Form 1A

Version 6

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 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.

Deaths resulting from the provision of health care or the failure to provide health care are reportable under this category in the following circumstances:

A. Deaths following the provision of health care

A death will be reportable if the health care caused or contributed to the death AND, before the health care was provided, an independent person* would not have expected the person to die.

Health care causes or contributes to death if the person would not have died at that time without the health care. The medical practitioner should ask the following questions to determine if the health care caused or contributed to the death:

- Would the person have died at about the same time without the health care?
- Did the death result directly from an underlying disease or condition?
- Was the health care carried out with all reasonable care and skill?

If no to ANY of the above, the death is reportable. If yes to ALL the death is not reportable under this category of reportable death.

Office use only

To determine whether the death was unexpected the medical practitioner should adopt the perspective of (or consult with) an independent person* and ask the following questions:

- Before the health care was provided, was the person's condition such that death was more likely than not to occur?
- Was the person told that death was more likely than not to occur?
- Was the decision to provide the health care reasonable in all of the circumstances?

If no to ANY of the above, the death is reportable.

B. Deaths following a failure to provide health care

A death will be reportable if a failure to provide health care caused or contributed to the death AND, when health care was sought an independent person* would have expected that health care would be provided.

A failure to provide health care causes or contributes to death if the person would not have died at that time if health care had been provided. The medical practitioner should ask the following question to determine if a failure to provide health care caused or contributed to the death:

 Would the person have died at about the same time if health care had been provided?

If no, the death is reportable. If yes the death is not reportable under this category of reportable death.

To determine whether a failure to provide health care was unexpected the medical practitioner should adopt the perspective of (or consult with) an independent person* and ask the following questions:

- When the health care was sought and not provided, was the person's condition such that death was more likely than not to occur?
- Was the person told that death was more likely than not to occur?
- Was the decision not to provide the heath care reasonable in all of the circumstances?

If no to ANY of the above, the death is reportable.

*The independent person

The independent person/professional peer should be appropriately qualified in the relevant area of health care and have regard to all of the circumstances including the state of the person's known state of health as it was thought to be at the time health care was provided or sought; the clinically accepted range of risk associated with the health care; and the circumstance in which the health care was sought or provided.

In appropriate cases, a Form 1A may be used to report a health care related death directly to the coroner. Consideration should always be given to scene preservation. The coroner can advise whether a scene should be preserved for investigation.

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

A medical practitioner must issue a cause of death certificate where he/she can form an opinion as to the probable cause of death and the death is otherwise not reportable. If the practitioner is unsure whether there is sufficient evidence to form such an opinion, or to distinguish alternative causes of death, he/she should use a Form 1A. However, if after exercising clinical judgment the practitioner cannot form any opinion as to the cause of death the Form 1A is NOT to be used - the 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 /YYYYY_		
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	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
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	
	4. Medical practitioner details
If yes, give details of concerns	I am a medical practitioner registered in Queensland
	Yes No
	I was involved in this person's care
	└── Yes
	I have knowledge of the cause of death/course of admission
3. Circumstances of death	Yes No
Preferably a typed discharge summary should be provided.	Name:
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).	Position title:
with these issues).	
	Phone number:
	Mobile / pager number:
	Fax number:
	Signature:
	Signature.
	Date: //

Instructions to police (coroners clerk to fax form to **Section B - to be completed by the coroner** appropriate district office): Coroner's actions This death is a reportable death and I direct that: This death is not reportable under the Coroners Act 2003 because: the body be transported to a government mortuary a supplementary Form 1 be completed Name: OR Deputy State Coroner State Coroner This death is reportable under the Coroners Act 2003 because: the death may be violent or otherwise unnatural Signature: the death may be suspicious the death may be health care related Date: ____ /___ /__ a cause of death certificate has not been issued and is not likely to be issued Time: Place: 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):

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