The Hon Roger Cook MLA
Deputy Premier
Minister for Health; Mental Health

Our Ref: 60-17060

Ms Dawn Wright
Manager Listings
Office of the State Coroner
Level 10, Central Law Courts
501 Hay Street
PERTH WA 6000

Dear Ms Wright

Thank you for your letter of 10 May 2019 regarding the completion of the coronial inquest into the circumstances surrounding the death of Matthew Neil Hardy Tonkin. I note the recommendations made by Coroner, Barry Paul King.

The Department of Health's Coronial Review Committee is due to review the findings at the next meeting. The Committee will determine what actions should be taken at a system level to address the recommendations. Following this discussion, the appropriate services will be responsible for developing strategies that are necessary to implement recommendations; this may include consultation with other government agencies. Any actions taken by the Western Australian public health system in relation to the recommendations will be included in the Coronial Liaison Unit's routine six-monthly progress reports to the State Coroner.

I trust this information, and that provided in the ongoing six-monthly reports, will assist the State Coroner to fulfil the annual reporting requirements to the Attorney General.

Yours sincerely

HON ROGER COOK MLA
DEPUTY PREMIER
MINISTER FOR HEALTH; MENTAL HEALTH

10 JUN 2019

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