

Form 1A

Version 4

*Coroners Act 2003 (Section 12(2)(b))***Medical practitioner report of death to a coroner****Form 1A may be used where:**

- the medical practitioner seeks advice from the coroner about whether a death is/is not reportable (see Categories of reportable deaths below)
- the death is reportable and the medical practitioner seeks the coroner's authority to issue a death certificate because the cause of death is known and no autopsy or investigation appears necessary.

Please email (preferred method) or fax this completed form along with:

- discharge summary
- recent admission notes, and
- draft Cause of Death Certificate (Form 9) to coroner.

Categories of reportable deaths**1. Health care related death**

Health care related death is defined in section 10AA of the *Coroners Act 2003*.

Health care means a 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, diagnostic or other health related procedure, including a consultation or giving an anaesthetic or other drug.

A death is reportable under this category if:

A. the health care caused or contributed to the death**OR****a failure to provide health care caused or contributed to the death****AND****B. death was an unexpected outcome of the health care being provided.****A. Health care causes or contributes to a person's death**

if the person would not have died at that time if the health care had not been provided. The medical practitioner should ask the following questions to determine whether health care caused or contributed to the death:

- Would the person have died at about the same time without the health care? Yes/No

- Did the death result directly from the underlying disease or injury? Yes/No
- Was the health care carried out with all reasonable care and skill? Yes/No

If No to ANY, the death is reportable under this category.

If Yes to ALL, the death is not reportable under this category.

A failure to provide health care causes or contributes to a person's death if the person would not have died at that time had health care been provided.

B. Death is an unexpected outcome if, before the health care was provided, a **professional peer** of the treating medical practitioner **would not have expected the person to die**. The **professional peer** should be appropriately qualified in the relevant area of health care and have regard to all relevant matters including:

- the person's known state of health before the health care was provided, for example, whether they had any underlying disease, condition or injury
- the clinically accepted range of risk associated with the health care.

To determine whether the death was an unexpected outcome of the health care, the medical practitioner should adopt the perspective of a professional peer and ask the following questions:

- Before the health care was provided, was the person's condition such that death was foreseen as more likely than not to occur? Yes/No
- Was the person told that death was foreseen as more likely than not to occur? Yes/No
- Was the decision to provide the health care reasonable given the person's condition including their quality of life if the health care wasn't provided? Yes/No

If No to ANY, the death is reportable under this category.

If Yes to ALL, the death is not reportable under this category.

If appropriate, a Form 1A may be used to report a health care related death directly to the coroner.

2. Violent or unnatural death

A death is violent or unnatural if it is not the result of the natural progression of a disease but is caused by accident, suicide or homicide. Examples include drug/alcohol/poison related deaths, drowning or deaths caused by traumatic events such as a fall resulting in fractured neck of femur or subdural haemorrhage. Deaths are reportable under this category even if there is a prolonged interval between the incident and death. **Deaths caused by suicide or homicide, workplace accidents and motor vehicle accidents must always be reported to police.**

If appropriate, a Form 1A may be used to report a violent or unnatural death directly to the coroner.

3. Death in care

A death is a 'death in care' if the person who died:

- had a disability under the *Disability Services Act 2006* and lived in either a level 3 accredited residential service (hostel) or a government funded or provided residential service
- was subject to involuntary assessment or treatment under the *Mental Health Act 2000* and was either being taken to or detained in an authorised mental health service, detained because of a court order or undertaking limited community treatment
- was a child awaiting adoption under the *Adoption of Children Act 1964* or a child placed in "out of home" care under the *Child Protection Act 1999*.

If appropriate, a Form 1A may be used to report a death in care directly to the coroner.

4. Cause of death certificate not issued and not likely to be issued

The cause of death cannot be identified with sufficient certainty to allow the medical practitioner to complete a death certificate. Form 1A is NOT to be used – **death MUST be reported to police.**

5. Suspicious circumstances

Homicide is suspected or cannot be excluded. Form 1A is NOT to be used – **death MUST be reported to police.**

6. Death in custody or as a result of police operations

The person who died was either in custody, escaping from custody or trying to avoid being put into custody, or the person died during or because of a police operation. Form 1A is NOT to be used – **death MUST be reported to police.**

7. Unknown Person

The identity of the deceased is unknown. Form 1A is NOT to be used – **death MUST be reported to police.**

Section A - to be completed by a medical practitioner

1. Deceased's details

URN

Date of birth DD / MM / YYYY

Date of death DD / MM / YYYY

Gender: Male Female

Family name:

Given names:

Address:

Place of death:

Was the deceased Aboriginal or Torres Strait Islander (ATSI)?

- Yes, Aboriginal Yes, Torres Strait Islander
 No Unknown

2. Deceased's family member details

Family member means the first available person from the following list:

- person nominated by the deceased before death
 spouse (including de facto spouse)
 adult child
 parent
 adult sibling
 adult with sufficiently close relationship to deceased
 if the deceased was an ATSI person, an appropriate person according to ATSI tradition and custom.

Name:

Address:

Contact number:

Has the family member raised any concerns about the circumstances preceding hospitalisation or about the treatment received or end of life care provided?

Yes No

If yes, please give details of concerns

Has the family member been informed that the coroner may order an autopsy?

Yes No

If yes, have any concerns been raised by the family member about an autopsy involving internal examination?

Yes No

If yes, give details of concerns

3. Circumstances of death

Preferably a typed discharge summary should be provided. If this is not possible, provide a brief chronology of the circumstances of death and outline why the death is being reported to a coroner (or attach a typed statement dealing with these issues).

Is an autopsy necessary to explain the cause of death or circumstances of death?

Yes No

If yes, report the death to police. Form 1A is **NOT** to be used.

Are there any issues or concerns about treatment, pre-hospital care (including care at another hospital) or transportation / transfer / conveyance?

Yes No Don't know

If yes, please give details

4. Medical practitioner details

I am a medical practitioner registered in Queensland

Yes No

I was involved in this person's care

Yes No

I have knowledge of the cause of death/course of admission

Yes No

Name:

Position title:

Phone number:

Mobile / pager number:

Fax number:

Signature:

Date: ___ / ___ / ___

Section B - to be completed by the coroner

Coroner's actions

This death is not reportable under the *Coroners Act 2003* because:

OR

This death is reportable under the *Coroners Act 2003* because:

- the death may be violent or otherwise unnatural
- the death may be suspicious
- the death may be health care related
- a cause of death certificate has not been issued and is not likely to be issued
- the death is a death in care
- the death occurred as a result of police operations
- the death is a death in custody
- the identity of the deceased is unknown.

I further determine that:

- No further investigation is required. No autopsy is necessary and the medical practitioner identified above is authorised to issue a Cause of Death Certificate Form 9 (section 12(2) *Coroners Act 2003*).
- The death requires further investigation, including autopsy. Please contact police to arrange transport of body to a government mortuary.

Other instructions (including directions authorising removal of medical treatment items from deceased):

Instructions to police (coroners clerk to fax form to appropriate district office):

This death is a reportable death and I direct that:

- the body be transported to a government mortuary
- a supplementary Form 1 be completed

Name:

- State Coroner Deputy State Coroner Coroner

Signature:

Date: ___ / ___ / ___

Time:

Place: