Witness Name: André J A Rebello
Statement No.: WITN7210001
Exhibits: 0
Dated: 21.07.22

INFECTED BLOOD INQUIRY

WRITTEN STATEMENT OF ANDRÉ JOSEPH ANTHONY REBELLO

I provide this statement in response to a request under Rule 9 of the Inquiry Rules 2006 dated 20th July 2022.

I, André Joseph Anthony Rebello OBE, Honorary Secretary of the Coroners' Society of England and Wales will say as follows: -

1. I am the Senior Coroner for Liverpool & Wirral Coroner Area and was first appointed as HM Coroner for Blackburn Hyndburn and Ribble Valley districts of Lancashire starting my office in January 1984.

Section 1: Introduction

2. The Coroners' Society of England and Wales was founded in 1846. It is the oldest judicial association in England and Wales. I have been the Honorary Secretary and executive officer of the Society since September 2006. The Society is an unincorporated association and is not a statutory body.
3. The Objects of the Society have changed little since our foundation however the Chief Coroner was added to the objectives in 2013. The objects are currently:
    a. the promotion of the usefulness of the office of coroner to the public;
    b. the ascertainment in questions of difficulty of the duties which devolve on coroners;

c. the advancement of such amendments to the law as seem desirable;
d. the establishment and maintenance of contact with HM Government and the Chief Coroner; and
e. the protection of the rights and interest of coroners

4. The Society has no staff or premises and is run by working coroners.
5. Until July 2013 the Society was the principal link between Coroners and Executive Government and its arms-length bodies and agencies.
6. It must be appreciated that coroners are Judges however they are not given central government support in the same way that the Judicial Office and HM Courts and Tribunal Service support other judges. Coroners are appointed by relevant authorities (Sched 2 para 3 Coroner and Justice Act 2009) who appoint coroners to a coroner area on behalf of all local authorities geographically covered by the area. Coroner areas were previously know a jurisdictions under the Coroners Act 1988.
7. No disrespect is intended to the Inquiry, however the Society has been contacted at very short notice and my commitments are such that there is very little time to respond to the request without it adversely affecting my statutory duty. In the circumstance I would wish to draw the inquiries attention to the society's substantive submissions made to the Justice Committee of the House of Commons in 2020 when the committee was inquiring into the progress of the Coroner reform project of Government which had the Ministry of Justice as the responsible department - https://committees.parliament.uk/writtenevidence/10556/pdf/
8. I have contacted a retired Coroner Nicholas Rheinberg former coroner in East Somerset and Former Senior Coroner for Cheshire who still conducts inquests as a retired coroner under Schedule 10 CJA who holds the Society archives and have been advised, *"I have gone through the index of documents held within the archives and there is nothing of interest to the Inquiry. In particular as far as I am aware the Society never issued any advice to members."*
9. I have also contacted Michael J C Burgess, CVO, OBE, who was Hon Secretary of the Society 1st October 1991 to 31st August 2003 and is now retired. He advises me, "Without being specific, and although I held coronial office for 37 years I have no recollection of any death being referred which might possibly be within the scope of this inquiry and I do not recall it ever being raised by

members or at Council meetings!" He also says that he has no recollection of the Home Office Circular *(on HIV cases)* nor indeed of Dr John Burton raising it in meetings.

10. Dr John David Keith Burton *CBE, MVO was the Honorary Secretary of the Coroners' Society from 1971 to 1991. He died on the 8th December 2004*

11. I was appointed HM Coroner in 1994 and I knew Dr Burton well. In my early years as coroner he was the "go-to" source of advice for most coroners. Coroners are judges and each is personally responsible for judicial decision making arising out of the office held. Up until 2013 coroners worked in geographic jurisdictions the number of which has varied from year to year in1989 there were 155 such jurisdictions now with mergers there are just over 80 coroner areas. In each jurisdiction there was one HM Coroner, one deputy and one assistant coroner. The deputy and assistant usually only worked when HM Coroner was away. This meant that office holders were very isolated, unlike e.g. judges working out of a Crown Court Centre. This often meant coroners raised matters which they found troubling with the Secretary of the Coroners' Society, who always provided support. This was not advice as such as each coroner was and is responsible for carrying out his or her own judicial duties based upon the facts, the law and the presenting case specific evidence. Such communications in those days before email and messaging may have been by telephone call or letter but invariably this would lead to a telephone discussion. These would not be minuted, but even if they were they have not been preserved in the Society archives which are records of meetings.

12. It is important to touch upon the constitutional position of the separation of powers. The inquiry needs no introduction to this given the Chairs familiarity with the Constitutional Reform Act 2005. This separated the State's Executive duties from Judicial Function by making the Lord Chief Justice Head of the Judiciary, with the Lord Chancellor having a solely Executive/Political role. The Lord Chief Justice and to a lesser extent the Senior President of Tribunals are in a different position than other judges in that it is necessary for them to meet with the Lord Chancellor with regard to policy bearing upon judicial function and judges. The Constitutional Reform Act 2005 bypassed the Coronial Jurisdiction and it was only with the evolving coroner reform project culminating in the Coroner and Justice Act 2009, implemented in 2013 that the coroners service was formally embraced as part of the judicial family. However as a

result of the preserved resourcing and funding methodology, leaving this with local authorities, more akin to distant cousins rather than siblings.

13. Since 2013 there is a Chief Coroner who provided leadership and tone to the Coroner's service. However discipline remains with the Lord Chancellor.
14. Until the advent of the Chief Coroner the lacuna in linking Coroners with the Executive was bridged by the Coroner's Society. In my time as coroner this linked coroners with the Home Office, (when we were in the Animals. Byelaws and Coroners department), the Department for Constitutional Affairs and following the disbanding of the Lord Chancellors department after the Constitutional Reform Act, the Ministry of Justice, where we remain.
15. There was a Coroners Advisory Group and a Coroners Study Group (eventually supported by the Judicial Studies board and now the Judicial College). These were all committees of the Government department and meetings were minuted. The Coroner's Advisory Groups was a vehicle where the department consulted with senior coroners about possible changes to policy to better inform ministers for their decision making. The Coroners Study Group organised Coroner training. There was also latterly Coroner stakeholder meetings for the minister to consult through officials with coroners and public sector partners on policy. It was before my time but there may have been discussions about HIV infections and whether they were natural or unnatural at these meetings. I was not aware that there was a Ministerial Coroner's Working Party, but the existence of that does not surprise me as there have been various ad hoc groups consulted by the department on the coroner reform project over the past 25 years. The work of these groups was in confidence and for Government policy.

Section 2: General

16. I have been sent portable document format bundle of ad hoc scanned documents. I have not seen any of these documents previously, other than a copy of the Senior Coroner in Birmingham and Solihull recent communication with the inquiry to which I was copied in.
17. Anecdotally I recall the subject matter of the letter signed GRO-A on page 45. I can recall that there was concern amongst some coroners that a coroner was conflating morality with unnatural for the purposes of the duty to hold an

inquest under s8 Coroner's Act 1988. This was an atypical application of the duty. However this was before my time.

18. The times when John Burton was my predecessor were very different from today. Today I have the advantage of the Coroners' Society website to inform the public and others of the Coroners' Service. This was not available to Dr John Burton so he may have clarified the law and been quoted by journalists in relation to the health and safety consideration of post-mortem examination of those with blood borne viruses. As a judge I am not quoted in the media, as with all judges I do my talking in court hearings. However in the days of John Burton there was not a Chief Coroner and it was important to explain that with precautions the risk of infection could be managed in a post-mortem examination. The obvious parallel with today is Covid 19 SARS infection. There was initially much concern amongst pathologists about the safety of conducting post-mortem examination in these cases. Chief Coroner, Coroners and the Society have not needed to issue guidance as this has been managed by the Royal College of Pathologists. I am not aware that the Society has ever issued guidance on safely conducting post-mortem examination in the case of infection. This of course does not mean that Dr John Burton who was not only a coroner but also a doctor may not have given advice, which may well have been within his expertise.
19. The Society does not issue guidance but newsletters, law sheets, circulars and guidance have been issued from time to time by the government department with coroner policy and since 2013 by the Chief Coroner. The Chief Coroner's guidance for the time being is in the public domain.
20. The inquiry should understand that the Coroners' Society does not deal with death reports and case files from investigations. These matters are held within Coroner jurisdictions and the successor Coroner areas. Case files from inquest are held for a minimum of 15 years and any correspondence with the society would if it still exists be within the area archives. There would not necessarily be a corresponding copy with the society as we do not keep case related communications.
21. The Coroners' Society does not direct or guide coroners. We are a mere judicial association akin to the Circuits Judge and District Judge associations.

22. The law relating to file retention was in the Coroners Act 1988 under s56 Coroners Rules 1984 - Retention and delivery of documents

Any document (other than an exhibit at an inquest) in the possession of a coroner in connection with an inquest or post-mortem examination shall, unless a court otherwise directs, be retained by the coroner for at least ***fifteen years****: Provided that the coroner may deliver any such document to any person who in the opinion of the coroner is a proper person to have possession of it.*

23. Since July 2013 the law on retention is under the Coroner and Justice Act 2009 - regulation 27 The Coroners (Investigations) Regulations 2013 Retention and release of documents

(1) Any document in the possession of a coroner in connection with an investigation or post-mortem examination must, unless a court or the Chief Coroner otherwise directs, be retained by or on behalf of the coroner for at least ***15 years*** *from the date that the investigation is completed.*

(2) The coroner may provide any document or copy of any document to any person who in the opinion of the coroner is a proper person to have possession of it.

(3) A coroner may charge for the provision of any document or copy of any document in accordance with any regulations made under Schedule 7.

24. As secretary of the coroners' society I cannot give legal advice and I do not have access to death reports and retained files to which the Inquiry may need access. I am happy to help and to clarify anything – however I am a full time working coroner and I manage the Society's affairs in addition to my judicial duties.

Statement of Truth

I believe that the facts stated in this witness statement are true.

Signed GRO-C

Dated 21st July 2022