 days of completion of finding

Jurisdiction	2014-15	2013-14	2012-13	2011-12
ACT	93	97	99	98
NSW	55	47	27	20
NT	78	91	98	98
QLD	68	23	77	63
SA	100	100	99	99
TAS	56	75	82	90
VIC	12	22	38	59
WA	98	99	99	99
NZ[5]	94	87	53	38

[5] The New Zealand closure within 60 days statistics for the 2012-13 and 2011-12 financial years were affected by the back-coding of cases closed since 1st of July 2007. The current year is a reflection of the current court processes.

Table 7 displays a breakdown of the total number of cases closed on the NCIS by jurisdiction and financial year. Case volume is generally commensurate to jurisdiction population.

The results show that New South Wales, South Australia and Tasmania saw a moderate rise in case closure volume on the previous year, while Victoria had a restoration to levels expected after a significant low in 2013-14. The Australian Capital Territory, Western Australia and New Zealand have a very similar case closure volume to the previous year. The Northern Territory and Queensland saw a drop in case closure volume on the NCIS.

Table 7: Total number of cases closed on the NCIS by Jurisdiction

Jurisdiction	cases closed 2014-15	cases closed 2013-14	cases closed 2012-13	cases closed 2011-12
ACT	326	325	374	299
NSW	6,262	6,057	8,158	6,074
NT	258	327	288	267
QLD	2,829	3,197	2,296	3,977
SA	2,470	2,038	1,769	2,339
TAS	501	445	303	446
VIC	3,907	1,607	4,279	4,411
WA	2,055	2,062	2,224	2,183
NZ	3,112	3,149	3,278	3,104

5 Quality assurance

During 2014-15 a review of the NCIS quality assurance (QA) process was undertaken to increase efficiencies. The growing backlog of cases for quality assurance necessitated the review. The review made four recommendations to reduce the backlog of cases and ensure sustainability of the quality assurance process. Details of the recommendations and the outcomes are listed below.

- Focus QA efforts on the review of external cause deaths which are more complex to code than natural cause deaths and more used for research. The NCIS team will continue to conduct a full review of external (non-natural cause) cases and prioritise the review of such cases over natural cause case records. Non-natural cause records make up approximately 45% of the cases contained on the NCIS.
- Coding corrections will be made directly onto the NCIS during the QA review process, rather than the current practice of sending required corrections back to coroners' courts for update on local systems. The current practice results in significant delays between the identification and correction of errors and places extra resourcing pressures on jurisdictions.
- Redesign error classification categories so they more comprehensively reflect the impact of certain error types.
- Revision of the reporting provided to courts to ensure feedback promotes improved data quality and understanding of coding requirements. This will involve the provision of summary error reports to coronial courts that highlight the main quality issues identified.

The changes outlined here are still in the process of being implemented and communicated to all jurisdictions. It is anticipated the results of the changes will be clearly seen by a decrease in non-natural cause cases awaiting quality assurance review in the next annual report.

5.1 Quality assurance results

Table 8 displays the total number of cases on the NCIS that were quality assured in 2014-15. In total, 17,599 cases were reviewed. This is 4,244 more cases than the previous year, an increase of 31%. There was also an increase in the total number of errors detected: 43% of cases reviewed contained one or more error, up from 28% in the previous year (Table 9).

A large proportion of these errors was identified in New Zealand cases. Of the 2,638 New Zealand cases reviewed, 82% (2,177 cases) contained an error. Approximately 25% of the errors were attributed to system upload issues between the NZ case management system and the NCIS and (considered to be procedural errors). These types of errors do not impact the ability to search for a case of relevance on the NCIS. These issues have now been rectified and should not occur to a similar extent in future.

Part of the review of the quality assurance process includes appraisal of all error categories to ensure the categories adequately reflect the impact of the error.

2014-15 is the first year New Zealand cases have been included in the standard quality review process.

Table 8: Total number of cases quality assured in 2014-15 by jurisdiction.

Jurisdiction	Number of cases quality assured	% of total cases quality assured
ACT	259	1%
NSW	4,834	27%
NT	264	2%
QLD	3,409	19%
SA	1,290	7%
TAS	216	1%
VIC	3,235	18%
WA	1,454	8%
NZ	2,638	15%
Total	**17,599**	**100%**

Table 9: Results of quality assurance assessment

Quality Assurance Results	2014-15	2013-14
Cases reviewed with no error detected	10,013 (57%)	9,615 (72%)
Cases reviewed with one or more error detected.*	7,586 (43%)	3,720 (28%)
Total	**17,599 (100%)**	**13,335 (100%)**

*A significant proportion of the errors detected were determined to be procedural errors and do not impact the ability to search for or locate a relevant case on the NCIS. New error categories to be applied in the revised QA process will allow for more detailed analysis of the type of errors based on their impact on case identification.

6 Research and Publications

Academic publications that cite data contained on the NCIS

BAMBACH, R. & MATTOS, G.A. 2015 Head and Spine Injuries sustained by Motorcyclists in Head-Leading Collisions with Fixed Roadside Objects. Traffic Injury Prevention, Vol. 16, Iss. 2, Pgs 168-176 February 2015

BEILES, B., HANSEN, D., RETEGAN, C., WOODFORD, N., & VINLUAN, J. 2015 Comparison of the Victorian Audit of Surgical Mortality with coronial cause of death. Published in ANZ Journal of Surgery. Published online but not yet attributed to an issue.

BERENDS, L., CHALMERS, J., & LANCASTER, K. 2015 Trust, Agency and Control: Perspectives on methadone takeaway dosing in the context of the Victorian Policy Review. Drug and Alcohol Review, Vol. 34, Pgs 483-486 September 2015

CHEUNG, G., MERRY, S., & SUNDARAM, F. 2015 Medical Examiner and coroner reports: uses and limitations in epidemiology and prevention of late-life suicide. Published in the International Journal of Geriatric Psychiatry, Vol. 30, Issue 8, Pgs 781-792 August 2015

CUSSEN, T. & BRYANT, W. 2015 Indigenous and non-Indigenous homicide in Australia. Published in Research in Practice, Australian Institute of Criminology (AIC), Report No. 37, May 2015

DUCAT, L., McEWAN, T.E., & OGLOFF, J.RP. 2014 An investigation of firesetting recidivism: Factors related to repeat offending. Published in Legal and Criminal Psychology, Vol. 20, Iss. 1, Pgs 1-18 February 2015.

GHARAIE, E., LINGARD, L., & COOKE, T. 2015 Causes of Fatal Accidents Involving Cranes in the Australian Construction Industry. Journal of Construction Economics and Building, Vol. 15, Iss. 2, Pgs 1-12 2015

HAYMAN, J., & OXENHAM, M. 2015 Peri-mortem disease treatment: a little known cause of error in the estimation of the time since death in decomposing human remains. Published in Australian Journal of Forensic Sciences. Published online but not yet attributed to an issue.

IBRAHIM, J.E., BUGEJA, L., RANSON, D., KITCHING, F., & MURPHY, B. 2015 The Nature and Extent of External Cause Deaths Among Nursing Home Residents in Victoria, Australia. Published in the Journal of American Geriatrics Society Vol. 63, Iss. 5, Pgs 954-962 May 2015

KITCHING, F.A., OZANNE-SMITH, J., GIBSON, K., CLAPPERTON, A., & CASSELL, E. 2015 Deaths of Older Australians related to their use of motorised mobility scooters. International Journal of Injury Control and Safety Promotion. Published online but not yet attributed to an issue.

LINGARD, H., COOKE, T., & GHARAIE, E. 2015 Causes of fatal accidents involving cranes in the Australian construction industry. Published in Construction, Economics and Building, Vol. 15, Iss. 2, Pgs 1-12, 2015

MITCHELL, R.J., WARE, L., & BAMBACH, M. 2014 "The role of evidence, standards and education in rock fishing safety in New South Wales, Australia." Australian and New Zealand journal of Public Health Vol. 38, Iss. 6, Pgs 579-584, 2014.

MITCHELL, M. & GOODA, M. 2015 Self-harm and help-seeking among Aboriginal and Torres Strait children and young people. Published in the Indigenous Law Bulletin, Vol. 8, Iss. 17, Pgs 24-29 2015

OGILVIE, R., CURTIS, K., LAM, M., MCCIOUGHEN, A & FOSTER, K (2014). The burden of youth: major traumatic injury in adolescents and young people managed in the Australian Capital Territory. Published

in *Journal of Trauma Nursing*, Vol. 21, Iss. 5, Pgs. 218-227 2014

PILGRIM, J. L., YAFISTHAM, S. P., GAYA, S., SAAR, E. & DRUMMER, O. H. 2014. An update on oxycodone: lessons for death investigators in Australia. Published in Forensic Science, Medicine and Pathology, Vol. 11, Iss. 1, Pgs. 3-12 November 2014

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YAP, S., & DRUMMER, O. 2015 Prevalence of new psychoactive substances in Victorian fatally-injured drivers. Published in Australian Journal of Forensic Sciences- Published online but not yet attributed to an issue, June 2015

Media reports

The Australian October 2014 Does the right to a peaceful death extend to the young and depressed

BARUAH, B. June 2015 High Suicide Rates Found Among Emergency Workers; Figures Reveal Almost All Of Them Are Men. International Business Times.

BUTT, C. June 2015 Coroner's report finds high suicide rates among emergency services. The Age/ Sydney Morning Herald

BUTTLER, M. December 2014 Shock Meth Toll: Soaring drug death figures. Herald Sun Online & Print

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MICKELBUROUGH, P. August 2014 Popular painkiller Oxycodone has been linked to more overdose deaths than heroin for the first time. Herald Sun

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SILMALIS, L. December 2014 Youth suicide: Students counselled after Sydney primary school girl, 10, takes her own life. The Daily Telegraph

VAN DEN BERG, L. November 2014. Prescription painkiller Oxycodone blamed for more than 600 Australian deaths. Herald Sun

Government/Research Reports

AUSTRALIAN HUMAN RIGHTS COMMISSION 2014. Children's Rights Report 2014 ISSN 2204-1176, Canberra: Australian Human Right Commission https://www.humanrights.gov.au/publications/childrens-rights-report-2014

AIHW 2014. Suicide and hospitalised self-harm in Australia: trends and analysis. Injury research and statistics series no. 93. Cat. no. INJCAT 169. Canberra: AIHW.

BAKER, A. & CUSSEN, T. 2015 Deaths in Custody in Australia: National Deaths in Custody Program 2011-12 and 2012-2013. Australian Institute of Criminology (AIC)

BRYANT, W. & CUSSEN, T. 2015 Homicide in Australia: 2010-11 to 2011-12: National Homicide Monitoring Program report. Australian Institute of Criminology (AIC) Monitoring Reports

Department of Health WA, Drug and Alcohol Office Annual Report, July 2014, presented to Community Program for Opioid Pharmacotherapy Mortality Review Committee

LOWER, T. 2015 Mapping Work Health and Safety Risks in the Primary Industries. Primary Industries Health and Safety Partnership, RIRDC Publication No. 14/127

Queensland Family and Child Commission Annual Report 2013-2014 *Annual Report: Deaths of children and Young People, Queensland 2013-2014* which was tabled in Parliament in 2014

ROYAL LIFE SAVING 2014 National Drowning Report 2014

SURF LIFE SAVING WESTERN AUSTRALIA 2014. 2014 WA Coastal Safety Report - Saving Lives and Building Great Communities

The National Coastal Safety Report (2014): Surf Life Saving Australia. SLSA: Sydney.

Safety Campaigns

Australian Competition and Consumer Commission (ACCC) warns parents about quad bike dangers for kids - https://www.accc.gov.au/media-release/accc-warns-parents-about-quad-bike-dangers-for-kids and corresponding YouTube clip https://www.accc.gov.au/media-release/accc-warns-parents-about-quad-bike-dangers-for-kids

7 Staffing

Within the NCIS team there were several staff changes and vacancies in the 2014-15 year. Vacant positions were redefined to ensure currency with our vision and strategic goals. The staff and roles listed below are current at 1 July 2015.

Manager

Natalie Johnson

Deputy Manager

Jessica Jackson (0.6)

Quality Manager

Leanne Daking

Research & Engagement Manager

Eva Saar

Quality Assurance/IT Officer

Tony Chan

Senior Research & Support Officer

Thomas Burgess

Quality Assurance Assistant

Dannielle Murphy (0.6)

Access Liaison Officer

Jessica Bryan

Administration Officer

Nicole McLean

8 Financial Reports

Statement of Receipts and Expenditure – NCIS

For the year ended 30 June 2015

	2015 $	2014 $
Opening balance (Cash in bank)	**888,287**	**618,251**
Add Receipts		
Income		
Government Grants - AU	**1,018,318**	**1,064,747**
Government Grants - NZ	**91,609**	**91,600**
User pays (1)	**50,825**	**106,083**
TOTAL	**1,160,752**	**1,262,430**
Less Expenses		
Professional Services (2)	**3438**	**5983**
Contractors, consultants and professional service expenses (3)	**44,141**	**87,311**
Depreciation	**12,166**	**10,992**
Employee related expenses	**666,183**	**679,025**
Information technology expenses	**297,462**	**305,286**
Other operating expenses (4)	**2500**	**51**
Postage and communication expenses	**715**	**1,544**
Printing, stationery and other office expenses	**960**	**1,299**
Staff training and development expenses (5)	**42,981**	**3,730**
Travel, entertainment and personal expenses	**12,743**	**10,996**
Utilities and services	**123,612**	**121,672**
TOTAL	**1,206,901**	**1,227,889**
Balance for the year	**(46,149)**	**34,541**
Capital expenditure (6)	**-56,386**	**7,633**
Accrued expenses	**10,046**	**-178**
Depreciation	**12,166**	**10,992**
Grants paid in advance	**-25,000**	**-72,503**
Accounts receivable (7)	**-14,758**	**-265,978**
Movement in employee provisions (8)	**-23,606**	**23,573**
Closing balance (Cash in bank)	**774,116**	**888,287**

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 involved legal advice from the Victorian Government Solicitor's Office.

(3) The majority of contractor expenditure related to the approved engagement of administration support for NCIS during the time the permanent position was vacant.

(4) Other Operating Expenditure relates to the write off of a bad debt for Centenary Institute.

(5) Staff Training and development involved the following - Oracle database SQL workshop & PL/SQL workshop, VPS Colloquium and facilitation for a team workshop. The Oracle database training is part of the Oracle project. The NCIS Board of Management approved the use of funds within the NCIS Trust for the Oracle project and accordingly this training expense was not included as part of the NCIS operating budget.

(6) Capital Expenditure relates to the purchase of a new server for the Oracle project.

(7) Accounts Receivable balances have been reduced significantly from last year and also managed to ensure all significant outstanding debts are paid and cleared accordingly.

(8) 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 2014-15

Table 10: Government Funding Contributions made in 2014-15

Agency	Amount contributed $AUD (GST Exclusive)
Commonwealth	503,364
New South Wales	165,008
Victoria	130,204
Queensland	104,983
New Zealand	91,609
Western Australia	51,028
South Australia	37,892
Tasmania	12,295
ACT	8,185
NT	5,359
TOTAL	**1,109,927**

9 Governance Structure and Advisory Panels

NCIS Board of Management

Mr Greg Wilson (Chair)

Secretary Victorian Department of Justice & Regulation

Representative of Host Agency (VIC)

Mr Andrew Bridgman

Secretary Ministry of Justice New Zealand

Representative of Large Jurisdictions (NSW, QLD, NZ)

Mr Simon Overland

Secretary Tasmanian Department of Justice

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

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 July and October 2014 and April 2015

NCIS Advisory Committee

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

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
Head of International Programs
Victorian Institute of Forensic Medicine

Ms Natalie Johnson
Manager NCIS
Victorian Department of Justice & Regulation

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
Deputy Director (Academic Programs)
Victorian Institute of Forensic Medicine

Ms Leanne Daking
NCIS Quality Manager
Victorian Department of Justice & Regulation

There were no meetings of the NCIS Advisory Committee held in 2014-15