

SPI #

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POLICE REPORT OF DEATH TO A CORONER

OCCURRENCE #:

SUDDEN DEATH SUMMARY

DEATH REPORTED TO: Brisbane Coroner

DECEASED NAME: _____,

DECEASED DOB:

TYPE OF DEATH: Death due to natural/non violent causes: [Natural causes – cause of death unknown; Unexpected Infant/child death (SUIDI)]
Violent/unnatural death: [Drug/alcohol/poison related death; Drowning/water-related death; Fire/burn-related death; Other (specify): OTHER; Child/ infant death (Non SUIDI); Suspected suicide; Transport-related death; Unknown; Weapon/firearm death; Work-related death]
Death resulting from health procedure
Death due to suspicious circumstances: [Known suspect investigation continuing; Unknown suspect investigation continuing; Suspect already in custody]
Death in care: [Disabled person cared for by a funded carer ; Person under Mental Health Act (Undertaking supervised community treatment) (Being detained by Court Order) (Being taken/detained to a Mental Health Service) (Being transported to a Mental Health Service); The person was a child in a placement with the consent of a parent or guardian; Child under licensed care service or in foster care; Child under guardianship or custody of Chief Executive; NDIS participant]
Death in custody/detention: [The deceased was in custody: (In a police watchhouse/station) (In a corrective services facility) (Under the escort of a corrective services officer) (Under ss. 41, 43, 120 or 121 of the Juvenile Justice Act 1992; or); The deceased was trying to avoid being put into custody; The deceased was escaping, or trying to escape, from custody (As a result of a Police operation)]
Death of unknown person]
Domestic and family violence related 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 recently e.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 disease e.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 the senior / nominated family member been advised by police? Yes No

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 hierarchy of next of kin)

- Person nominated by deceased before death
- Spouse Adult child
 (including de facto spouse) (spouse not available)
- Parent Adult Sibling
 (spouse or adult child not available) (spouse, child, parent not available)
- ATSI family member Adult with sufficient relationship to deceased
 (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 Aboriginal or Torres Strait Islander origin? Yes No Unknown

- If Yes, Aboriginal origin
 Torres Strait Islander origin (If both, tick both)

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

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

The death appears to be-

- Death of an unknown person Violent or otherwise unnatural death
- Death in suspicious circumstances Death in custody

Death in care

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 of _____, _____
(Day) (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

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 (tick all relevant boxes)

Other (specify)

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

Field below filled in on print out or saving

Was there an emergency examination order 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 abuse 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
<input type="checkbox"/>	Doctor	
<input type="checkbox"/>	Psychiatrist	
<input type="checkbox"/>	Psychologist	
<input type="checkbox"/>	Case manager	

Has the deceased recently attended a mental health unit either voluntarily or due to police action under the Mental Health Act? 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 surrounding the death)

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

Field below filled in on print out or saving

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

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 (07) 3235 9902) 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 **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

Method of delivery

Vaginal C-section Unknown

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

Type

Tin Concrete Brick Weatherboard Unknown

Other (specify)

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

Yes No Unknown

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

Type of mattressFoam Fabric covered foam Water Innerspring

Other (specify)

Brand/model Thickness cm

Hardness Hard Medium Soft Stains present Yes No Unknown

If Yes, explain

Bedding

Bedding over child	Bedding under child
Number of adult blankets	Number of adult blankets
Number of child blankets	Number of child blankets
Number of sheets	Number of sheets
Number of adult doonas	Mattress protector (describe)
Number of child doonas	Sheepskin
Other	Item directly under child (please identify)
	Other

Cot protector (e.g., side padding) present? Yes No Was bedding soiled? Yes No

If Yes describe

Was infant swaddled (wrapped)? Yes No 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

Other (specify)

NappyDisposable Cloth Other (specify)Was it soiled? Yes No Unknown

If Yes describe

Circumstances of the eventWas 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

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

Position of child when put down

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)

Was child sleeping alone?

Yes No

If No, with whom?

Position of child at commencement of co-sleeping

Lying back to adult On top of adult Lying facing adult

Other (specify)

Position of child at time of discovery

On top of adult Lying facing adult Lying back to adult Underneath
(including partially)

Other (specify)

Was child between adults at commencement? Yes No

Was child between adults when discovered? 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

Illicit/prohibited drugs.

Describe

Poisons or gases (including carbon monoxide).

Describe

Injecting or other drug paraphernalia (e.g., needle, syringe, tourniquet, bong, straw).

Describe

Statement by deceased prior to death or by witness.

Describe

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

Describe

Other: (specify)

Suspected drug/substance **abuse (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
<input type="checkbox"/> Abuse of alcohol	
<input type="checkbox"/> Abuse of prescription or over-the-counter drugs	

Item	Source(s) of information
<input type="checkbox"/> Abuse of volatile substances	(e.g., petrol, glue, paint)
<input type="checkbox"/> Exposure to poisons or gases	
<input type="checkbox"/> Drug treatment program(s)	
Abuse of other drugs <input type="checkbox"/> Heroin or other opiates <input type="checkbox"/> Amphetamines <input type="checkbox"/> Cocaine <input type="checkbox"/> Marijuana <input type="checkbox"/> Type unknown <input type="checkbox"/> 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)	<input type="checkbox"/>	Bathtub	<input type="checkbox"/>	Spa (external)	<input type="checkbox"/>
Beach (surf)	<input type="checkbox"/>	Canal	<input type="checkbox"/>	Spa (internal)	<input type="checkbox"/>
Bucket/Container	<input type="checkbox"/>	Dam	<input type="checkbox"/>	Irrigation channel	<input type="checkbox"/>
Cattle/Sheep dip	<input type="checkbox"/>	Lake	<input type="checkbox"/>	Pond/Ornamental feature	<input type="checkbox"/>
Harbour/Bay	<input type="checkbox"/>	Ocean	<input type="checkbox"/>	Swimming pool (in ground)	<input type="checkbox"/>
Wading pool	<input type="checkbox"/>	River/Creek	<input type="checkbox"/>	Swimming pool (above ground)	<input type="checkbox"/>
Other	(specify)				

Activity at time of incident (tick all relevant boxes)

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

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

Fell/Wandered/Jumped into water	<input type="checkbox"/>	Injury/Accident	<input type="checkbox"/>
Hypothermia	<input type="checkbox"/>	Swept away by water	<input type="checkbox"/> (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

Field below filled in on print out or saving

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:

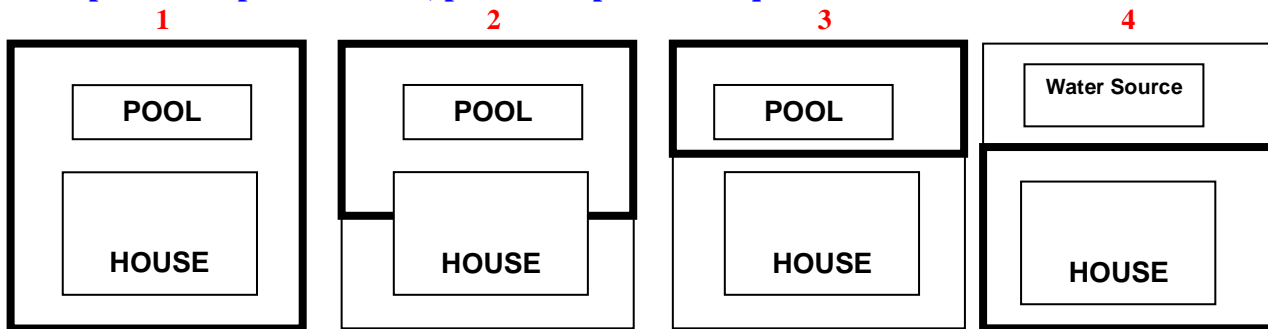
Premises – Owned/buying Renting

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

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 (07) 3235 9902) 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 | <input type="checkbox"/> | Mental illness | <input type="checkbox"/> |
| Domestic violence | <input type="checkbox"/> | Recent unemployment | <input type="checkbox"/> |
| Sexual abuse | <input type="checkbox"/> | Prospect of criminal sanction | <input type="checkbox"/> |
| Gambling | <input type="checkbox"/> | Relationship breakdown | <input type="checkbox"/> |
| Child custody issues | <input type="checkbox"/> | Alcohol/Drug dependency | <input type="checkbox"/> |
| Financial problems | <input type="checkbox"/> | Bereavement/Loss of a loved one | <input type="checkbox"/> |
| Unknown | <input type="checkbox"/> | | |

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)
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 <input type="checkbox"/> Possibly over <input type="checkbox"/> Likely over <input type="checkbox"/> Definitely over <input type="checkbox"/> N/A <input type="checkbox"/>
Vehicle 2				Within limit <input type="checkbox"/> Possibly over <input type="checkbox"/> Likely over <input type="checkbox"/> Definitely over <input type="checkbox"/> N/A <input type="checkbox"/>
Vehicle 3				Within limit <input type="checkbox"/> Possibly over <input type="checkbox"/> Likely over <input type="checkbox"/> Definitely over <input type="checkbox"/> N/A <input type="checkbox"/>
Vehicle 4				Within limit <input type="checkbox"/> Possibly over <input type="checkbox"/> Likely over <input type="checkbox"/> Definitely over <input type="checkbox"/> N/A <input type="checkbox"/>

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)