NATIONAL CORONIAL INFORMATION SYSTEM

NCIS Annual report

2019-20

ncis.org.au | ncis@ncis.org.au

National Coronial Information System

GPO Box 123, Melbourne VIC 3001
1300 395 723 (Aus only) | +61 3 9094 2303 (international)
ncis@ncis.org.au
ncis.org.au

Authorisation

This report was prepared by the National Coronial Information System (NCIS) Unit and approved by the NCIS Board of Management.

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Acknowledgments

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DIRECTOR'S FOREWORD

I am pleased to present the National Coronial Information System Annual report 2019-20.

It has been another busy year for the NCIS Unit. A major codeset upgrade and a series of system enhancements delivered significant updates to the NCIS database. We strengthened our role in death an injury prevention through a new awareness campaign and increased publications. Importantly we maintained service delivery as usual throughout the COVID-19 pandemic. The transition to working from home was smooth due to the positive attitude of staff and existing enabling technology.

The NCIS exists as a valuable research database due to the support of Australian and New Zealand State and Chief Coroners, and their staff. I thank them wholeheartedly for their ongoing support and contributions to this unique national dataset. I also thank the Australian and New Zealand justice departments, and the Australian Commonwealth for their continued financial support enabling us to continue providing services to Coroners, death investigators, researchers and the broader community.

The core NCIS dataset is supported by supplementary data supplied by the Australian Bureau of Statistics, the New Zealand Ministry of Health, Safe Work Australia and the Australian Births, Deaths and Marriages registries. I thank these organisations for their continued support and the additional data that enriches the NCIS data collection.

The NCIS remains in a healthy financial position with the NCIS Trust balance being $687,763 as at 30 June 2019. We ended the year with $64,983 overspend of the operational budget primarily due to information technology costs, however the overspend was heavily reduced from the previous financial year ($232,431).

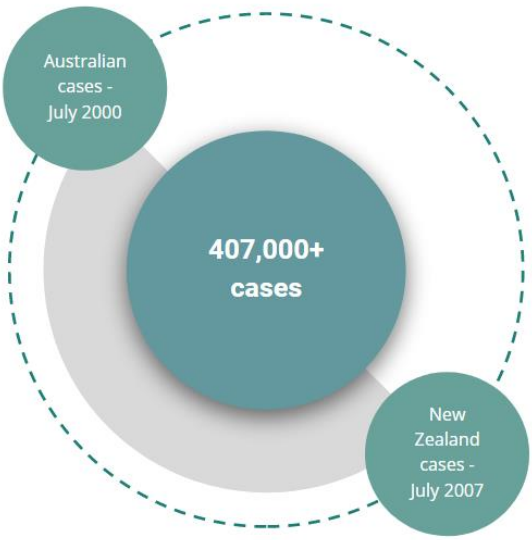
The NCIS Unit relocated offices to Carlton, Victoria in February 2020. After many years located at the Victorian Institute of Forensic Medicine (VIFM), this move represented a big change. I would like to thank the NCIS Unit and support staff from VIFM and the Victorian Department of Justice and Community Safety for their efforts to ensure a smooth transition.

We look forward to 2020-21 when we will celebrate the important milestone of 20 years since the launch of the NCIS - 1 July 2020.

Fiona Dowsley
Director, National Coronial Information System

About us

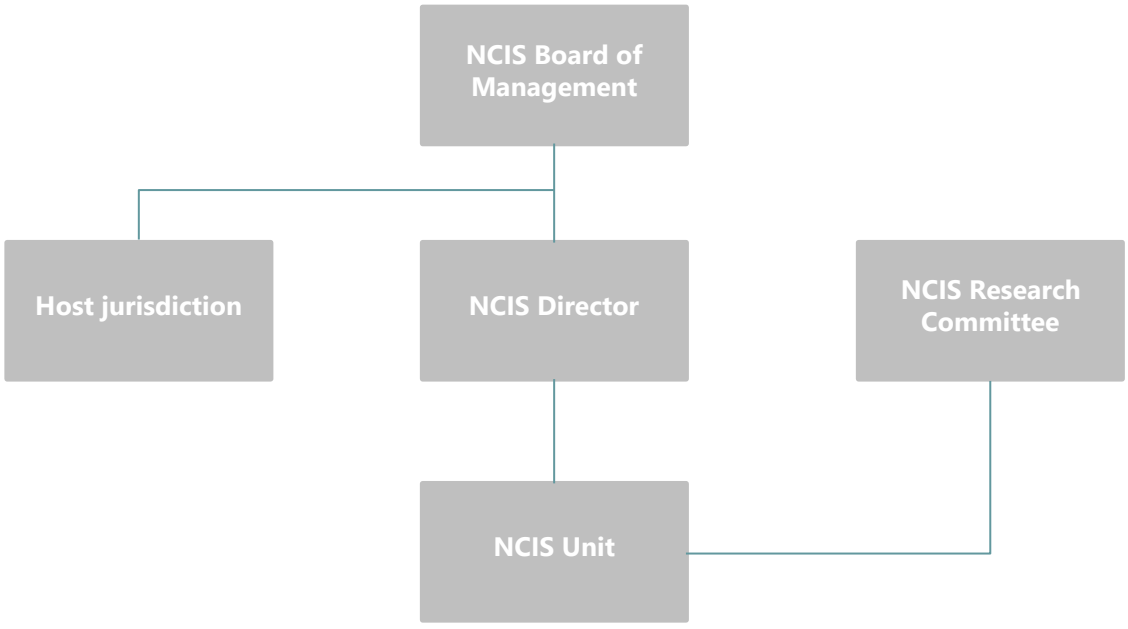
The National Coronial Information System (NCIS) is a secure research database of information on deaths reported to a coroner in Australia and New Zealand. Information concerning every death reported to Australian coroners since July 2000 (January 2001 for Queensland) and New Zealand coroners since July 2007 is stored within the system.



Data includes demographic information on the deceased, contextual details on the nature of the fatality and searchable medico-legal case reports including the coronial finding, autopsy and toxicology report and police notification of death.

The database is available to coroners to assist investigations and appropriate access is available on application for eligible groups who require coronial data for research or monitoring projects.

Our structure



NCIS Board of Management

The NCIS Board of Management's ensures the effective management of funds, provides strategic direction and ensures all legal and financial responsibilities are met in line with the requirements set out in NCIS Memorandum of Understanding. The Board comprises:

- One coronial representative
- One public health representative nominated by the Commonwealth Department of Health
- One representative nominated from the Victorian Department of Justice and Community Safety as the NCIS' host jurisdiction
- One larger jurisdictions representative (Queensland, New South Wales and New Zealand)
- One smaller jurisdictions representative (Tasmania, Western Australia, South Australia, Northern Territory and Australian Capital Territory).

Host jurisdiction

The NCIS is hosted by the Victorian Department of Justice and Community Safety as an independent unit.

NCIS Unit

The NCIS Unit's function is to develop and maintain a high quality information service for coroners, policy makers and researchers to benefit the Australian community by contributing to a reduction in preventable death and injury.

NCIS Research Committee

The NCIS Research Committee (NRC) reviews all applications from third party researchers seeking direct access to Australian data on the NCIS to assess whether the application is suitable for referral to the ethics committee. The NRC comprises:

- An Australian state or chief coroner (or their delegate) on a rotating basis
- NCIS Manager
- NCIS Access Liaison Officer

The NCIS utilises the Justice Human and Research Ethics Committee (JHREC) convened by the Secretary of the Victorian Department of Justice and Community Safety.

Read more about the NCIS

COVID-19 RESPONSE

Transition to home based working

All NCIS staff began working from home on a full time basis from Tuesday 17 March 2020.

Existing tools, secure systems and a virtual private network allowed for a relatively seamless transition to home based working. Measures were quickly established to support the well-being of NCIS staff including strengthening internal communication channels, providing access to COVID-19 information and support services and regular discussions about working from home. The team responded well to the changes and sustained a high level of productivity throughout the work from home period.

Service delivery

The NCIS Unit maintained operational service delivery with minimal disruption.

Third party researchers with approved direct access to the NCIS were surveyed in April 2020 to determine what impact working from home arrangements may have on approved projects. Whilst there was a significant increase in researchers indicating that they were working from home, no major security issues were identified.

The NCIS Unit is not a real-time reporting service due to the time taken to finalise coronial processes and close cases on the NCIS. As a result, data report requests on deaths associated with COVID-19 have been unable to be facilitated and were instead referred to the relevant coroners court.

The NCIS Unit expanded its existing video conferencing capabilities to broaden engagement with stakeholders and clients, and to deliver training. The NCIS website and online database interface remained operational and well supported through the pandemic.

Capturing COVID-19 deaths in the NCIS

Consistently coding deaths related to the COVID-19 pandemic is essential to ensure the deaths can be accurately identified within the court systems, the NCIS and the ICD-10 coding performed by the Australia Bureau of Statistics (ABS).

The NCIS Unit created a multiple fatality event (MFE) to identify COVID-19 related deaths on the NCIS. Whilst technically a pandemic does not meet the all the requirements of the MFE as the dates are spread across weeks or months, utilising the MFE functionality within the NCIS allows for immediate capture of COVID-19 related deaths without the need to implement system changes.

View the Coding COVID-19 deaths on the NCIS advice

KEY ACHIEVEMENTS

Provision of comprehensive coronial data to those who need it. *This is our mission*

Saving lives through the power of data. *This is our vision*

The NCIS Strategic Plan 2017-21, approved by the Board of Management in December 2017, outlines four strategic goals to support our mission and vision:

- Ensure efficient and comprehensive acquisition of data
- Ensure data quality is of the highest possible standard
- Provision of quality coronial data to stakeholders
- Assurance of system continuity and security

The NCIS Unit continued to make progress against its strategic goals through the 2019-20 business plan which identified three key focus areas:

Redefining the NCIS identity to better promote our value

This focus area concentrated on activities to ensure the NCIS' unique value is clearly articulated, our service offering is better defined, and NCIS data is promoted to a wider audience. Key achievements included:

Activity	Aim	Outcomes delivered
New funding agreement	To secure funding for the next five years from an NCIS core funder	• Successfully established a new five year agreement with the Australian Department of Health
NCIS awareness program	To develop a presentation that articulates information about the NCIS and can be easily reused for various audiences with minimal effort	• Presentation pack developed that can be easily adjusted based on audience • Three information sessions specifically targeted at Victorian Coroners and their staff delivered in late 2019 • Six information sessions held with existing and prospective third party researchers,

Activity	Aim	Outcomes delivered
		interested government agencies and the Justice Human Research Ethics Committee • Remote videoconferencing effectively used to deliver presentations as well as in-person presentations (pre pandemic)
Expand existing fact sheet series	To increase the NCIS' public contribution to suicide prevention	• Intentional self-harm series: ISH among emergency services personnel in Australia published on World Mental Health Day in October 2019 • Common interest series: Animal related deaths published in March 2020

Establish the Mortality data series (Australia) fact sheets	To develop and publish new mortality data series allowing comparable data across a number of years	• Established process to easily and quickly reuse data prepared for the annual mortality reports delivered to the Australian Department of Health
		• First Mortality data series instalment published in October 2019 included:
		  ○ Injury deaths in Australia (three fact sheets: 2014, 2015 and 2016)
		  ○ Intentional self-harm deaths in Australia (three fact sheets: 2014, 2015 and 2016)
		  ○ Drug related deaths in Australia (three fact sheets: 2014, 2015 and 2016)
		• Second instalment published in May 2020:
		  ○ Injury deaths in Australia 2017
		  ○ Intentional self-harm deaths in Australia 2017
		  ○ Drug related deaths in Australia 2017

Fatal facts backlog project	To implement a systematic approach to bring Fatal facts up to date	• Backlog significantly reduced from 5.5 years to 12 months • Team capacity to complete Fatal facts summaries increased from one staff member to five • Increased communications about new editions released via Mailchimp communications and NCIS news feed

Activity	Aim	Outcomes delivered
		• User survey indicated overall high level of satisfaction with the resource (4.2/5)
NCIS Internship program expansion	To expand the NCIS internship program to include an offering to Bachelor level students	• One 10 day placement offered and completed throughout the 2019-20 summer

Discovering and implementing opportunities to work smarter

This focus area concentrated on identifying ways to make our tools and process work harder and to improve access to information to better support informed and evidence based decisions. Key achievements included:

Activity	Aim	Outcomes delivered
Assessment tools	To develop a variety of tools to ensure more consistent assessments and evidence to support decisions made by the NCIS Unit	• Governance decision matrix articulates key decisions required, who makes the decision and in accordance with which policy or instrument • Developed and implemented a series of assessment templates and checklists to support the NCIS Unit's core functions
Supporting strategic decisions	To refresh or create tools to support better decision making by the NCIS Board of Management and the NCIS Research Committee (NRC)	• Series of new Board templates created including board paper, agenda, annotated agenda for the Chair, minutes and out of session decision • Revamped NRC assessment forms
Technology support	To explore and implement technology options to improve NCIS processes and practices to streamline activities and enhance access to information	• Redesigned and increased use of corporate tools used to manage information and workflow • Introduction of Microsoft Teams, including channels, increasing internal communications and reducing email traffic, and providing video conferencing capabilities • Improved use of MailChimp to disseminate NCIS news

Improving how we manage the NCIS database to keep it relevant

This focus area concentrated on making improvements to how the NCIS database operates and its functionality. Key achievements included:

Activity	Aim	Outcomes delivered
Database development road map	To provide a high level strategic plan for technical development of the NCIS database	• NCIS Database roadmap 2020-2023 developed and will assist in managing the future development of the NCIS database. The roadmap articulates three broad principles (security, usability and support structures), with high level goals and a series of measures supporting them.
Codeset upgrade	To expand and improve the NCIS codesets resulting in a wider scope of meaningful coding To reduce the incidence of free text field coding To increase functionality of NCIS searches by mapping existing coding to more appropriate codes, existing or new	• More than 460 new codes were added to the NCIS dataset and 245 existing codes were amended. • New validation rules were applied to existing and new codes • Automated and manual mapping of existing cases on the NCIS from old codes to new codes occurred • Codeset changes integrated into most local court systems. Worked with courts unable to immediately apply upgrade to determine implementation timeline and map old codes to new codes in the NCIS in the interim. • Published the updated Data dictionary and Coding manual to reflect the codeset changes, provide more clarity and ease of use and reflect new NCIS branding
Database development	To implement a series of fixes and enhancements to increase usability	• 15 changes implemented
Implement BDM Indigenous and Place of birth supplementary data	To finalise the inclusion of data sourced from Australian births, deaths and marriage registries as a supplementary data source	• Indigenous status data provided by the Births, Deaths and Marriages (BDM) registries in each Australian jurisdiction uploaded to NCIS • Place of birth data provided by the Births, Deaths and Marriages (BDM) registries in each Australian jurisdiction uploaded to NCIS

OPERATIONAL REPORT

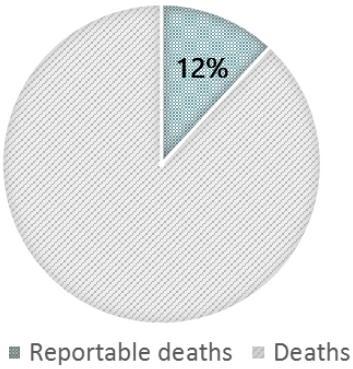
Data contained on the NCIS is provided by each coronial court in Australia and New Zealand. The NCIS Unit ensures the data received from the coronial courts is quality assured and nationally consistent.

Supplementary data is also provided by external organisations and updated annually including:

- ICD-10 coding provided by the Australian Bureau of Statistics and the New Zealand Ministry of Health. All deaths occurring in Australia and New Zealand are coded in accordance with the International Classification of Death – Tenth Revision (ICD-10) codes
- Work-related fatality supplementary data including occupation, industry and injury type is provided by Safe Work Australia. There is no equivalent for New Zealand data
- Data about the indigenous status and birthplace of individuals is provided by each state/territory BDM registry. This data originates from the death registration process and/or medical certificate cause of death.

DATA COLLECTION

Each year the total number of cases contained on the NCIS increases, subsequently growing the value of the data to death investigators and researchers.



The number of deaths reported to an Australian or New Zealand coroner has remained relatively constant over the last five years, accounting for approximately 12 per cent of all deaths.

There were 23,188 new cases added to the NCIS during 2019-20, bringing the total number of cases contained in the NCIS at 30 June 2020 to 415,547.

Table 1: Total number of cases contained on the NCIS by financial year

Financial year	New cases	Total number of cases
2000 - 2001	13,085	13,093
2001 - 2002	17,465	30,558
2002 - 2003	21,548	52,106
2003 - 2004	18,851	70,957
2004 - 2005	18,884	89,841
2005 - 2006	19,650	109,491
2006 - 2007	17,462	126,953

Financial year	New cases	Total number of cases
2007 - 2008	17,614	144,567
2008 - 2009	19,384	163,951
2009 - 2010	18,129	182,080
2010 - 2011	18,088	200,168
2011 - 2012	17,488	217,656
2012 - 2013	30,371	248,027
2013 - 2014	24,683	272,710
2014 - 2015	24,898	297,608
2015 - 2016	24,752	322,360
2016 - 2017	23,364	345,724
2017 - 2018	23,185	368,909
2018 - 2019	23,450	392,359
2019 – 2020	23,188	415,547

Table 2: Total number of cases closed on the NCIS by jurisdiction and financial year

Jurisdiction	2015-16	2016-17	2017-18	2018-19	2019-20
Australian Capital Territory	211	309	263	286	356
New South Wales	4805	4453	4313	5733	7257
Northern Territory	376	354	227	335	340
Queensland	2589	2182	2329	2524	2039
South Australia	2173	1795	2801	2700	2419
Tasmania	478	516	578	483	677
Victoria	4016	9548	5525	3282	8042
Western Australia	2047	2437	2329	2296	2833
New Zealand	3190	2902	3009	3189	2928
Total	**19,885**	**24,406**	**21,374**	**20,828**	**26,891**

Table 3: Total number of closed cases on the NCIS by jurisdiction and case type during 2019-20

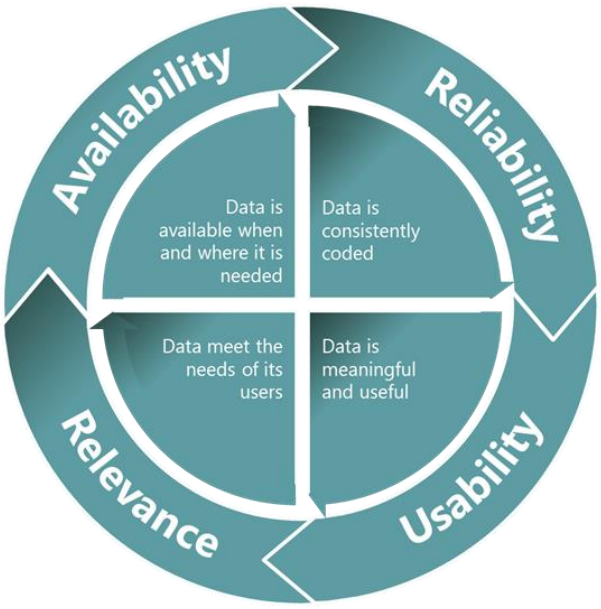
Jurisdiction	Natural case	Non-natural case	Total closed cases
Australian Capital Territory	171	185	356

Jurisdiction	Natural case	Non-natural case	Total closed cases
New South Wales	4058	3199	7257
Northern Territory	154	186	340
Queensland	559	1480	2039
South Australia	1523	896	2419
Tasmania	307	370	677
Victoria	3797	4245	7257
Western Australia	1235	1598	2833
New Zealand	1784	1144	2928
Total	**13,588**	**13,303**	**26,891**

View current cases closure and document attachment statistics

QUALITY ASSURANCE

The NCIS is committed to providing high quality and fit-for-purpose data. Our quality program encompasses a range of activities to maintain the highest possible standards of data quality and consistency.



Read more about our Quality assurance program

The NCIS Unit undertakes manual quality assurance on all eligible cases. To be included in a quality review a case must meet at least one of the following criteria:

- Case type completion is non-natural death [*Death due to external cause(s)*, *Body not recovered* or *Unlikely to be known*]
- Case type completion is *Death due to natural cause(s)* and
  - at least one mechanism/object screen is coded
  - *Cause of death* field contains one of the nominated keywords or
  - Coroners recommendations/warning field is *Recommendations made/warning made*

During 2019-20, the review of closed cases was suspended to enable the implementation of the codeset update and corresponding revisions to the quality process. The impact of this was decreased capacity pf the QA team during the second and third quarter and a decline in the number of cases reviewed during the period.

Table 4: Total number of cases quality assured by jurisdiction and financial year

Jurisdiction	2015-16	2016-17	2017-18	2018-19	2019-20
Australian Capital Territory	398	347	366	122	441
New South Wales	2757	6099	4142	11,226	2482
Northern Territory	378	427	473	201	136
Queensland	7815	3833	2951	1708	1396
South Australia	3954	2109	2134	1145	1027
Tasmania	557	520	678	306	266
Victoria	689	4477	11,320	2531	3816
Western Australia	1075	3386	2766	1468	3375
New Zealand	2752	4039	6717	1708	717
Total	**20,375**	**25,237**	**31,547**	**20,409**	**13,656**

Table 5: Total number of closed cases awaiting QA review by jurisdiction and financial year

Jurisdiction	2015-16	2016-17	2017-18	2018-19	2019-20
Australian Capital Territory	341	226	31	81	143
New South Wales	6012	2695	901	876	3213
Northern Territory	492	293	35	55	162

Jurisdiction	2015-16	2016-17	2017-18	2018-19	2019-20
Queensland	4281	1931	714	529	1112
South Australia	2268	1014	435	352	795
Tasmania	603	395	115	88	270
Victoria	5194	5712	1511	1291	3518
Western Australia	2895	1820	600	489	1002
New Zealand	7373	5435	863	225	616
Total	**30,059**	**19,521**	**5205**	**3986**	**10,831**

In February 2016 the NCIS Unit revised its processes for the type of cases that are manually quality reviewed. This significantly impacted the numbers of cases that were awaiting quality review between 2015-16 and 2016-17 as seen in the above tables.

The NCIS Unit moved from manually quality reviewing every case on the system to reviewing those cases that were most likely to be involved in monitoring, research and death prevention. Manual quality reviews are now undertaken on all external cause deaths, those with recommendations, or where an external factor contributed to the death. This has allowed these cases to be quality reviewed in a timelier manner and maximised the impact of the finite quality review resources within the NCIS Unit.

NCIS DATA ACCESS

NCIS direct access is available to the following groups:

Death investigators are individuals who directly assist with the investigation of deaths reported to a coroner. They include coroners, coronial clerks, forensic pathologists and police assisting a coroner. Death investigators may utilise the NCIS in the investigation process to review circumstances and outcomes in similar cases occurring in any jurisdiction in Australia and New Zealand.

Third party users include researchers, universities, policy makers or government departments with a bona fide involvement in monitoring and preventing injury and death in the community. Ethical approval for research projects is required for access to the NCIS.

Providing agencies are approved to on-provide NCIS data under certain conditions. Providing agencies may be current approved third-party researchers or may be apply as new agencies for the sole purpose of data on-provision. They must have assessment processes in place to ensure that NCIS sourced data remains secure and will only be on-provided to receiving agencies for research or statistical purpose.

Approved death investigators

There were 148 new death investigators approved for NCIS access in 2019-20. There are active death investigator users in every jurisdiction represented in the NCIS, including staff at the coroners courts.

Table 6: Total number of NCIS searches conducted by death investigators by type and financial year

Search type	2015-16	2016-17	2017-18	2018-19	2019-20
For specific known case	27,154	17,298	9927	9995	11,814
For similar cases	2282	1492	1956	1908	1553
Total searches	**29,436**	**18,790**	**11,883**	**11,903**	**13,394**

Approved third party research projects

There were 89 active third party research projects utilising NCIS data as at 30 June 2020. Of these, 15 were new projects that commenced in the 2019-20 financial year. There were 13 projects completed and eight renewed in the same period. There were 39 research publications and reports published by researchers accessing the NCIS.

Table 7: Total number of new and renewed third party applications for access to NCIS by financial year

Projects	2015-16	2016-17	2017-18	2018-19	2019-20
New	34	25	16	17	15
Renewed	18	12	16	23	8
Completed	21	13	23	22	15
Active projects at end of financial year	86	102	93	91	89

The ethics approval period changed from three to five years during 2019-20. As a result, fewer applications required full renewal in this financial year.

Table 8: Total number of NCIS searches conducted by third party users by type and financial year

Search type	2015-16	2016-17	2017-18	2018-19	2019-20
For specific known case	100,049	91,665	90,294	80,759	98,501
For similar cases	6990	9122	8637	9272	10,222
Total searches	**107,039**	**100,787**	**98,931**	**90,031**	**108,723**

A full list of publications is provided in Appendix C – Research publications

Approved data on-provision agencies

Table 9: Total number of data on-provision applications by financial year

Projects	2015-16	2016-17	2017-18	2018-19	2019-20
New	1	1	1	1	
Renewed	1	1	3		3

DATA REPORTING

The NCIS Unit produced a total of 67 data reports at the request of coroners, death investigators and external parties (38 to coroners and death investigators, and 29 to external parties). The reports are used as evidence to inform public discussion and decision making.

Table 10: Total number of reports prepared by NCIS for death investigators and external parties by financial year

Service	Organisation	2015-16	2016-17	2017-18	2018-19	2019-20
Coronial report	Death investigators	55	70	57	32	38
Data report	External parties	32	43	43	19	27
Data report	Media organisations	6	8	4	2	2
	Total	**93**	**121**	**108**	**53**	**67**

NCIS coronial report service

There were 38 coronial reports delivered in 2019-20, which represents a 18.8 per cent increase from the previous year.

Over one fifth (21.1%, n=8) of these reports examined intentional self-harm deaths, and 13.2 per cent (n=5) examined administrative or operational statistics relating to the number of deaths reported, cases closed or autopsy procedures undertaken. There were four reports each regarding drug and alcohol-related deaths and sport and recreation deaths.

The largest proportion of coronial report requests were made by New South Wales (36.8%, n=14), followed by Queensland (23.7%, n=9) and Victoria (21.1%, n=8).

A key feature within NCIS functionality is the capability for full text, keyword searching of descriptions about the fatal incident and medical and legal findings. This allows detailed searching for particular locations, drug types or environmental conditions that are not possible

via other mortality data collections. Coroners can then use this information for comparison and trend analysis purposes.

View the list of NCIS coronial reports in Appendix A - NCIS Coronial reports

NCIS data report service

Data reports can be used as supporting evidence for external parties with an interest in death and injury prevention and can provide vital information regarding community safety. All information provided is non-identifying.

There were 29 data reports delivered in 2019-20. There were 12 reports which provided data on intentional self-harm deaths. Four reports provided data on each of the following topics: drug and alcohol-related deaths, transport incident deaths and medical or physical health-related deaths.

Over half of these data reports (n=19) were requested by government, regulatory or statutory agencies.

View the list of NCIS data to external parties in Appendix B - NCIS Data reports

Commonwealth reporting requirements

The NCIS Unit delivered three mortality reports to the Australian Department of Health, a requirement of the partnership agreement held between the Commonwealth of Australia and the NCIS Unit. These reports included:

- NCIS Injury mortality data report 2017
- NCIS Drug mortality data report 2017
- NCIS Intentional self-harm mortality data report 2017

DATA PUBLISHING

The NCIS Research agenda was outlines the NCIS Unit's research and reporting priorities, activities and outcomes for the 2018-21 calendar years. The agenda identifies areas that will contribute to the assessment of mortality trends in coronial data through three key activity streams: reporting services, publications and tools.

View the NCIS Research agenda 2018-21

Coronial recommendations: Fatal facts

A coroner may make recommendations as part of their inquiry into a death. Recommendations are made to help prevent similar deaths from occurring in the future.

Subject to coronial approval, the NCIS Unit publishes summaries of Australian cases in which a coroner has made a recommendation. These summaries are made available in two formats:

- Coronial recommendations: Fatal facts - a PDF publication containing summaries of cases with coronial recommendations made within a three month period.
- Fatal facts search – an interactive search tool allowing users to search by pre-defined case categories to identify cases relevant to the selected category.

In July 2019, publication of Fatal facts was five and a half years behind the most recently closed cases. The NCIS Unit has committed additional resources throughout 2019-20 to bring the Fatal facts publication more up to date. This resulted in an equivalent four-year reduction in the backlog of cases. The latest edition of Fatal facts published in 2019-20 covered cases closed by a coroner from October to December 2018.

The NCIS Unit published 21 editions of Fatal facts in 2019-20, a publication increase of over ten times from the previous year.

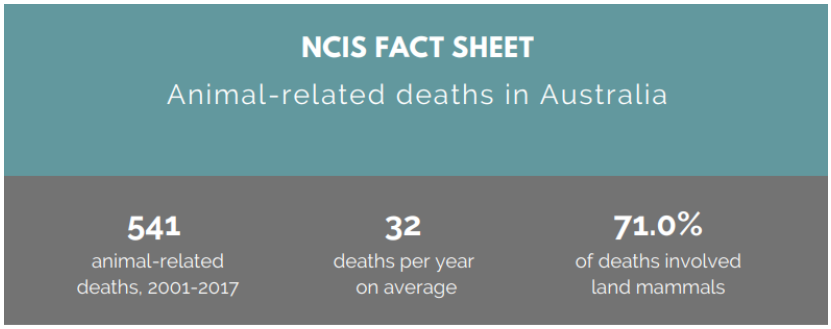
NCIS Facts sheets

NCIS fact sheets are unique NCIS products, free and publicly available via the NCIS website. They include statistical information on deaths reported to a coroner and cover specific topics of public interest. They aim to raise awareness of mortality risks and to inform death and injury prevention strategies. All NCIS publications require coronial approval before they can be released.

The NCIS Unit published a number of new fact sheets in 2019-20:

The Intentional self-harm deaths of emergency services personnel in Australia fact sheet was released on World Mental Health Day 2019.

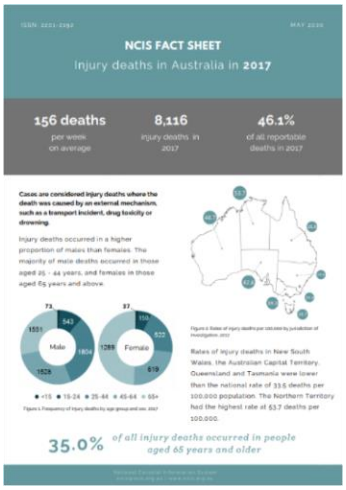
View the Intentional self-harm deaths of emergency services personnel in Australia fact sheet



The Animal-related deaths in Australia fact sheet was released in March 2020 as an update to a previously released fact sheet.

View the Animal-related deaths in Australia fact sheet

The NCIS Mortality data series is a new group of fact sheets examines closed case external cause deaths due to injury, drug contribution and intentional self-harm reported to an Australian coroner. The series provides yearly data on each type of death to enable comparisons over time.



View the Mortality data series

NCIS data for external research publications

The NCIS database is available for direct access by researchers with ethically approved research projects. There were 89 active projects utilising NCIS data as at 30 June 2020. Many of these research projects result in professional and peer reviewed publications which are often cited by media outlets which subsequently inform public discussion.

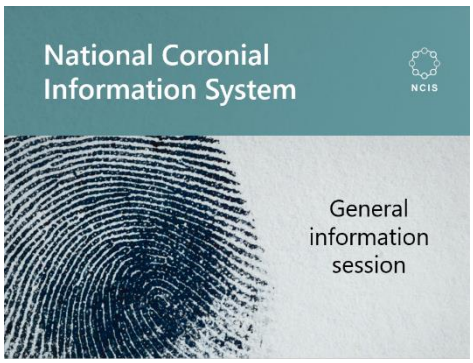
There were 39 research publications and reports that utilised NCIS data published during 2019-20. The research covered a range of topics including deaths in aged care, traffic-related deaths and drug related fatalities.

View the full list of publications in Appendix C – Research publications

TRAINING AND SUPPORT

The NCIS Unit provides training and support to court staff, approved NCIS users, interested parties and students.

General information



The NCIS Unit developed the NCIS General information session originally as an education presentation for Victorian Coroners and their staff in late 2019. Following this success, the program was expanded for broader delivery.

The NCIS General information session provides an overview of the NCIS - how it came about, what it is and how it works. Participants gain an understanding of how NCIS data may be accessed and the services offered by the NCIS Unit. The session is now delivered online (using Microsoft Teams or Zoom) and runs for approximately 40 minutes.

The session was delivered on nine occasions throughout 2019-20 to various coroners, court staff, approved third party researchers, data report recipients and others interested in NCIS data.

Support for courts and coders

The NCIS Unit continued to provide support to coronial court staff responsible for entering the data that is transferred to the NCIS:

- NCIS online coder training modules designed to assist staff in coronial offices with responsibilities for entering data used for the NCIS. Each of the nine modules focuses on a particular aspect of the NCIS data entry process
- The NCIS Data dictionary and Coding manual are references for those entering data used for the NCIS. Both underwent a complete update during 2019-20 as part of the Codeset upgrade project
- Guidelines for coders include coding advice and tips specifically for NCIS coders. Three new or revised guidelines were published in 2019-20:
  - Coding tips: Codeset upgrade (February 2020)
  - Coding tips: Alcohol and drugs (February 2020)
  - Coding advice: Covid-19 related deaths (March 2020)
- Quality assurance (QA) reports provided quarterly to each jurisdiction give an overview of the outcomes of the NCIS Unit quality assurance reviews of closed cases and provide areas of focus we are currently working on with jurisdictional coding staff. Quarterly QA summary reports are produced for coronial managers to identify overall QA trends.

Support for third party researchers and death investigators

The NCIS Unit has continued to increase the availability of database search training for approved third party researchers and death investigators to ensure users maximise the value of their NCIS access. Tailored training sessions are delivered online via video conferencing in addition to a series of search guides available online.

Internship program

The NCIS Internship program is designed to introduce students to a professional workplace where the skills and knowledge gained through study can applied. Placements are considered learning opportunities for the next generation of criminology, research and health information management professionals.

The NCIS Unit does not expect students to have expert knowledge of the NCIS or its workings. All students are provided with:

Working on site at the NCIS offices (pre-pandemic) or remotely

A tailored work program

Full workplace induction, training and support

The NCIS Unit aims to provide students with a positive and productive placement. In return, students are expected to participate in office life and complete assigned tasks.

The NCIS Unit offers two internship streams:

Quality	Research
The Quality stream provides students with an opportunity to participate in quality assurance activities such as: • Completing targeted quality review of cases against NCIS coding protocols and practices Students from information management and health information management backgrounds are welcome to apply.	The Research stream provides students with an opportunity to participate in the production of NCIS publications such as: • Preparing an NCIS fact sheet • Preparing Fatal facts case summaries Students from all disciplines are welcome to apply, though those with a criminology or sociology background would be most suitable.

Quality placement 2019-20

The NCIS Unit has a long standing history of hosting La Trobe University students as part of formal studies required for the Master of Health Information Management.

One student was hosted for a 24-day placement from mid to late 2019. Key outcomes included:

- **Quality review WA closed cases:** Reviewed WA cases to assess if coding recommendations made during the quality assurance program were implemented
- **Cause of death data comparison:** Reviewed medical and legal cause of death data to identify trends
- **Fatal fact case summaries**: Contribution to developing case summaries for inclusion in the NCIS' Coronial recommendations: Fatal facts.

Student testimonial

My placement with the National Coronial Information System (NCIS) Unit has proved invaluable in allowing me to apply the theoretical knowledge I have learnt whilst at university in a practical setting. I did not imagine prior to placement that I would be able to use many of the skills taught to me in a variety of projects specifically related to coronial and death data (especially given that I have previously analysed `health' data whilst at university).

I appreciated being able to work and be involved in varied projects which I have been told will be beneficial for the team. These projects included:

- Reviewing coronial cases from Western Australia to assess if requested amendments have been made and if so, are the amendments appropriate

- Data analysis of why the cause of death field is being amended during the NCIS quality assurance process.

- Reviewing coronial cases and preparing summaries for inclusion in a NCIS publication (Fatal Facts)

- Reviewing object codes and keywords in preparation for the future NCIS code set upgrade

- Developing a PowerPoint summary on my placement block and presenting it to the NCIS team

The most significant part of the placement for me personally was the ability to attend a two-day coronial inquest. This inquest involved the unexplained death of an inpatient at a psychiatric hospital. During the inquest, I observed how the patient's record is used as part of the medico-legal process. The inquest showed the importance of documentation standards that has clinical information recorded as soon as possible after an event. Health Information Management students are consistently taught how important it is to document medical records accurately and in a timely manner and the inquest illustrated just how important it is to do so.

Thank you for allowing me to undertake placement with the NCIS team; I particularly appreciated the documented Student Placement Plan developed specifically for me. This document was very useful to refer to and clearly outlined all my assigned tasks for this

placement block. I very much appreciate the well-organised supervisor and I know that I have learnt more than I thought I ever could. I also appreciate all the time everyone in the team has taken to make me feel welcome, explain their roles as well as sharing how coronial data provides vital statistics and information to government departments, researchers, and other interested parties. I was made to feel that my small contribution of work was worthwhile and valued. I wish the team all the best in its future work.

Research placement 2019-20

The NCIS Unit hosted a Bachelor level student from Monash University for a 10 day placement for the first time in January and February 2020. Key outcomes included:

- **Fatal fact case summaries**: Contribution to developing case summaries for inclusion in the NCIS' Coronial recommendations: Fatal facts

Student testimonial

Over a 5-week period in January and February, I undertook an 80-hour internship at NCIS as part of my bachelor's degree at Monash University. I was almost at the end of my degree and had the option to do an internship subject as an elective. I thought an internship would be the perfect way to gain practical skills in a professional working environment. Although I have learnt a large amount of theoretical knowledge during my degree, I felt I was lacking work experience in a setting related to my course.

Before beginning my internship, I wasn't sure exactly what to expect and how I would fit into the workplace. However, I was able to gain a strong understanding of my role once I began and the team were all really helpful at assisting me to settle in. During my first week, I had individual meetings with each team member where I was able to gain a better understanding of how the organisation functions as a whole and how each person's role works. I was also able to go to team meetings while I was there which allowed me to feel like I was a part of the team. I was never made to feel pressured or overwhelmed if I wasn't sure about how to complete something. Everyone was really supportive and encouraging towards me whenever I had a question or wasn't sure about something.

I feel that I was really able to broaden my criminological thinking while I was there through the work I was completing. I completed two editions of *Fatal facts* during my time there which will later be published on the NCIS website. Through doing the *Fatal facts*, I was able to gain an understanding of the coronial division within the criminal justice system and how it is intertwined which is not something I have dealt with previously. As well, I was able to apply my research skills that I have developed during my course through the preparation of *Fatal facts* summaries. I navigated the NCIS database by searching for and analysing the data of each individual case. I then

summarised cases, selecting relevant detail to include within the summary. The process was very interesting and rewarding for me as I feel I was able to achieve a lot while I was there and feel happy that the work, I did will be able to aid in public discourse.

The work I did was confronting and difficult at times. However, from the beginning of the internship, the team placed a strong emphasis on my emotional wellbeing and so I knew I had support if I didn't feel comfortable in writing about a certain topic. I am really thankful for not only the opportunities I was awarded while I was there, but also the flexibility that NCIS allowed me to have in spreading out my internship hours over a period of 5 weeks to ensure I could still work my usual hours at my current part-time job.

FINANCIAL REPORT

Statement of receipts and expenditure year ended 30 June 2020

	2020 $	2019 $
Opening balance (cash in bank)	**706,389**	**877,511**
Add receipts		
Income		
Government grants – Australia (1)	1,085,834	1,085,834
Government grants – New Zealand (2)	91,609	91,609
User pays (3)	194,322	188,317
Total	**1,371,765**	**1,365,760**
Less expenses		
Contractors, consultants and professional service expenses (4)	-	11,868
Depreciation (5)	22,888	35,810
Employee related expenses (6)	937,095	1,033,799
Information technology expenses (7)	350,455	370,679
Postage and communication expenses	835	716
Printing, stationery and other office expenses	207	1,923
Staff training and development expenses (8)	1,671	9,569
Travel, entertainment and personal expenses	-	4,826
Utilities and services	123,597	129,000
Total	**1,436,748**	**1,598,191**
Balance for the year	**(64,983)**	**(232,431)**
Capital expenditure	-	-
Accrued expenses and accounts payable (Net)	(7,183)	(22,737)
Accumulated depreciation (net of asset movements)	22,888	35,810
Grants pain in advance	-	-
Accrued revenue	-	-
Accounts receivable	23,718	11,262
Movement in employee provisions (9)	34,243	59,498
Closing balance (cash in bank)	**687,763**	**706,389**

Explanatory notes for statement of receipts and expenditure

1. Refer to the next section *Government funding contributions* for more details
2. Refer to the next section *Government funding contributions* for more details
3. User pays income includes annual fees from third party researchers and fees from data reports.
4. There was no expenditure related to contractors, consultants or other professional services incurred in 2019-20.
5. Depreciation costs were lower in 2019-20 due to a NCIS server being fully depreciated by the end of 2019.
6. Employee related expenses decreased from 2018-19 due to a role vacancy.
7. Information technology expenditure include annual charges to the NCIS' IT service provider and expenditure required for servers and various licences
8. Staff training and development expenses decreased due to a focus on utilising in-house training programs provided by the Victorian Department of Justice and Community Safety.
9. Provisions for employee benefits or entitlements consist of amounts for annual leave and long service leave accrued by employees. Provisions are recognised when the NCIS Unit 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. There was no significant leave taken throughout the year.

Government funding contributions

The following funding contributions were made by governments this financial year:

Jurisdiction	Agency	Amount contributed $AU (GST exclusive)
Commonwealth of Australia	Australian Department of Health	400,000
	Australian Institute of Criminology	24,819
	Australian Competition and Consumer Commission	18,614
	Department of Infrastructure, Regional Development and Cities	26,000
	SafeWork Australia	95,455
	Sub-total	**564,888**
Australian states and territories	Australian Capital Territory	8348
	New South Wales	165,008
	Northern Territory	5382
	Queensland	106,991
	South Australia	38,649

Jurisdiction	Agency	Amount contributed $AU (GST exclusive)
	Tasmania	12,540
	Victoria	133,000
	Western Australia	51,028
	Sub-total	**520,946**
New Zealand	New Zealand	91,609
Total		**1,177,443**

Appendix A - NCIS Coronial reports

The NCIS Unit prepared and issued 38 coronial reports during 2019-20:

Australian Capital Territory

Reference	Title	Client	Issued
CR19-22	Fire-related deaths as a result of a gas leak in Australia, 2014 - 2019	Coroner's Court of the Australian Capital Territory	Jul-Sep 2019
CR20-12	Opioid-related deaths reported to an ACT coroner 2000-2019	Coroner's Court of the Australian Capital Territory	Apr-Jun 2020
CR20-13	Autopsy examination frequency for Australian coronial cases 2001-2017	Coroner's Court of the Australian Capital Territory	Apr-Jun 2020

New South Wales

Reference	Title	Client	Issued
CR19-17	Deaths of cyclists in New South Wales 2016 - 2019	Coroners Court of New South Wales	Jul-Sep 2019
CR19-21	Drug-related deaths in Western New South Wales 2016 - 2019	Coroners Court of New South Wales	Jul-Sep 2019
CR19-23	Intentional self-harm deaths in New South Wales January - June 2019	Coroners Court of New South Wales	Jul-Sep 2019
CR19-24	Deaths in Long Bay Correctional Centre 2014 - 2019	Coroners Court of New South Wales	Oct-Dec 2019
CR19-34	Deaths reported to a NSW Coroner 2000 - 2019	Coroners Court of New South Wales	Oct-Dec 2019
CR19-35	Skateboarding deaths in Australia 2000 - 2019	Coroners Court of New South Wales	Oct-Dec 2019
CR19-35.1	Skateboarding deaths in Australia 2000 - 2019	Coroners Court of New South Wales	Jan-Mar 2020
CR20-01	Intentional self-harm deaths at The Gap 2000 - 2020	Coroners Court of New South Wales	Jan-Mar 2020
CR20-07	Intentional self-harm deaths following contact with Lismore mental health services	Coroners Court of New South Wales	Jan-Mar 2020

Reference	Title	Client	Issued
CR20-11A	Intentional self-harm deaths reported in New South Wales 2018-20 (open cases only)	Coroners Court of New South Wales	Apr-Jun 2020
CR20-11B	Intentional self-harm deaths reported in New South Wales 2018-20 (closed cases only)	Coroners Court of New South Wales	Apr-Jun 2020
CR20-19	Choking deaths of nursing home residents in Australia 2000 - 2020	Coroners Court of New South Wales	Apr-Jun 2020
CR20-21	Deaths reported to a New South Wales coroner in 2019	Coroners Court of New South Wales	Apr-Jun 2020
CR20-23	Kitesurfing deaths in Australia 2010 - 2020	Coroners Court of New South Wales	Apr-Jun 2020

Northern Territory

There were no reports issued to the Northern Territory in this financial year.

Queensland

Reference	Title	Client	Issued
CR19-28a	Assault deaths of indigenous females in Australia 2000 - 2019 (based on coronial data)	Coroners Court of Queensland	Oct-Dec 2019
CR19-28b	Assault deaths of indigenous females in Australia 2000 - 2019 (based on BDM data)	Coroners Court of Queensland	Oct-Dec 2019
CR19-31	Motorcycling event deaths involving track barriers in Australia and New Zealand 2014 - 2019	Coroners Court of Queensland	Oct-Dec 2019
CR19-32	Deaths of missing indigenous females in Australia 2000 - 2019	Coroners Court of Queensland	Oct-Dec 2019
CR20-04	Coronial recommendations relating to defibrillators 2012-2020	Coroners Court of Queensland	Jan-Mar 2020

National Coronial Information System

Reference	Title	Client	Issued
CR20-10	Intentional self-harm deaths involving helium gas in Australia 2001-2020	Coroners Court of Queensland	Apr-Jun 2020
CR20-14	Autopsy examination frequency for Australian coronial cases 2001-2007	Coroners Court of Queensland	Apr-Jun 2020
CR20-16	Coronial findings regarding bus incidents and seat belts	Coroners Court of Queensland	Apr-Jun 2020
CR20-20	Coronial recommendations regarding drug use in Queensland 2010-2020	Coroners Court of Queensland	Apr-Jun 2020

South Australia

Reference	Title	Client	Issued
CR19-26	Deaths involving tyre inflation incidents 2009 - 2019	Coroner's Court of South Australia	Oct-Dec 2019
CR19-33	Firearm-related deaths involving police operations in Australia 2009 - 2019	Coroner's Court of South Australia	Oct-Dec 2019

Tasmania

Reference	Title	Client	Issued
CR20-22	Intentional self-harm deaths of ambulance officers and paramedics in Australia 2010-2020	Magistrates Court of Tasmania - Coronial Division	Apr-Jun 2020

Victoria

Reference	Title	Client	Issued
CR19-20	Cases closed on the NCIS by the Coroners Court of Victoria 2018 - 2019 financial year	Coroners Court of Victoria	Jul-Sep 2019

Reference	Title	Client	Issued
CR19-25	Deaths associated with the education sector in Australia 2007 - 2016	Coroners Court of Victoria	Oct-Dec 2019
CR19-30	Fall-related deaths involving stairs in Australia 2015 - 2019	Coroner's Court of Victoria	Oct-Dec 2019
CR19-36	Infant deaths involving amphetamines in Australia 2013 - 2018	Coroners Court of Victoria	Jan-Mar 2020
CR20-03	Recommendations regarding intentional self-harm deaths of defence force veterans 2010-2020	Coroners Court of Victoria	Jan-Mar 2020
CR20-05	Food bolus-related deaths in Victoria 2014-2018	Coroners Court of Victoria	Jan-Mar 2020
CR20-06	Child deaths involving blind cord strangulation in Australia 2010-2019	Coroners Court of Victoria	Jan-Mar 2020
CR20-09	Deaths involving tree felling and chainsaw-related incidents in Victoria 2000-2020	Coroners Court of Victoria	Apr-Jun 2020

Western Australia

Reference	Title	Client	Issued
CR19-18	Coroner's Court of Western Australia	Vehicle incident deaths involving police operations, 2015 - 2019	Jul-Sep 2019

New Zealand

There were no reports issued to New Zealand in this financial year.

APPENDIX B - NCIS DATA REPORTS

External parties

The NCIS Unit prepared and issued 27 coronial approved data reports during 2019-20 to external parties (excluding media outlets):

Reference	Title	Client	Issued
DR19-26	Intentional self-harm deaths of persons with terminal or debilitating physical conditions in Queensland 2016 - 2017	Queensland Parliament	Jul-Sep 2019
DR19-30	Intentional self-harm deaths of Australian Defence Force personnel 2006 - 2016	Soldier.ly	Jul-Sep 2019
DR19-32	Intentional self-harm deaths of Cardinia Shire residents 2000 - 2016	Cardinia Shire Council	Jul-Sep 2019
DR19-39	Toy-related deaths in Australia 2011 - 2016	Australian Competition and Consumer Commission	Jul-Sep 2019
DR19-40	Deaths involving songraphers or songraphy equipment in Australia and New Zealand 2000-2017	Australasian Sonographers Association	Jul-Sep 2019
DR19-45	Carbon monoxide poisoning deaths in Australia 2012-2016	Therapeutic Goods Administration	Jul-Sep 2019
DR19-51	Railway incident deaths in Australia 2015 - 2018	Department of Health and Human Services (Vic)	Jul-Sep 2019
DR20-03	Unintentional deaths in disused mining features in Australia 2000-2017	Indigo Shire Council	Apr-Jun 2020
DR20-07	Intentional self-harm deaths of farming and agriculture and heavy vehicle transport workers	OzHelp	Apr-Jun 2020

Reference	Title	Client	Issued
DR20-12	Vehicle incident deaths involving stolen vehicles in Australia 2012-2017	National Motor Vehicle Theft Reduction Council	Apr-Jun 2020
DR20-13	Autopsy examination frequency for Australian coronial cases 2001-2017	Forensic Science South Australia	Apr-Jun 2020
DR19-49A (addendum)	Intentional self-harm deaths involving the Northern Beaches LGA 2000-2017	Northern Beaches Council	Jan-Mar 2020
DR19-55	Deaths of children due to laryngotracheobronchitis (croup) in Australia 2000-2016	Consultant Paediatrics	Jan-Mar 2020
DR19-59	Thyroidectomy-related deaths 2000-2016	St Vincent's and Austin Hospitals	Jan-Mar 2020
DR19-60	All-terrain and side-by-side vehicle incident deaths in Australia 2001-2017	Federal Chamber of Automotive Industries (FCAI)	Jan-Mar 2020
DR19-61	Vehicle incident deaths on public roadways in Australia 2000-2017	Australian Government Department of Infrastructure, Transport, Cities and Regional Development	Jan-Mar 2020
DR19-63	Pentobarbitone-related deaths in Australia 2000 - 2017	Therapeutic Goods Administration	Jan-Mar 2020
DR19-65	Intentional self-harm deaths reported to a Western Australian Coroner 2006 to 2018	Western Australia Mental Health Commission	Jan-Mar 2020
DR19-67	Allergy-related deaths in Tasmania 2000-2017	Tasmanian Health Service	Jan-Mar 2020
DR19-69	Intentional self-harm deaths of farmers and farm workers in Victoria 2000-2017	Department of Jobs, Precincts and Regions (Vic)	Jan-Mar 2020
DR20-06	Reissue: DR19-62 Opioid-related deaths in Australia 2010-2016	Australian Government Department of Home Affairs	Jan-Mar 2020

Reference	Title	Client	Issued
DR19-49	Intentional self-harm deaths involving the Northern Beaches Local Government Area 2000-2017	Northern Beaches Council	Oct-Dec 2019
DR19-50	Intentional self-harm deaths of construction industry workers in Australia 2001 - 2016	University of Technology Sydney	Oct-Dec 2019
DR19-52	Pentobarbitone-related deaths in Australia 2000 - 2019	Forensic Science South Australia	Oct-Dec 2019
DR19-56	Intentional self-harm deaths in the Kimberley 2006 - 2018	Western Australia Mental Health Commission	Oct-Dec 2019
DR19-57	Intentional self-harm deaths of usual residents of the Kimberley 2006 - 2018	Western Australia Mental Health Commission	Oct-Dec 2019
DR19-64	Intentional self-harm deaths in the South West health region of Western Australia 2016 - 2018	Western Australia Mental Health Commission	Oct-Dec 2019

Media outlets

The NCIS Unit prepared and issued two coronial approved data reports during 2019-20 to media outlets:

Reference	Title	Client	Issued
DR19-37	Assault deaths perpetrated by intimate partners and family members in Australia 2007-2016	The Australian	Jul-Sep 2019
DR19-62	Opioid-related deaths in Australia 2010-2016	The Age	Jan-Mar 2020

APPENDIX C – RESEARCH PUBLICATIONS

The NCIS provides data to experts who investigate mortality and develop death and injury prevention strategies. Annual reports using NCIS data include:

- Causes of death – Australian Bureau of Statistics
- Deaths in custody – Australian Institute of Criminology
- Work-related fatalities – Safe Work Australia
- Homicide in Australia – Australian Institute of Criminology
- National coastal safety – Surf Life Saving Australia
- NSW child deaths – NSW Ombudsman

View the full list of publications and reports using NCIS data

Access to NCIS data is available for ethically approved research projects. The following research publications and reports using NCIS data were released during this financial year:

Drowning and water

Publication citation	Publication date
Exploring Flood-Related Unintentional Fatal Drowning of Children and Adolescents Aged 0–19 Years in Australia Peden, A. E & Franklin, R. C. *ResearchGate*	July 2019
Drowning mortality in children aged 0–14 years in Victoria, Australia: detailed epidemiological study 2001–2016 Chang, S.S.M & Ozanne-Smith, J. *Injury Prevention*	August 2019
Media reporting of summer drowning: A partial picture, useful for advocacy Peden, A. E, Willcox-Pidgeon, S. & Franklin, R. C. *Wiley Online Library*	September 2019
Causes of distraction leading to supervision lapses in cases of fatal drowning of children 0-4 years in Australia: A 15-year review Peden, A. E & Franklin, R. C. *Europe PMC*	October 2019
Autism spectrum disorder and unintentional fatal drowning of children and adolescents in Australia Peden, A. E & Willcox-Pidgeon,S. *BMJ Journals*	March 2020
A 10 Year national review of lake, dam and lagoon drowning over the last 25 Years Peden, A. E & Taylor, D. H. *Royal Life Saving Australia*	April 2020
Medical Conditions in Scuba Diving Fatality Victims in Australia, 2001 to 2013 Lippmann, J & Taylor DM. *National Library of Medicine*	June2020
Rescue and resuscitation factors in scuba diving and snorkelling fatalities in Australia, 2001-2013 Lippmann, J. *National Library of Medicine*	March 2020

Drugs and alcohol

Publication citation	Publication date
Circumstances of death of opioid users being treated with naltrexone Darke, S., Farrell, M., Duflou, J., Larance, B. & Lappin, J. *Wiley Online Library*	July 2019
Paracetamol poisoning-related hospital admissions and deaths in Australia, 2004–2017 Cairns, R., Brown, J., Wylie, C., Dawson, A., Ibsbister, G. & Buckley, N. *Medical Journal of Australia*	August 2019
Characteristics and Circumstances of Death Related to new Psychoactive Stimulants and Hallucinogens in Australia Darke, S., Duflou, J., Farrell, M., Peacock, A. & Lappin, J. *ScienceDirect*	September 2019
Characteristics and circumstances of heroin and pharmaceutical opioid overdose deaths: comparison across opioids Roxburgh, A., Hall, W.D., Gisev, N., Degenhardt, L. *ScienceDirect*	October 2019
The case for a second safe injecting facility (SIF) in Sydney Tomsen, S & Dertadian, G. C. - *Taylor Francis Online*	December 2019
40th International Congress of the European Association of Poisons Centres and Clinical Toxicologists (EAPCCT) 19-22 May 2020 Bates, N. *Clinical Toxicology*	May 2020
Characteristics and circumstances of death related to the self-administration of ketamine Darke, S., Duflou, J., Farrell, M., Peacock, A. & Lappin, J. *MD Linx*	June 2020

Farm and workplace

Publication citation	Publication date
Decade of fatal injuries in workers in New Zealand: insights from a comprehensive national observational study Lilley R., McNoe, B., Davie, G., Horsburg, S., Maclennan, B. & Driscoll, T. *BMJ Journals*	March 2020

Health and medical

Publication citation	Publication date
Epilepsy and seizure-related deaths: Mortality statistics do not tell the complete story Panelli, R. & O'Brien, T. *Epilepsy & Behavior*	August 2019
Using the WHO International Classification of patient safety framework to identify incident characteristics and contributing factors for medical or surgical complication deaths Mitchell, R., Faris, M., Lystad, R., Pulido, D. F., Norton, G., Baysari, M., Clay-Williams, R., Hibbert, P., Carson-Stevens, A. and Hughes, C. *Applied Ergonomics*	August 2019
Fatal pulmonary thromboembolism: deep vein thrombosis incidence at coronial autopsy	February 2020

Publication citation	Publication date
Rivers-Kennedy, A., Van Den Heuvel, C., Byard, R.W., Quill, R. & Langlois, N. E. I. *Journal of the Royal College of Pathologists of Australasia*	
Characteristic Histopathological Findings and Cardiac Arrest Rhythm in Isolated Mitral Valve Prolapse and Sudden Cardiac Death Parsons, S., The, A.W., Saunders, P., Leong, T. et al, *Journal of the American Heart*	April 2020
Rates, characteristics and manner of cannabis-related deaths in Australia 2000-2018 Campbell, G., Darke, S., Degenhardt, L., Townsend, H., C.A., Zahra, E. *ScienceDirect*	April 2020

Suicide

Publication citation	Publication date
Program Evaluation and Decision Analytic Modelling of Universal Suicide Prevention Training (safeTALK) in Secondary Schools Kinchin, I., Russell, A., Petrie, D., Mifsud, A., Manning, L. & Doran, C. *SpringerLink*	August 2019
Suicide in Queensland: 2019 Annual Report *Australian Institute for Suicide Research and Prevention*	September 2019
A comparison of sex-specific rates and characteristics of youth suicides in Australia over 2004–2014 Stefanac, N., Hetrick, C., Spittal, M.J., Witt, K., Robinson, J. *SpringerLink*	October 2019
A drink before suicide: analysis of the Queensland Suicide Register in Australia Kõlves, K., Koo, Y.W., de Leo D. *Epidemiology and Psychiatric Sciences*	February 2020
A suicide prevention initiative at a jumping site: A mixed-methods evaluation Kõlves, K., Koo, Y.W., de Leo D. - *EClinicalMedicine*	February 2020
Prevalence and Characteristics Associated with Chronic Noncancer Pain in Suicide Decedents: A National Study Campbell, G., Darke, S., Degenhardt, L., Townsend, H., Carter, G., Craper, B., Farrell, M., Duflou, J, Lappin, J. *Wiley Online Library*	March 2020
Protocol for a stepped-wedge, cluster randomized controlled trial of the LifeSpan suicide prevention trial in four communities in New South Wales, Australia Shand, F., Torok, M.,Cockayne, N., Batterham, P.J., Calear, A.L. Mackinnon, A., Martin, D. Zbukvic, I.Mok, K., Chen, N., McGillivray, L., Phillips, M., Cutler, H., Draper, B., Christensen, H. - *BMC*	April 2020
Australian Suicide Prevention using Health-Linked Data (ASHLi): Protocol for a population-based case series study Chitty, K.M., Schumann, J.L., Schaffer, A.,Cairns, R., Gonzage, N. J., Raubenheimer, J.E., Carter, G., Page, A,. Pearson, SA., Buckley, N. A. *BJM Open*	May 2020

Publication citation	Publication date
Acute alcohol use in Australian coronial suicide cases 2010-2015 Chitty, K.M., Schumann, J.L., Buckley, N.A., Chong, D.G. - *Science Direct*	May 2020
Economic and epidemiological impact of youth suicide in countries with the highest human development index Doran, C.M., Kinchin, I. *PLOS ONE*	May 2020

Trauma

Publication citation	Publication date
Epidemiology of burn-related fatalities in Australia and New Zealand 2009-2015 Minnes, J. A., Cleland, H. J., Cameron, P. A., Darton, A., Tracy, L. M., Wood, F. M., Singer, Y. & Gabbe, B. K. - *ScienceDirect*	July 2019
Preventable residential fire fatalities: July 2003 - June 2017 Coates, L., Kaandorp, G., Harris, J., van Leeuwen, J., Avci, A., Evans, J., George, S., Gissing, A., van den Honert, R. & Haynes, K. - *Bushfire and Natural Hazards CRC*	August 2019
Methods in population study of orofacial injuries in Victorian family violence homicides Sarkar, R., Bassed, R., Ozanne-Smith, J. *SpringerLink*	October 2019
Homicide in Australia 2014–15 Bricknell, S. *Australian Institute of Criminology*	November 2019
Homicide in Australia 2015–16 Bricknell, S. *Australian Institute of Criminology*	November 2019
Injury Detection in Traumatic Death: Postmortem Computed Tomography vs. Open Autopsy Wijetunga, C., O'Donnell, C., So, T. Y., Varma, D., Cameron, P., Burke, M., Bassed, R., Smith, K., & Beck, B. *Forensic Imaging*	May 2020
Homicide in Australia 2016-17 Bricknell, S. *Australian Institute of Criminology*	May 2020
Homicide in Australia 2017-18 Bricknell, S. *Australian Institute of Criminology*	May 2020