EDITORS' INTRODUCTION

Welcome to the second AILR Special Edition for Volume 12, which takes as its theme 'Coronial Reform and Preventing Indigenous Death'. We are nearing two decades on after the conclusion of the Royal Commission into Aboriginal Death in Custody ('RCIADIC'), the inquiry established to investigate the high rates at which Aboriginal and Torres Strait Islander people were dying in prisons, police cells and juvenile detention centres around Australia. Among the many issues brought to light by the RCIADIC's extensive five-volume *National Report* were substantial deficiencies in the coronial systems in operation throughout Australia's States and Territories. Many of the RCIADIC recommendations for the improvement of coronial law remain unimplemented.

One of the key messages to emerge from the RCIADIC on the issue of coronial reform was the need to enhance the increasingly recognised preventive function coronial inquests can have – a function chiefly resident in the coronial recommendation-making power. Following the conduct of a thorough investigation into a death, a coroner, having ascertained the circumstances and causes of the death, has the power to make recommendations to government and other agencies in order to prevent the occurrence of further deaths in similar circumstances. Despite this recommendation-making capacity possessed by coroners, in most Australian jurisdictions there is no obligation on government and other agencies to respond to or even consider the potentially life-saving recommendations that come out of coronial inquests.

Making the need for a robust and effective coronial system all the more urgent are the tragically high rates of mortality and lower life expectancies that are a statistical reality for Aboriginal and Torres Strait Islander peoples. Clearly, it is crucial that the preventive potential of coronial inquests is fully realised so as to avert the occurrence of further Indigenous deaths and to, in whatever way possible, help reverse such alarming statistics. Yet it is also plain, as many pieces in this edition show, that effective and culturally sensitive coronial processes are required to show respect for the deceased and their families.

The original impetus for this Special Edition came from a study conducted by Professor Ray Watterson, Penny Brown and John McKenzie, which investigated the implementation of coronial recommendations throughout Australia. While this national study uncovered some successes in coronial process, the key findings of the study reveal the repeated neglect of coronial recommendations in the absence of a consistent legislative framework. The report of that study forms the centrepiece of this Special Edition.

The other pieces published in this edition were primarily sourced from people working in Aboriginal and Torres Strait Islander legal services across Australia. These pieces provide important insights into the different coronial systems operating throughout Australia, and voice the concerns of the Aboriginal and Torres Strait Islander families, and their representatives, who have involvement with the coroner. To preserve the essence of these pieces, they have not, unless otherwise indicated, been peer-reviewed.

Aboriginal and Torres Strait Islander people should be aware that some of the articles reproduced in this edition contain the names of deceased persons.

NB. As this edition was going to print, a number of amendments were made to the Victorian Coroners Bill 2008. The amended Bill was subsequently passed, and received Royal Assent on 11 December 2008. Of the greatest relevance to this Special Edition was the amendment requiring that public statutory authorities in receipt of coronial recommendations must respond to those recommendations within three months, advising of any action taken in relation to the recommendations.