1. In March 2008, the State Coroner handed down his findings from the inquest into four police shooting deaths. The deceased all had a history of mental illness, the symptoms of which brought them into contact with police, and were shot and killed in separate incidents between 2003 and 2006.
2. The Coroner found that each of the four deaths was legally justifiable and the police acted in a reasonable manner. The Coroner made a total of 17 recommendations relating to mental health care and the interaction between police officers and those with mental illness.
3. The families of three of the deceased men subsequently prepared a supplementary report which made 23 recommendations. This report was provided by the families to the Premier and the then Minister for Police, Corrective Services and Sport in a meeting in April 2008. The former Attorney-General and the State Coroner also met with the families to discuss the coronial issues.
4. The draft *Final Response to the Coroner’s Recommendations* supports or supports in principle 15 of the 17 Coroner’s recommendations.
5. Cabinet endorsed the Government’s *Final Response to the Coroner’s Recommendations*.
6. Cabinet noted that the families of the deceased men would be consulted prior to the release of the response.
7. *Attachments*

* [*Final Response to the Coroner’s Recommendations*](Attachments/response.docx)