



The Principal

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18th July 2012

Coroner Audrey Jamieson
Coroners Court of Victoria
Level 11
222 Exhibition Street
Melbourne Vic 3000

Dear Coroner Jamieson,

Inquest into the death of Nathan Francis
Court ref: 1212/07

I refer to your findings and recommendations handed down on 1st June 2012, into the tragic death of Nathan Francis.

On behalf of Scotch College, I advise that prior to the findings and recommendations being handed down, the School had already revised its students' 'action management plans' to incorporate strategies to prevent exposure to allergens for the individual student in both in-school and out-of-school settings, as a required component for individual anaphylaxis management plans under Ministerial Order No. 90.

I further advise, that, in accordance with your recommendations, the plan will be reviewed annually by the School together with the parent/carer, as a requirement of Ministerial Order No. 90.

The School will continue to do all it can to learn from this tragedy.

Please feel free to contact me should you feel I can be of any further assistance.

Yours faithfully,



Tom Batty
Principal