Form 1

QUEENSLAND
Coroners Act 2003
Section 7(4)

SPI #

Ver 16 – 31/01/2024
Δ1
Ω2020-A-086

POLICE REPORT OF DEATH TO A CORONER

OCCURRENCE #:

SUDDEN DEATH SUMMARY

DEATH REPORTED TO: **Please select**

DECEASED NAME: _____, **DECEASED DOB:**

TYPE OF DEATH:
(Click Type of Death button to update)

DATE OF DEATH:

LOCATION OF DEATH:

MORGUE DECEASED LODGED AT:

INVESTIGATING OFFICER: Name Rank Reg. No.

IDENTIFICATION DETAILS

Has the deceased been positively identified Yes ☐ No ☐
If No, what action is being taken to identify?

Method of identification
Date identified Time identified (hh:mm)
Place identification completed

Name of person performing the identification
Street address
Suburb/Town State Postcode
Country
Phone: Home Work Mobile
Relationship to deceased (if any) How long known deceased for
Name of police officer performing identification

DETAILS OF ANY KNOWN OR SUSPECTED INFECTIOUS OR CHEMICAL HAZARDS

Has the deceased person had a fever in the past week? Yes ☐ No ☐ (if Yes, specify)

Has the deceased had a known or suspected infectious disease recentlye.g.TB, HIV, Hepatitis, Covid-19? Yes ☐ No ☐ (if Yes, specify)

Was the deceased overseas in the last month? Yes ☐ No ☐

If Yes, please give the date of entry into Australia and list the countries visited:

Has the deceased had recent contact with a case of known or suspected infectious diseasee.g. Ebola, TB, Covid-19? Yes ☐ No ☐ (if Yes, specify)

Could the deceased's body be contaminated with toxic chemicals e.g. cyanide, hydrogen sulphide, agricultural chemicals? Yes ☐ No ☐ (if Yes, specify)

FAMILY MEMBER

Has a family member been advised by police? Yes ☐ No ☐

If No, what action is being taken?

Family name

Given name(s) (Please ensure address and contact numbers imported from Qprime are correct)

Street address

Suburb/Town State Postcode

Country

Phone: Home Work Mobile

Email:

Relationship to deceased: (Please select 1st available from below. Coroners Act provides for a heiarchy of next of kin)

Executor under Will OR ☐

Person nominated by deceased before death

Spouse (including de facto spouse) ☐

Adult child (spouse not available) ☐

Parent (spouse or adult child not available) ☐

Adult Sibling (spouse, child, parent not available) ☐

First Nations person ☐

Adult with sufficient relationship to deceased ☐

Specify relationship

(spouse, adult child, parent, adult sibling not available)

Is the family member from a non English speaking background? Yes ☐ No ☐

If Yes, specify

Is the family member a member of a faith? Yes ☐ No ☐ Unknown ☐

If yes, specify

Is the family member of First Nations origin? Yes ☐ No ☐ Unknown ☐

If Yes, ☐ Aboriginal origin

☐ Torres Strait Islander origin (If both, tick both)

If Yes, Do they have a Spirit / Skin name Yes ☐ specify No ☐ Unknown ☐

What is your Community of Origin

Is English your first language? Yes ☐ No ☐ specify Unknown ☐

Is the family member Male ☐ Female ☐

AUTOPSY – ADVICE TO FAMILY

(The coroner will consider this information when deciding what form of autopsy is to be conducted.)

Have police discussed the possibility of an internal autopsy with the nominated family / senior family member spokesperson?

Yes ☐, Who No ☐ Unable to contact family ☐ (to be advised by Supplementary Form 1)

Has the family member raised any concerns about an autopsy involving an internal examination?

Yes ☐ No ☐ Unable to contact family ☐ (to be advised by Supplementary Form 1)

If Yes, specify:

Religious/Cultural reasons ☐

An invasive and unnecessary procedure ☐

Unnecessary due to pre-existing illnesses ☐

Concerned over appearance of deceased after autopsy ☐

Unnecessary as cause of death believed to be known ☐

Other- ☐

If Other, specify

Are there any cultural or religious beliefs or practices specific to the deceased you would like to make the Coroner aware of? Yes ☐ If Yes No ☐

REPORTING OFFICER'S ASSESSMENT (Choose applicable option(s))

The death appears to be-

Death of an unknown person ☐

Death in suspicious circumstances ☐

Death in care ☐

Violent or otherwise unnatural death ☐

Death in custody ☐

Death as a result of Police operations ☐

If death in care, give details

(Give details of issues been raised about the care of the deceased person including name and contact details of the person raising the concerns)

Health care related death ☐

Death where cause of death certificate not issued and unlikely to be issued ☐

HAS ANY CRIMINAL PROCEEDING BEEN COMMENCED AGAINST ANY PERSON IN RELATION TO THIS DEATH: Yes ☐ No ☐ Unknown ☐

I, the reporting officer, declare this information is true and correct to the best of my knowledge and belief.

Reporting officer

(Name)	(Rank)	(Reg. no.)

(Police Station)	(Phone)

Dated this _____ (Day) day of _____ (Month), _____ (Year)

DECEASED PERSON'S DETAILS

Family name _____

Given name(s)

Aliases (if known) _____

Gender

Date of birth Age ( ) (Note – if under 18 to be treated as a child death)

Residential Address

Common Name (e.g., hostel name, hospital)

Street address

Suburb/Town State Postcode

Country

Name of care facility / boarding house / hostel / nursing home (if relevant)

Person Information

Place of birth , , (Town, state, country)

Marital status Never married ☐ Married/De facto ☐ Single ☐ Unknown ☐
Divorced ☐ Separated ☐ Widowed ☐

Citizenship

Residency Permanent ☐ Interstate visitor ☐ Homeless ☐
Itinerant ☐ Overseas visitor ☐ Unknown ☐

Occupation

Was the deceased an ADF member? Yes ☐ If Yes, PM Keys Number No ☐
Unknown ☐

Employment status: Full Time ☐ Part Time ☐ Casual ☐ Retired ☐ Unemployed ☐
Disability pension ☐ Unknown ☐ Time in current job:

Highest level of education: Primary / Secondary ☐ TAFE ☐ University ☐ Unknown ☐

Was the deceased from a non–English speaking background? Yes ☐ No ☐ Unknown ☐

If yes, specify

Did the deceased practice any religion? Yes ☐ No ☐ Unknown ☐

If yes, specify

What was the deceased's ethnic origin?

Aboriginal origin ☐ Torres Strait Islander origin ☐ (If both, tick both)
Caucasian ☐ Asian ☐ Māori ☐ (tick all relevant boxes)
Other ☐ (specify)

If of First Nations origin please specify,

Spirt / Skin name Yes ☐ specify No ☐ Unknown ☐

Community of Origin

Was English first language? Yes ☐ No ☐ specify Unknown ☐

History

Did the deceased have a criminal history?

Yes ☐ No ☐ Unknown ☐ (only ticked if unknown deceased or nil QPRIME access)

(Should the Coroner require further information, contact should be made with the investigating officer.)

Was the deceased the subject of an involuntary treatment order at time of death?

Yes ☐ No ☐ Unknown ☐

Was there an emergency examination authority or authority to return in place at the time of death?

Yes ☐ No ☐

If the deceased was a child, was the child:

- ☐ under guardianship or custody of Chief Executive? (Department of Communities – Child Safety)
- ☐ under licensed care service or in foster care?
- ☐ in a placement with the consent of a parent or guardian?

MEDICAL INFORMATION

Was the deceased recently hospitalised/treated by a doctor? Yes ☐ No ☐ Unknown ☐

If Yes, were hospital records/charts obtained? Yes ☐ No ☐

If Yes, where are they being held?

Doctor

Name

Street address

Suburb/Town State Postcode

Phone: Home Work Mobile

Date last visited doctor

Dentist

Name

Street address

Suburb/Town State Postcode

Phone: Home Work Mobile

Date last visited dentist

Known medical history? Yes ☐ No ☐

If Yes, specify

Known mental health history? Yes ☐ No ☐

If Yes, specify

Was the deceased known to be on medication? Yes ☐ No ☐

If Yes, specify

Was the deceased suspected of having an infectious disease at time of death? Yes ☐ No ☐

If Yes, specify including details of source

UR (hospital registration) number

Location (e.g. hospital)

MENTAL HEALTH INFORMATION

Has the deceased been diagnosed with a mental illness? Yes ☐ No ☐ Unknown ☐

If Yes: Depression ☐ Bipolar ☐ Schizophrenia ☐ Substance use disorder ☐ Anxiety ☐

Personality disorder ☐ Other (Specify)

Was the deceased recently hospitalised for a psychiatric condition? Yes ☐ No ☐ Unknown ☐

Was the deceased recently treated/seen by any of the following professionals for a mental illness? (Tick all relevant boxes)

	Name	Contact number
☐ Doctor		
☐ Psychiatrist		
☐ Psychologist		
☐ Case manager		

Has the deceased recently attended a mental health unit either voluntarily or due to police or QAS action under the Mental Health Act or Public Health Act 2005? Yes ☐ No ☐

If Yes, specify

Was the deceased a Forensic or Classified person under the Mental Health Act? Yes ☐ No ☐

Was the deceased known to be on medication for a psychiatric illness? Yes ☐ No ☐

If Yes, specify

Did the deceased show any behaviour that suggested they had an undiagnosed mental illness?

Yes ☐ No ☐

If Yes, specify

INVOLVED PERSONS

Last seen alive by (prior to the incident)

Family name _____ Given names

Relationship to deceased

Street address

Suburb/Town State Postcode

Country

Phone: Home Work Mobile

Person finding deceased (found by)

Family name _____ Given names

Relationship to deceased

Street address

Suburb/Town State Postcode

Country

Phone: Home Work Mobile

Death reported to police by (date and person who reported the death to the police)

Date Approximate time (hh:mm)

Family name _____ Given name(s)

Street address

Suburb/Town State Postcode

Country

Phone: Home Work Mobile

INCIDENT DETAILS

Last seen alive (Prior to the incident)

Date Approximate time (hh:mm)

Street address

Suburb/Town State Postcode

Country

Incident details (If different from above eg Traffic Accident Scene)

Incident date Approximate time (hh:mm)

Incident address

Suburb/Town State Postcode

Country

Name of care facility / boarding house
hostel / nursing home (if relevant)

Place of death (If not place of incident e.g hospital. If same as incident type "as above")

Date Approximate time (hh:mm)

Street address

Suburb/Town State Postcode

Country

REPORTING INFORMATION

Reporting officer

Family name & initials

Rank Reg. no.

Police station District

Phone: Work Mobile

Investigating officer

Family name & initials

Rank Reg. no.

Police station District

Phone: Work Mobile

Police responses

CAD/IMS job number

Other units involved FCU ☐ CIB ☐ Scientific ☐

SOC ☐ CPIU ☐ Ballistics ☐

Other ☐ (specify)

Ambulance responses

Did an ambulance attend the scene? Yes ☐ No ☐

Was the deceased treated by ambulance officers? Yes ☐ No ☐

Were drugs administered by medic/paramedic prior to death? Yes ☐ No ☐ Unknown ☐

If Yes, specify

Other agencies response

Agency WPHS ☐ QFRS ☐ ATSB ☐ QAS ☐ Comcare ☐

Other ☐ (specify)

Name

Phone: Work Mobile

To add or delete agencies, select from dropdown list and click in checkbox ☐

SUMMARY OF INCIDENT

When completing this summary please provide the information in a chronological order and provide the source of the information and what you believe to be the validity and reliability of the information. Should this information be a speculation or a suspicion, please indicate.

(Provide sufficient details so that the Coroner/Pathologist are able to fully appreciate the circumstances leading up to and surounding the death)

(Do not use terms “Informant”, “Partner”, or “NOK” unless previously named in full)

The sub-headings below are the minimal information required at each sudden death. The Sudden Death Aide Memoir, located on the Coronial Support Unit website, provides further guidance for specific types of sudden deaths.

Summary of circumstances

[Triple click here to add text]

Description of Scene:

[Triple click here to add text]

Description of Body at Scene:

[Triple click here to add text]

Medications/Compliance:

[Triple click here to add text]

Usual State of Health:

[Triple click here to add text]

Recent State of Health:

[Triple click here to add text]

Attempts to obtain a cause of death certificate (if applicable)

[Triple click here to add text]

PRÉCIS OF STATEMENTS

Witness details

Family name
Given names
Street address
Suburb/Town State Postcode
Country
Occupation
Relationship to deceased
Date of birth
Phone: Home Work Mobile
Email address
Notebook issued to
Notebook no.
Notebook pages to

Provide a brief statement of witness

(If not a resident of Queensland, include the temporary address in Queensland and date intending to leave Queensland.)

INFANT/CHILD DEATH (Suspected SUDI)

Age of child 0–12 months ☐ >12–24 months ☐

Was the child in out-of-home care? Yes ☐ No ☐

If Yes, was the child reported missing? Yes ☐ No ☐

If this infant/child death is a 'death in care' then the Death in Care section must also be completed.

Has any sibling predeceased this deceased child? Yes ☐ No ☐ Unknown ☐

If Yes, provide details

Mother

Family name

Given name(s)

Aliases (if known)

Parental status Biological ☐ Adoptive ☐ Step ☐ Foster ☐

Date of birth Age ( )

Place of birth **Town/state/country**

Marital status Never married ☐ Divorced ☐ Single ☐
Married/De facto ☐ Separated ☐ Unknown ☐

Street Address

Suburb/Town State Postcode

Country

Ethnicity **Australian** If other, specify

Phone: Home Work Mobile

Occupation Employment status

Living with child at time of death? Yes ☐ No ☐ Unknown ☐

Father

Family name

Given name(s)

Aliases (if known)

Parental status Biological ☐ Adoptive ☐ Step ☐ Foster ☐

Date of birth Age ( )

Place of birth **Town/state/country**

Marital status Never married ☐ Divorced ☐ Single ☐
Married/De facto ☐ Separated ☐ Unknown ☐

Address

Suburb/Town State Postcode

Country

Ethnicity **Australian** If other, specify

Phone: Home Work Mobile

Occupation Employment status

Living with child at time of death? Yes ☐ No ☐ Unknown ☐

Emergency contact (different from above)

Name _____ Phone

Sibling(s) of deceased

Name _____

Date of birth

Gender Male ☐ Female ☐

Relationship Biological ☐ Adoptive ☐ Step ☐ Foster ☐

Living with child at time of death? Yes ☐ No ☐ Unknown ☐

To add or delete siblings, select from dropdown box and click in checkbox ☐

RESULTS OF AGENCY CHECKS REGARDING DECEASED AND DECEASED'S FAMILY

(Investigator to provide Child Safety Services response to the Pathologist and Coroner prior to autopsy.)

First response officer is to contact Child Safety After Hours Service Centre (phone 1800 177 135) and complete 'QPS Child Death Information Request' Form (Forms Select has a link to form on CSU webpage), email form to **CSAH_PIC.checks@communities.qld.gov.au**

What were the results of the inquiries with these departments?

Queensland Police Service

No history ☐ History ☐ (specify)

Child Safety Services

No history ☐ History ☐ (specify)

To be advised by Supplementary Form 1 ☐

Identification of person(s) in residence 24 hours preceding death?

Family name _____ Given names

Date of birth

Address

Phone

To add or delete persons in residence, select from dropdown box and click in checkbox ☐

Identification of usual/frequent residents in premises?

Family name _____ Given names

Date of birth

Address

Phone

To add or delete usual/frequent residents, select from dropdown box and click in checkbox ☐

Event information

Time found unresponsive (hh:mm)

Date found unresponsive

Ambulance called Yes ☐ No ☐

Field below filled in on print out or saving

Caregiver/person who found child unresponsive

Mother ☐ Father ☐ Other **state name/relationship to child**

Last seen alive: Time Date By whom?

Medical information

Did the child have any of the following during the past two weeks prior to the event?

Cold ☐ Wheezing ☐ Recent injury or other illness ☐

Sniffles ☐ Vomiting ☐ Recent inoculation ☐

Cough ☐ Diarrhoea ☐ Fever ☐

Other ☐ (specify)

Was the child known to have

Medical equipment in use ☐ Recent hospital visits ☐

Abnormal development ☐ Known allergies ☐

Any known medical problems ☐ Exposure to contagious disease ☐

Explain

Did the child have any changes in behaviour over the last 48–72 hours prior to the event?

No ☐ Yes ☐

If Yes, explain

Did the child receive, in the past 24 hours any prescription or over the counter medications?

No ☐ Yes ☐

If Yes, describe

Child's paediatrician/maternal child health nurse/health care provider

Name Phone

Name Phone

Name Phone

Child's health book present Yes ☐ No ☐ (Child's health book should be seized.)

History of family illness

Has there been any history of a family illness affecting the mother, father or siblings of deceased child?

Yes ☐ No ☐

If Yes, provide details (e.g., mental/physical illness)

Have there been any other children die in the family? Yes ☐ No ☐

If Yes, provide details (e.g., mental/physical illness, unexplained infant death, suicide)

Birth information

Place of birth

Birth weight Gestational age weeks

Number of pregnancies Premature births

Birth abnormalities Yes ☐ No ☐ Unknown ☐

If Yes, explain

Multiple births Yes ☐ No ☐ Unknown ☐

If Yes, explain

When was child last fed? Not applicable ☐

Time (hh:mm)

Date

Last fed by whom?

Was the child breast fed? In the past ☐ Currently ☐ Unknown ☐

Was the child formula fed? In the past ☐ Currently ☐ Unknown ☐

Did the child eat solid food prior to death? Yes ☐ No ☐ Unknown ☐

If Yes, describe-

After eating did the child :

Vomit ☐ Gag ☐ Turn blue ☐ None ☐

Other (specify)

Location of event

Normal place of residence Yes ☐ No ☐ Unknown ☐

If No identify location and circumstances

Identify place

House ☐ Flat/Unit ☐ Hospital ☐ Caravan/Mobile home ☐

Other (specify)

Condition of residence (inside)

Clean ☐ Dirty ☐ Tidy ☐ Untidy ☐

Number of rooms

Estimated number of residents

Signs of habitual smoking at location of event

Yes ☐ No ☐ Unknown ☐

Any evidence of alcohol or drug use at location of event in proximity to the death

Yes ☐ No ☐ Unknown ☐

If Yes please indicate substance/s

If Yes please explain who was using the substance/s, including amount used/taken including time of last use

Any history of family violence

Yes ☐ No ☐ Unknown ☐

If Yes please explain

Did event occur during childbirth? No ☐ **Yes** ☐ (if Yes, this section is now complete)

Room where infant was found

Type of weather

Hot ☐ Cold ☐ Rainy ☐

Other (specify)

Daily temperature (from newspaper) Min. Max.

Room where deceased child located

Deceased's bedroom ☐ Parents' bedroom ☐

Other (specify)

Temperature in room where deceased was found

Cold ☐ Cool ☐ Warm ☐ Hot ☐

Other (specify)

Humidity in room where deceased was found

Low ☐ Medium ☐ High ☐

Other (specify)

Bedside humidifier/vaporiser Yes ☐ No ☐ Unknown ☐

Room ventilation

Window open ☐ Fan on ☐ Door ajar ☐ Unknown ☐

Air conditioning ☐ On ☐ Off ☐

Other (specify)

Heating (on in room where deceased was found)

Electric ☐ Fireplace ☐ Natural gas ☐ None ☐

Central heating/Air conditioning ☐ On ☐ Off ☐

Other (specify)

Type of surface infant/child was found on

Bed ☐ Bassinet ☐ Couch ☐ Pram/Stroller ☐ Bean bag ☐

Cot ☐ Water bed ☐ Cradle ☐ Baby capsule ☐

Floor ☐ Mattress on floor ☐ Pillow on floor ☐

Other (specify)

If a cradle (a) identify the maximum angle of tilt

(b) the position of the security pin

If infant was in an infant product (e.g. pram, stroller, bassinet, car capsule): record brand, type and condition of product

If sofa/couch/chair describe size, type, condition and amount of cushions/padding

Describe the Sleeping surface including firmness and condition

Type of surface infant/child was found on

If sleeping surface was a mattress please describe type of mattress

Foam ☐ Fabric covered foam ☐ Water ☐ Innerspring ☐

Other (specify)

Brand/model Thickness cm

Hardness Hard ☐ Medium ☐ Soft ☐

Stains present Yes ☐ No ☐ Unknown ☐

If Yes, explain

Condition of mattress and bedding, including any sag (i.e. trough effect) present

Bedding

Describe the bedding over and under the child

Was the bedding tucked in? Yes ☐ No ☐ Unknown ☐

Were any of these items near/over the infant's face when the infant was found (Could the infant breathe easily)? Please describe

Were pillows used in the space where the infant was sleeping? Please describe (e.g. 4 adult pillows on the bed/mattress, infant's head was on a pillow, infant face down in pillow, infant propped/inclined on boomerang pillow, 2 pillows on the bed but not near where infant was found/sleeping)

Ensure entire sleep space is photographed as close as possible to how it was when the infant was found (before individual items are taken off to be photographed) and attached

Cot protector (e.g., side padding) present? Yes ☐ No ☐

Was bedding soiled? Yes ☐ No ☐

If Yes describe

Was infant swaddled (wrapped)? Yes ☐ No ☐

Was a commercial swaddle suit used? Yes ☐ No ☐

If Yes state brand and design (if known)

Were any items covering the head? Yes ☐ No ☐

If Yes list items

Was the bedding tucked in at the sides?Yes ☐ No ☐

Clothing on child

Singlet ☐ Pyjamas ☐ Jumper ☐ Jumpsuit ☐ Socks ☐

Tracksuit pants ☐ T-shirt ☐ Cardigan ☐ Beanie ☐ Hood ☐

Other (specify)

Nappy

Disposable ☐ Cloth ☐ Other ☐ (specify)

Was it soiled? Yes ☐ No ☐ Unknown ☐

If Yes describe

Circumstances of the event

Was the child moved from the time found to the time of the first responder's arrival? Yes ☐ No ☐

Was resuscitation attempted by first responder? Yes ☐ No ☐ Unknown ☐

Characteristics of the child when found (describe lividity and attach photographs)

Mottled ☐ Cold ☐ Sweaty ☐ Blue ☐

Other (specify)

When infant/child was found, was there any discharge around the mouth (blood/froth)?

Yes ☐ No ☐ Unknown ☐

Was there debris/object in the mouth? Yes ☐ No ☐ Unknown ☐

If Yes describe

Was the infant still awake or feeding when last seen alive?

Infant was asleep ☐ **Infant still feeding** ☐ **Infant awake** ☐ **Unsure** ☐

Position of child when placed to sleep/fell asleep

Supine/On back ☐ Prone/Stomach ☐ Head to right side ☐ Side ☐

Other (specify)

Position of child when found

Supine/On back ☐ Prone/Stomach ☐ Head to right side ☐ Side ☐

Other (specify)

Infant face nose and mouth when found:

☐ **Face, nose and mouth free (unobstructed)**

☐ Face, nose or mouth resting against/close to soft bedding/ object/person

☐ Face pressed into soft bedding/object/ person

Was child sleeping alone?

Yes ☐ No ☐

If No, with whom?

Position of child at commencement of shared sleeping

Lying back to adult ☐ Being held/On top of adult ☐ Lying facing adult ☐ Propped on adult (i.e. head on chest or in crook of arm) ☐ Being fed by adult ☐

Other (specify)

Position of child at time of discovery

Being held/On top of adult ☐ Lying facing adult ☐ Lying back to adult ☐ Propped on adult ☐ Underneath ☐

(including partially)

Other (specify)

Was child between adults at commencement? Yes ☐ No ☐

Was child between adults when discovered? Yes ☐ No ☐

Please provide a diagram of the shared sleeping arrangement at the start of sleep and when found.

Any drugs, medication or alcohol consumed by primary care givers or anyone sharing the sleep surface/room with the infant should be documented.

Were/are sleep surface sharers (this includes beds/couches bean bags etc) intoxicated by alcohol or illicit substances? Yes ☐ No ☐ Could they have driven legally? Yes ☐ No ☐

Did the sleep surface sharers take any prescribed/unprescribed medications prior to sleeping with the infant?

Yes ☐ No ☐ If Yes, please list

Has testing been conducted (on all adults who shared the bed, not just breast feeding mothers)? Yes ☐ No ☐

Duration of normal sleeping pattern (hours)

Normal sleeping arrangement

Recent changes in sleeping pattern

Frequency of co-sleeping (nights per week)

Normal duration of co-sleeping per night (hours)

Was the child found in an unusual position? Yes ☐ No ☐

If Yes, please explain

Any other comments

SUSPECTED DRUG/ALCOHOL/POISON RELATED DEATH

Was there evidence of drug/alcohol/substance use? Yes ☐ No ☐ (tick all relevant boxes)

☐ Alcohol or empty containers.

Describe

☐ Prescription or over-the-counter drugs.

Describe

☐ Unregulated drugs.

Describe

☐ Poisons or gases (including carbon monoxide).

Describe

☐ Injecting or other drug paraphernalia (equipment used to administer drugs).

Describe

☐ Statement by deceased prior to death or by witness.

Describe

☐ Items related to volatile substance use (e.g., petrol, paint, glue).

Describe

Other: (specify)

Suspected drug/substance **use (excluding alcohol)**

Apparent substance(s) used (if known)

Date of last use

Time of last use (hh:mm)

Location of last use

Administered by Self ☐ Other (specify)

Symptoms of drug use

When symptoms first appeared

Was there evidence of drug/substance administration on the deceased body? Yes ☐ No ☐

If Yes, specify (e.g., injection marks, powder on nose)

Route of administration (tick all relevant boxes)

Oral ☐ Injection ☐ Inhalation ☐ Unknown ☐

Other (specify)

History

Did the deceased have a history of any of the following?

Tick all relevant boxes. Sources of information may include medical records, police records, other official records, or family/friends.

Item	Source(s) of information
☐ Problematic use of alcohol	
☐ Problematic use of prescription or over-the-counter drugs	

Item	Source(s) of information
☐ Problematic use of volatile substances	(e.g., petrol, glue, paint)
☐ Exposure to poisons or gases	
☐ Drug treatment program(s)	
Problematic use of other drugs ☐ Heroin ☐ Methamphetamine ☐ Cocaine ☐ Cannabis ☐ MDMA ☐ Other opioids (describe): ☐ Type unknown ☐ Other (specify)	

Prescription medication

Was there evidence or advice the deceased was recently prescribed any medication? Yes ☐ No ☐

If Yes, date obtained from chemist

Prescribing doctor

Address

Phone Facsimile

Date last visited doctor

Particulars of prescribed drugs

Name of drug

Quantity prescribed

Amount located

To add or delete drugs, select from dropdown box and click in checkbox ☐

HOSPITAL/HEALTH CARE RELATED DEATH

For deaths connected with any health procedure or any care, treatment, advice, service or goods provided for the benefit of human health. A health procedure includes any dental, medical, surgical or other health related procedure including giving an anaesthetic, analgesic, sedative or other drug. It includes deaths resulting from a failure to provide health care. (Refer to Medical Information in Part One of this Form).

Patient

UR (hospital registration) number

Location (e.g., hospital)

The reason for the health procedure

Specify health procedure involved

Person providing information to police

Name Position held

Phone: Home Work Mobile

What practitioner(s) was/were involved?

Name

Profession/Position

Phone

To add or delete practitioners, select from dropdown box and click in checkbox ☐

DROWNING/WATER–RELATED DEATH

Type of aquatic environment

Place

Private ☐ Public ☐ (NB if Public please ensure workplace questions are completed)

Location

Beach (non-surf) ☐	Bathtub ☐	Spa (external) ☐
Beach (surf) ☐	Canal ☐	Spa (internal) ☐
Bucket/Container ☐	Dam ☐	Irrigation channel ☐
Cattle/Sheep dip ☐	Lake ☐	Pond/Ornamental feature ☐
Harbour/Bay ☐	Ocean ☐	Swimming pool (in ground) ☐
Wading pool ☐	River/Creek ☐	Swimming pool (above ground) ☐

Other (specify)

Activity at time of incident (tick all relevant boxes)

Board riding (e.g., surfing, body boarding) ☐	Diving (e.g., scuba/SSBA/platform) ☐	Skin diving/snorkelling ☐
Swimming, paddling or wading ☐	Fishing ☐	Unknown, no witness ☐
Walking/Playing near water ☐	Bathing ☐	Attempting a rescue ☐
Incident involving a water vessel ☐	Water-skiing ☐	

Other ☐ (specify)

Did the activity involve any of the following? (tick all relevant boxes)

Fell/Wandered/Jumped into water ☐ Injury/Accident ☐

Hypothermia ☐ Swept away by water ☐ (e.g., off rocks, by rip or flood)

Deceased's swimming ability

Strong ☐ Competent ☐ Unknown ☐ Weak ☐ Non-swimmer ☐

Death involving a water vessel

Did the death involve a water vessel Yes ☐ No ☐

If Yes, how many vessels

If Yes, was the vessel

A motorised personal water vessel ☐ (PWV) (e.g. jet ski)

A motorised water vessel ☐

A non-motorised water vessel ☐

Type of vessel: Commercial ☐ Recreational ☐ Unknown ☐

Number of people on board the vessel

Number of people vessel registered to carry

Were life jackets/personal flotation devices available on the vessel? Yes ☐ No ☐

If Yes, was a life jacket/personal flotation device worn by the deceased? Yes ☐ No ☐

Did the driver/rider have a current licence authorising operation of that vessel? Yes ☐ No ☐

Supervision

Was the deceased under supervision? Yes ☐ No ☐

If Yes, by whom?

How many persons were in the pool?

What was the ratio of supervisors to swimmers (approximately)?

Level of the supervision

Was the deceased in direct line of sight of supervisor? Yes ☐ No ☐

If No, explain extent of supervision

Was the area being patrolled by life guards at the time? Yes ☐ No ☐ N/A ☐

What qualifications did the life guards have?

Conditions at time of the incident

What were the prevailing environmental conditions where the death occurred?

Weather	Clear ☐	Rain ☐	Unknown ☐
	Hazy ☐	Flood ☐	
	Cloudy ☐	Fog ☐	
Wind	None ☐	Strong ☐	Gale ☐
	Light ☐	Moderate ☐	Unknown ☐
Tide	In ☐	Out ☐	Unknown ☐
Waves	<1 metre ☐	1–2 metres ☐	>2 metres ☐
Unknown ☐			

Rescue and resuscitation

Was any attempt made to rescue the deceased? Yes ☐ No ☐

If Yes, by whom?

What equipment was used to assist in this rescue?

Was any attempt made to resuscitate the deceased? Yes ☐ No ☐

If Yes, by whom?

Was the person trained in resuscitation (other than QAS)? Yes ☐ No ☐ Unknown ☐

Signage

Were there warning signs in the area where the death occurred? Yes ☐ No ☐ N/A ☐

If Yes, specify

Marine animals

Was the death caused by a water animal? (e.g., shark, croc., box jelly fish) Yes ☐ No ☐

If Yes, specify

Swimming pools/spas/dam/pond

Was the pool/spa/dam fenced? Yes ☐ No ☐

If No, were there any other barriers restricting access from the house to the pool/dam/spa (e.g., doors or windows with child-resistant locks, spa covers, or house yard fenced)?

Yes ☐ No ☐ Unknown ☐

If pool is situated at a private residence please answer the following:

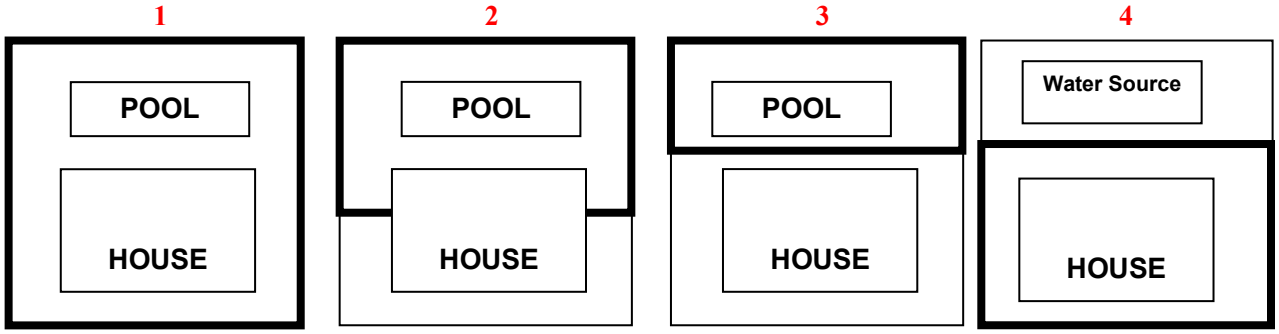
Premises – Owned/buying ☐ Renting ☐

How long has the occupant resided at the residence? < 3 months ☐ 6-12 months ☐ > 12 months ☐

Was the deceased an occupant of the residence? Yes ☐ No ☐

If No, specify circumstances of deceased being at location

If the pool/dam/spa was fenced, please complete these questions



Please indicate which diagram best fits the fence configuration 1 ☐ 2 ☐ 3 ☐ 4 ☐

Was there a door allowing direct access from the house to the pool? Yes ☐ No ☐

Was the fence defective? Yes ☐ No ☐ To be determined ☐

Were all the gates/doors allowing access to the pool/dam/spa self-closing and self-latching?
Yes ☐ No ☐

If No, please describe

Were all of the gates/doors allowing access to the pool/dam/spa in good working order?
Yes ☐ No ☐

If no, please describe

Was the gate or door open (e.g., propped or tied open) at the time of the incident?

Yes ☐ No ☐ Unknown ☐

If Yes, who opened gate/door?

Was there a final inspection of the pool barrier?

Yes ☐ No ☐ Unknown ☐

Is there a certificate of compliance in relation to the pool barrier?

Yes ☐ No ☐ Unknown ☐

How is the pool barrier best described?

Did the pool area have a visible resuscitation sign?

Yes ☐ No ☐ Yes, but not clearly visible ☐

How is visibility in the water source best described?

FIRE/BURN–RELATED DEATH

Setting of incident Private building ☐ Public building ☐ Outdoor area ☐

Other (specify)

If building

Extent of building damage?	Mild	☐	Severe ☐	Total	☐
Were smoke alarms present?	Yes	☐	No ☐	To be determined	☐
If Yes, were they activated?	Yes	☐	No ☐	To be determined	☐
How were alarms powered?	Battery operated	☐	Hardwired ☐		
Was a sprinkler system present?	Yes	☐	No ☐	To be determined	☐
If Yes, was it activated?	Yes	☐	No ☐	To be determined	☐
Were there barriers to escape?	Yes	☐	No ☐	To be determined	☐

If Yes, specify

Locked exits ☐ Barred windows ☐ Other ☐ (specify)

CHILD/INFANT DEATH (Other Than Suspected SUDI)

Age of child: (one option only) 0–2 years ☐ >2–4 years ☐ 5–14 years ☐ 15–17 years ☐

Was the child in out-of-home care? Yes ☐ No ☐

If Yes, was the child reported missing? Yes ☐ No ☐

If this child death is a 'death in care', 'transport related', 'drowning', etc., then those relevant sections must also be completed.

Has any sibling predeceased this deceased child? Yes ☐ No ☐ Unknown ☐

If Yes, provide details

Mother

Family name _____

Given name(s)

Aliases (if known)

Parental status Biological ☐ Adoptive ☐ Step ☐ Foster ☐

Date of birth Age ( )

Place of birth **Town/state/country**

Marital status Never married ☐ Divorced ☐ Single ☐
Married/De facto ☐ Separated ☐ Unknown ☐

Street Address

Suburb/Town State Postcode

Country

Ethnicity **Australian** Other (specify)

Phone: Home Work Mobile

Occupation Employment status

Living with child at time of death? Yes ☐ No ☐ Unknown ☐

Father

Family name _____

Given name(s)

Aliases (if known)

Parental status Biological ☐ Adoptive ☐ Step ☐ Foster ☐

Date of birth Age ( )

Place of birth **Town/state/country**

Marital status Never married ☐ Divorced ☐ Single ☐
Married/De facto ☐ Separated ☐ Unknown ☐

Street Address

Suburb/Town State Postcode

Country

Ethnicity **Australian** Other (specify)

Phone: Home Work Mobile

Occupation Employment status

Living with child at time of death ? Yes ☐ No ☐ Unknown ☐

Field below filled in on print out or saving

Emergency contact (different from above)

Name Phone

Siblings of deceased

Name

Date of birth

Gender Male ☐ Female ☐

Relationship Biological ☐ Adoptive ☐ Step ☐ Foster ☐

To add or delete siblings, select from dropdown box and click in checkbox ☐

RESULTS OF AGENCY CHECKS REGARDING DECEASED AND DECEASED'S FAMILY

(Investigator to provide Child Safety Services response to the Pathologist and Coroner prior to autopsy.)

First response officer is to contact Child Safety After Hours Service Centre (phone 1800 177 135) and complete 'QPS Child Death Information Request' Form (Forms Select has a link to form on CSU webpage), email form to **CSAH_PIC.checks@communities.qld.gov.au**

What were the results of the inquiries with these departments?

Queensland Police Service

No history ☐ History ☐ (specify)

Child Safety Services

No history ☐ History ☐ (specify)

To be advised by Supplementary Form 1 ☐

Identification of persons with or supervising the child/infant preceding death

Family name Given names

Date of Birth

Address

Phone

To add or delete persons, select from dropdown box and click in checkbox ☐

SUSPECTED SUICIDE

Does the family member authorise for their name and contact details to be provided to Lifeline Brisbane StandBy Response Service Support (for people bereaved by suicide) who, with my permission, will contact me? Yes ☐ No ☐

Method of suspected suicide?

Hanging ☐ Fall from height ☐ Carbon monoxide poisoning ☐

Weapon ☐ Motor vehicle ☐ Drugs/Alcohol/Poison overdose ☐

Train ☐ Incised wounds ☐ (stabbing/cutting) Fire ☐

Other (specify)

Did the deceased leave a suicide note / letter / recording?

Yes ☐ No ☐ Unknown ☐

Has the deceased been identified as the author of the note / letter / recording? Yes ☐ No ☐

If Yes, by whom

Relationship of identifier to deceased?

If No, what action is being undertaken to identify the author?

Copies of all suicide notes must be forwarded with the Form 1 to the Coroner.

Has the deceased previously communicated an intent to suicide? Yes ☐ No ☐ Unknown ☐

If Yes, who did they say this to?

Has the deceased previously attempted suicide? Yes ☐ No ☐ Unknown ☐

If Yes, approximate dates, number of times and method's used?

Has the deceased previously been hospitalised/treated for self harm? Yes ☐ No ☐ Unknown ☐

If Yes, approximate number of times

Is there any possible motive/trigger for the suicide? (tick all relevant boxes)

Physical illness	☐	Mental illness	☐
Domestic violence	☐	Recent unemployment	☐
Sexual abuse	☐	Prospect of criminal sanction	☐
Gambling	☐	Relationship breakdown	☐
Child custody issues	☐	Chronic or dependent alcohol or other drug use	☐
Financial problems	☐	Bereavement/Loss of a loved one	☐
Unknown	☐		

Other (specify)

Was deceased being treated/seen by any of the following professionals? (Tick all relevant boxes)

	Name	Contact Number
☐ Doctor		
☐ Psychiatrist		
☐ Psychologist		
☐ Case manager		

Was the death accompanied by the murder/suicide of other person(s)? Yes ☐ No ☐

If yes, what was the relationship between the deceased and the person(s)?

TRANSPORT–RELATED DEATH

Does not include water vessel. Describe road/rail and weather conditions in summary of incident section above.

Types of vehicles involved in incident (tick all relevant boxes)

Motor vehicle ☐ Motorbike ☐ Quad bike ☐ Aircraft ☐ Tram/light rail ☐ Train ☐ Bicycle ☐

Other (specify)

No. of vehicles involved

Description of where the accident occurred (tick all relevant boxes)

Residential street (up to 60km/h)	☐	Major street/road (60 to 90 km/h)	☐
Highway (100 km/h or above)	☐	Private property (no posted limits)	☐
Off-road (no posted limits)	☐		

Field below filled in on print out or saving

Other (specify)

Area speed limit

Role of the deceased at time of incident?

Driver/rider or pilot ☐ Passenger ☐ Where positioned in car?

Pedestrian ☐ Cyclist ☐

Other (specify)

Did the driver/rider have a current licence authorising operation of that vehicle? Yes ☐ No ☐

Does initial assessment indicate that any of these factors may have contributed to the incident?

Driver/Rider fatigue ☐ Drugs/Alcohol ☐ Excessive speed ☐

Driver/Rider lack of ability ☐ Environmental factors ☐ Physical factors ☐

Other (specify)(e.g., road works)

Vehicle/aircraft description(s)

Vehicle	**Type** (e.g., car, plane, motorbike)	**Make/Model/Description**	**Year**	**Speed category**
Deceased's				Within limit ☐ Possibly over ☐ Likely over ☐ Definitely over ☐ N/A ☐
Vehicle 2				Within limit ☐ Possibly over ☐ Likely over ☐ Definitely over ☐ N/A ☐
Vehicle 3				Within limit ☐ Possibly over ☐ Likely over ☐ Definitely over ☐ N/A ☐
Vehicle 4				Within limit ☐ Possibly over ☐ Likely over ☐ Definitely over ☐ N/A ☐

Was the deceased wearing a seat belt? Yes ☐ No ☐ Unknown ☐ N/A ☐

If a deceased child, was the child restrained in an age appropriate restraint? Yes ☐ No ☐

Were airbags installed/activated? Yes ☐ No ☐ N/A ☐

If Yes, specify	Driver	Front pass.	Right side	Left side	Other: (specify)
Installed	☐	☐	☐	☐	
Activated	☐	☐	☐	☐	

If cycle rider, was helmet being worn? Yes ☐ No ☐

DEATH INVOLVING A WEAPON/FIREARM

Type of weapon: Firearm ☐ Bladed ☐ Other ☐ (specify)

Who inflicted the fatal wound? Deceased ☐ Other person ☐ Unknown ☐

Firearm

Was the firearm recovered/known? Yes ☐ No ☐ (if yes, complete below)

Type of firearm (e.g., make, model, type, action, calibre, category)

Was the firearm registered in Queensland? Yes ☐ No ☐

If Yes, to whom? Deceased ☐ User (if not deceased) ☐ Other (specify)

If Yes, what was the weapon index number?

Was the user licensed to use that category of firearm? Yes ☐ No ☐ Unknown ☐

If Yes, what was the weapon index number?

Bladed

Type of blade (e.g., knife, box cutter, machete)

Was the bladed weapon recovered? Yes ☐ No ☐

If Yes where is the weapon?

If No provide a description of the weapon if known

WORK–RELATED DEATH

At work, travelling to/from work or travelling as part of work.

Type of work related death?

Electrocution ☐ Fall from height ☐ Machinery-related ☐ Vehicle-related ☐

Other (specify)

Did death occur while

- Working (including travelling for work) ☐
- Travelling to/from work (commuting) ☐
- Not known if working or commuting ☐

Activity at time of death

Industry involved in

Has Workplace Health and Safety or **Comcare** been advised Yes ☐ No ☐

Appointed WH&S **or Comcare** investigators details (if known)

DEATH IN CARE

For definition of 'death in care', see s. 9 of the *Coroners Act 2003*.

Note: A 'death in care' is determined by the legal status of the deceased not the location or circumstances of the death.

Name of person or agency with care of person

Relationship to person

Street Address

Suburb/Town State Postcode

Phone

Identify the government department that controls or funds the carers or agency that cares, treats and supervises the deceased

Was the deceased a NDIS participant who was not living in a private dwelling or an aged care facility?

Yes ☐ No ☐

Duration of care leading up to death

If No, please explain

Have any initial issues regarding the care, treatment and supervision been identified?

Yes ☐ No ☐ Unknown ☐

If Yes, please provide details (as provided to you)

Did a doctor complete a cause of death certificate (Form 9)? Yes ☐ No ☐

Doctor's name

Address

Suburb/Town State Postcode

Phone: Home Work Mobile

DOMESTIC AND FAMILY VIOLENCE RELATED

Was a domestic violence order (or application) registered involving the deceased or a parent/caregiver of the deceased in place at the time of death?

Yes ☐ No ☐ Unknown ☐ **(only ticked if unknown deceased or nil QPRIME access)**

If Yes, State / Territory:

QPRIME Occ #:

Has a suspect been identified: Yes ☐ No ☐ N/A (i.e. suicide) ☐

If Yes:

Family name DOB:

Given name(s)

Street Address

Suburb/Town State Postcode

Phone

If Yes, what is the relationship of the deceased to the suspect?

SPOUSAL RELATIONSHIP

Married ☐

Married & separated ☐

Divorced ☐

Reside together as a couple ☐

Have resided together as a couple ☐

Biological parents of a child ☐

INTIMATE PERSONAL RELATIONSHIP

Engaged or were engaged ☐

Betrothed or were betrothed under cultural or religious tradition ☐

Dated or have dated and lives are or were enmeshed ☐

FAMILY RELATIONSHIP

Relative of deceased by blood or marriage (eg. sibling, grandparent, aunt, nephew, child including an adult child over 18 years, stepchild, parent, cousin) or Suspect or victim regards or regarded themselves as a relative

INFORMAL CARE RELATIONSHIP

Was the deceased dependent on the suspect to help the person in an activity of daily living due to disability, illness or impairment with no fee being paid? Yes ☐ No ☐

Did the deceased have impaired capacity? Yes ☐ No ☐

If Yes, has the Adult Guardian been informed? Yes ☐ No ☐

Does the suspect have impaired capacity? Yes ☐ No ☐

If Yes, has the Adult Guardian been informed? Yes ☐ No ☐

DEATH IN CUSTODY OR AS A RESULT OF A POLICE OPERATION

Custodial Circumstances:

Legal status:

- ☐ Sentenced: no appeal current
- ☐ Sentenced: awaiting determination of any appeal (verdict or sentence)
- ☐ Detained as unfit to plead, not guilty on grounds of insanity
- ☐ Awaiting court hearing/trial extradition, purging of contempt, etc.
- ☐ Convicted but awaiting sentence
- ☐ Awaiting deportation
- ☐ Protective custody (i.e. for drunkenness where not an offence)
- ☐ Held for questioning/inquiries
- ☐ Unknown
- ☐ Other (please specify) e.g. escorting under mental health legislation, a siege or pursuit situation.

Has this person been granted bail? Yes ☐ No ☐

If not, why was this person not granted bail, e.g. too intoxicated; seriousness of offence; bail refused by court.

Full details of most serious offence relating to final period of custody or police operation, e.g. theft from dwelling, importing illegal drugs, assault with weapon. (Note: In some cases this would be the offence for which the person would most likely have been charged had he or she not died.)

Length of time in custody (where applicable)**:**

Time that the person was taken into custody (24hr clock)

Date that the person was taken into custody (24hr clock)

For sentenced prisoners only-
estimated earliest date of release

For sentenced prisoners only-
length of sentence bestowed by the court

Please indicate below the apparent general cause of death:

a. Suicide/self-inflicted ☐

b. Natural causes ☐

c. Accident ☐

d. Homicide ☐

e. Other (Please explain)