



POLICING TRANSMISSION

HIV CRIME SCENE

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A review of police handling of criminal investigations relating to transmission of HIV in England & Wales, 2005-2008.

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1. Executive summary and recommendations

- 1.1 The review of practice into the policing of HIV transmission allegations are based on disseminated findings from 'closed case' papers received from national forces across England. This first stage of work was undertaken by an ACPO (Association of Chief Police Officers) officer and administratively supported by police staff colleagues within the MPS (Metropolitan Police Service).
- 1.2 These case papers were analysed by the officer and the resulting reports informed a review by a Community Advisory Panel (CAP) of key stakeholders, who also drew on their experiences of investigations and of the affected communities. This panel produced the recommendations and oversaw the writing of the report in line with the findings. The resulting report includes a number of key recommendations for ACPO.
- 1.3 The review found that both HIV and the use of the criminal law in relation to its transmission were often, as a recently identified condition and an even more recent application of the law, poorly understood. This in turn led to disparities in the application of the law and a lack of common practice in the manner in which allegations were investigated.
- 1.4 However, the review also found a number of examples of good practice and ways in which this situation could be improved. These are contained in the recommendations below:

Training and support to officers

- A. Training should be provided for designated officers in each force who can provide support in management of these cases.
- B. Consideration should be given to all GBH allegations involving sexual transmission being handled, where possible, by SOIT-trained officers.
- C. ACPO should consider whether a national register should be drawn up of officers trained and experienced in managing such cases.
- D. "Critical Incident" status could help in accessing the resources to manage such cases and consideration should be given to using this designation.
- E. Investigating officers need access to easy-to-understand guides to the law in this area and related CPS guidance, which could be provided either on paper or via the Internet.
- F. Such guidance should also include accurate and up to date information on HIV and STIs including the actual risks of transmission in different acts and settings, and the implications of a positive diagnosis for someone's future health.
- G. It would also be helpful for such guidance to include a list of expert external agencies from which officers could seek guidance about specific circumstances.
- H. A checklist of consecutive actions should be constructed, helping officers to understand what needs to be proven or considered at each stage of the investigation in order to proceed appropriately. This should include Recommendations 9-15.
- I. A series of standard questions should be developed, possibly as part of the checklist, to establish at an early stage whether a viable case exists and to ensure appropriate actions are taken.
- J. Cases in which a complainant says that sexual activity has only taken place with the accused in the last few days would benefit from a timely HIV test for the accuser in order to establish whether they were already infected prior to the complaint.

- K. Evidence of both parties HIV status should be obtained before any charge relating to transmission is made.
- L. Where a complaint relates to sexual activity within the last 72 hours, post exposure prophylaxis should always be offered to the complainant.
- M. Officers should consider waiting for confirmation of transmission before going ahead with arrest and investigation.
- N. Wider investigation beyond the original complainant should only proceed once it is clear that they are infected and that a charge is possible.
- O. No plea should be accepted without virological checks and the taking of a full sexual history of both parties, as outlined in the Crown Prosecution Service Guidance.

Management of specific issues

- P. Care needs to be taken in cases where HIV transmission is a counter-allegation by someone accused of other crimes or misbehaviour.
- Q. Close attention should be given to any evidence of domestic violence or other forms of harassment within a case.
- R. Guidance is needed for officers on the passing of sensitive information such as HIV status to others.
- S. Officers should be supported to make decisions in advance of a CPS response on case closure where appropriate.

Response from the Association of Chief Police Officers (ACPO)

The Association of Chief Police Officers welcomes the Terrence Higgins Trust review of past police investigations into the transmission of HIV.

The review has highlighted a number of good practices from case studies provided by the Police Service, and makes a number of recommendations to help with future investigations. With the assistance of a Community Advisory Panel, the Terrence Higgins Trust review has developed a number of helpful themes ranging from general advice to police investigators through to medical disclosure and victim support, with the overall objective of improving community confidence by giving a better understanding of how allegations of HIV transmission should be investigated in the future.

In consultation with key community groups and Criminal Justice partners, such as the Crown Prosecution Service, ACPO will continue to work closely with both NAT (National Aids Trust) and the Terrence Higgins Trust to deliver the recommendations in order to give some clarity and consistency around this often complex and sensitive area of policing.

Deputy Chief Constable Mike Cunningham
ACPO LGB&T Lead

2. Introduction and acknowledgements

- 2.1 Policing any new offence is often fraught with difficulties and although the charge of Grievous Bodily Harm (GBH) is an old one, under the Offences Against The Person Act (1861), the use of it for transmission of a disease which is as loaded with misinformation and stigma as HIV is a relatively new departure. It is not surprising, therefore, that the cases investigated since 2003 in England and Wales have been complex and controversial.
- 2.2 A conviction for HIV transmission attracts a lengthy prison sentence; up to five years for reckless transmission and up to life for intentional. Yet these cases have usually been investigated, and often prosecuted, by people with experience of the law but little or no experience of HIV or other serious sexually transmissible conditions.
- 2.3 In discussion with those involved in the cases there appeared to be a wide range of different investigational behaviours and patterns. Anecdotal evidence suggested that there were areas in which the investigation and management of cases could be improved, not only to increase the consistency of justice but also to reduce police costs in cases where charges could not succeed. These cases were happening all over the country, but disproportionately in London, where more than half of people with HIV either live or use services.
- 2.4 In discussion with officers from the Metropolitan Police and Association of Chief Police Officers (LGBT Portfolio Group), all agreed with Terrence Higgins Trust (THT) that community confidence in policing and appropriate use of police resources were key goals of any work undertaken. And that, in turn, led to the project of which this is the report.
- 2.5 The text contains recommendations for guidelines and further action and this will be the subject of ongoing ACPO work in conjunction with NAT (National AIDS Trust). Examination of these cases has improved understanding all round of how they have been, and should be, conducted. We look forward to the eventual guidance which, in conjunction with the Crown Prosecution Service (CPS) Guidelines, should serve to bring helpful clarity and national consistency to a difficult area of policing work.
- 2.6 Thanks go to all the members of the Community Advisory Panel (CAP), listed in Appendix 1, who gave their expertise and experience. Thanks are also due to City Parochial for funding the work, Deputy Chief Constable Michael Cunningham, Chair of the ACPO LGBT Portfolio Group for supporting this project, Dee Caryl (LGBT Strand Lead, Diversity & Citizen Focus Directorate, MPS) and Carl Wonfor (Police/Communities Engagement Officer, ACPO LGBT Portfolio Group). Without Dee and Carl's support and explanations of police procedure, the report would have been by far the poorer. Chief Superintendent Carl Bussey also advised at the editorial stage.

3. Overview of prosecutions for HIV transmission in England and Wales

- 3.1 Until the start of the 21st century it was widely thought that no form of HIV transmission was a criminal offence in the UK. At least one widely publicised case had not been taken forward on this basis, although a prosecution of a clinician who transmitted Hepatitis B while continuing to work in full knowledge of his condition had succeeded. In February 2001, a heterosexual man was successfully convicted in Scotland under a Scots-specific charge of "reckless injury". It appears that this opened the door to reconsideration of the possibility of charges under English law.
- 3.2 As part of a wider consultation on a proposed Violence Bill in 1998, the Home Office had concluded that only intentional transmission of serious disease should be made a criminal offence. This was in response to submissions from THT and others which put forward the view that prosecutions for reckless transmission were not in the best interests of public health. However, this proposed legislation was never laid before the House and thus, when a formal complaint was made in London a few years later, police and the CPS relied upon the Offences Against The Person Act 1861 to bring a charge of Grievous Bodily Harm. This is a serious but not uncommon charge, usually dealt with by CID and most commonly relating to violent assault resulting in serious injury.
- 3.3 Following the first successful prosecution in 2003-4 there were a further seven cases in Crown Court between 2004 and 2006, in all but one of which the accused pleaded guilty and all of which resulted in convictions with sentences ranging from two to ten years (the latter for three separate charges). Widespread media publicity for the first cases resulted in a greater awareness of the possibility of such prosecutions. THT records for 2005-6 showed an average of one complaint under police investigated per fortnight and it is known that others existed which had not been referred to THT.
- 3.4 In some of these cases, scientific evidence showing similarities between the viral types of the accused and the complainant were cited in evidence of transmission. However, in a case which came to court in August 2006 after a two year investigation, the scientific evidence was challenged on the grounds that it could conclusively exclude someone from being the source of transmission but not prove positively that they were. This was subsequently reflected in the CPS Guidelines (2008), which have greatly improved the clarity of understanding of when a case should be prosecuted. Following that verdict, only two further cases have been successfully prosecuted in the following two years.
- 3.5 However, to our knowledge in September 2008 there are at least six further cases under consideration in the London area alone and many others which have been investigated and abandoned at relatively late stages in their investigation. In November 2008 a man was also successfully prosecuted for transmission of Hepatitis B in England. The policing of these cases since publication of the CPS Guidelines has thus been subject to ongoing interest and scrutiny and it is within this scenario that THT, advised by the CAP and supported by ACPO and MPS staff throughout 2007-8, has produced this report.

4. Outline of the project

- 4.1 In June 2006, an analysis of transmission-related police investigations known to Terrence Higgins Trust (THT) showed that cases coming to our attention had been running at an average of one a fortnight for the past year. This was far higher than the numbers of prosecutions finally brought from them (four in all, or one in six of those known to us at that time).
- 4.2 Since we knew from experience that not all cases involving police action were coming to our attention unless they made it to court, this made it highly likely that the real ratio was even greater. Additionally, THT Direct, the THT Policy Team and other community organisations were receiving calls from police officers trying to manage allegations without specific guidance or previous experience, since transmission of HIV had only been established as a criminal act by the first successful prosecution in 2003.
- 4.3 Monitoring of the cases we knew suggested that there were wide variations in practice across different cases, even where they involved the same police force. Variables included charges made upon arrest, stage of investigation arrest made at, level of evidence upon which arrest made and levels of understanding of HIV and its transmission.
- 4.4 During 2006-2008 the CPS, following dialogue with NAT and THT, undertook an exercise to establish guidance for prosecutions for transmission of disease. This involved an advisory board and a public consultation, following previous similar initiatives on hate crimes and domestic violence. This process took place across 2006-2008 and culminated in the production of Guidance, included here as Appendix 1.
- 4.5 This research project, which arose out of discussions between THT staff and a community liaison officer for the Metropolitan Police Service (MPS) recently seconded to the Association of Chief Police Officers (ACPO), evolved as the first part of a similar exercise on policing. The second part consists of work to support ACPO in turning these findings and other evidence into guidance for officers in such cases, and will be led by NAT.
- 4.6 Following the format of a previous MPS LGBT Independent Advisory Group review of homophobic murder, a Community Advisory Panel was set up to scrutinise cases identified by members of the Panel, provided by the MPS and other police forces and written up in digest form by the ACPO officer directly from case notes. The panel included representatives from the MPS Disability and LGBT Independent Advisory Groups with experience of the previous exercise and people from HIV organisations dealing closely with ongoing prosecutions. It was also attended by the original officer approached and a community liaison officer from the MPS.
- 4.7 This group signed confidentiality agreements in order to see the digests, from which key anonymised aspects have been used throughout this report. They explored, with the staff from ACPO and the MPS, how ordinary police practice had or had not worked in the cases, where common practice had not been followed and why, and what the impact and outcomes of the investigations had been. They also agreed a set of initial themes which informed the case reviews undertaken by the officer.

- 4.8 The Community Advisory Panel reviewed and discussed the cases, sharing concerns and insights, providing explanations and comparing practice across the cases. They went on to make a series of summary recommendations which form the core of this report. The rich material in the cases also provided a series of examples of good practice and concerns, and some learning points and recommendations for those supporting people with HIV either in clinical or community settings.
- 4.9 The review of cases took place between September 2007 and June 2008. In all, six full cases were reviewed, including cases where guilty and not guilty verdicts were returned and others where the case was dropped before trial. Both heterosexual and gay transmission accusations were included and those involved were from a variety of ethnicities. The first cases analysed were those volunteered by forces, followed by specific searches for others which would differ in outcome or content and provide a range of experiences and practice, informed by the wider review of cases previously undertaken by THT. In one of the more complex cases some papers were not available or not found, but those papers available were substantial enough to have a clear picture of the key issues. In other cases, all relevant papers were accessible. Only cases which had been fully resolved, up to dismissal or conviction, were included. The case studies were further augmented with interviews and illustrative comments from people directly involved in prosecutions in differing ways.
- 4.10 Throughout this review, individual cases or forces are not identified by name or geographical detail. This is partly in order to comply with the requirements of forces involved, but also to protect the confidentiality of the individuals involved in each case and because it is important that general lessons can be drawn from the cases rather than good or poor practice be ascribed to an individual force.

5. Findings, including recommendations to ACPO

5.1 Key themes and observations on them

Theme 1: Disclosure and recording of people's HIV status

Disclosure is an important issue within HIV because of the stigmatised nature of the condition, the implications which a diagnosis may hold for individuals and the way in which others may react to that knowledge or assumptions. It was chosen as a theme by the CAP because, in a number of cases, there had been allegations of inappropriate disclosure of status by police to others, both sexual partners and other third parties. Case papers were searched for information on how status had been identified and recorded; whether and how any onward disclosure had been managed and to whom; and whether any guidance had been sought or used in managing this.

In general, all cases examined showed that the HIV status of complainant and accused had been accurately recorded, including where the status of the complainant was unclear at the time of complaint. Further disclosure was in general handled with sensitivity and discretion, including allowing those involved to disclose directly to witnesses. However, in two of the cases examined, concerns were expressed by members of the CAP over particular police actions on disclosure.

In one case, investigating officers disclosed the accused's HIV status to an unknown number of people in the accused's circle of acquaintance and also considered a media strategy naming them "to trace/alert other witnesses". Interview records for this case show that the accused was urged to name other sexual partners and asked "how (they) would feel if the police put an appeal in the media for other partners to come forward". Fortunately, on consideration, it was noted in the Decision Log that "the proposal is not proportionate". This was one of a number of unusual actions in this case, taken by the investigating officers on the basis of an extreme set of assumptions about HIV and its transmission, which will be dealt with elsewhere in this report.

In the other case, although no charge was eventually made (and in fact no charge could have been made, as the CPS eventually advised), the accused's HIV status was disclosed after the investigation was closed, in the form of an Information Report to his local police force, which differed from that where the alleged offence took place. This is, in the experience of members of the CAP, an unusual event but was justified by reference to the Code of Practice on the Management of Police Information arising from the Bichard Enquiry into the murders in Soham in 2006. This code requires forces to share information on investigations into serious crime and, since HIV transmission is currently dealt with as GBH, it is included within this. It would be helpful to investigate what flexibilities may be available to forces within this. In any case, the objective could be met by disclosure of the basic charge of GBH without full and automatic disclosure of HIV status, and consideration is given to this in the Recommendations later in the report.

In a third case, it appeared that third party disclosures must have been made in the course of investigating other sexual partners of the complainant, but there was not enough data in the records to be clear as to how this had been handled and what, if any, permissions had been sought.

In no case examined did the officers appear to have access to any written guidance or any place of expertise on disclosure of an individual's HIV status to others. Under these circumstances and given the lack of precedents at the time most of these cases were investigated, it is surprising that more problems were not encountered. This is also dealt with in the recommendations.

Theme 2: Access to medical records

This theme was again chosen because of previous experience from members of the CAP of confusion around the issue. In particular, clinicians reported a lack of clarity as to when they were obliged to hand records over and what should be handed over. It was therefore agreed to examine practice in the reviewed cases in the hope of being able to inform good practice.

In three of the cases examined, no access to medical records was sought, in one case despite the case going as far as court appearances. The CAP expressed some surprise at this but in general it seems that, prior to the first acquittal in 2006 where medical records of both parties became central to the case, it was not always viewed as a prerequisite by investigating officers. In particular, where someone was expected to plead guilty as in most of the early cases it may not have been seen as an important part of the evidence. This is likely to have changed following that case and other more recent ones.

It was noted that there is, in general, considerable disparity in the practice of handing over of medical case notes or medical information by clinics and this is an area which needs further consideration. In one case examined, there was a pre-existing disclosure protocol between the local NHS Trust and the police force, which was noted and followed in the case records. However, the same case also threw up a major anomaly. Whereas in most cases of allegations of transmission, GUM (genito-urinary medicine, or special clinic) records only are accessed, in this case one side had been tested via their GP and their entire medical history notes were thus handed over, rather than solely those relating to sexually transmitted conditions. Given that this was the complainant, their whole medical history could thus have been disclosed to the defence during the course of the case.

In another case, the person accused did not consent to police accessing their medical records. Police sought and obtained a court order for their disclosure with no difficulty. However, it is notable that the medical facility involved did not hand over anything, in the absence of consent, without a court order. In the same case, medical and care staff also refused to tell the police the accused's whereabouts in a residential facility until a formal disclosure notice had been served on the hospital by the police.

Theme 3: Method of contact (how the case arose and who within the police handled it)

The third theme arose from a number of cases which gave rise to concerns within community support organisations about how cases were being brought. As it transpired, some of these concerns were not present in the cases where records were obtainable, or where individuals were available for interview and thus cannot be addressed in this report. This theme is related to disclosure, but also encompasses how the allegation was dealt with, who took charge of the investigation and how the police identified and contacted involved parties.

From the available evidence, a number of important concerns were identified by the CAP. Firstly, in most cases the original arresting officer became the Investigating Officer. This was a mix of uniformed and detective constables. In only one, particularly complex, case was the investigation transferred to a presumably more experienced detective constable. In another there was mention of the involvement of a Senior Investigating Officer, but most of the case was pursued by the original officer, up to and including media statements outside court after the conclusion of the case.

In two cases the manner of arrest was unusual. In one, the accused was arrested in hospital while being treated for injuries sustained in an assault by the complainant. In the other, officers attempted to arrest someone who had admitted themselves voluntarily to hospital on mental health grounds, only to be refused information on the patient's whereabouts. Having established this eventually via an application under the Data Protection Act, the police were refused entry to the facility (in order to arrest the accused) by both a senior nurse and a doctor. This was

subsequently backed up on examination of the accused by the Force Medical Examiner, a police doctor, who declared them unfit to be charged. Eventually they were charged ten days later on surrendering themselves to the police station.

In one case, the first complainant proved to be uninfected upon testing. However, by the time the testing was completed, investigations had uncovered a second party who had been infected by the accused, but who had not previously made a complaint to police. This second person ultimately became the complainant in court. It is unclear from police records in the case how this person came to change their mind about making a complaint.

In one case, although a uniformed Police Constable investigated the case, a decision not to pursue it was taken by a supervising officer without reference to CPS advice, for which they had been waiting for three months. In the cases examined, CPS advice took from one to ten months to be given.

Theme 4: Additional support or advice sought

Both HIV services and community representatives on the CAP had experience of being consulted by a variety of parties involved in transmission cases, including police officers investigating cases. There was a shared feeling that such interactions were beneficial in supporting police in a better understanding of HIV and its transmission, clarifying points of law, improving management of cases for all parties involved, avoiding wasted police time and minimising stress for complainants and accused. Case reports were therefore scrutinised for any contact from investigating officers with other sources of support both within and outside the force. This theme also explored what, if any, support was provided for the accuser and accused, especially where the accuser's HIV status remained unclear upon the allegation being made.

In most of the cases examined, no such support was recorded as sought either by the investigating officer for themselves or on behalf of the parties involved. Given that it was the first time for each of them managing such cases, and the extreme complexity of some of the cases, this is unfortunate. However, it was initially unclear to many officers quite how complex these cases could be, despite it having taken four attempts to obtain a conviction against the first person charged in England.

Where support was sought, it was usually either a random accident of knowledge e.g. a 999 operator who knew of the existence of post exposure prophylaxis (PEP) treatment to decrease immediate likelihood of transmission of HIV, and therefore suggested use of it to an officer, or an additional element of a standard part of an enquiry e.g. an officer who, while obtaining medical records from a hospital clinic, took the opportunity to also ask the doctor about how to advise the complainant on testing.

In one case, the custody officer consulted sexual offences specialist officers, but this was specifically the result of a 999 officer raising the issue of PEP. The officers do not appear to have been further engaged in the case despite an allegation of rape by one party. In another case, the use of a Family Liaison Officer was considered in order to support the complainant, who was awaiting the result of an HIV test, but the complainant themselves decided they were not needed.

In one case, despite evidence of domestic violence and poor mental health on the part of one of the parties involved and even discussion of these by the police and the CPS, there was no record of domestic violence or mental health specialists being consulted or involved. It was the view of those members of the CAP with experience of domestic violence and sexual offences cases in the MPS that, had SOIT (sexual offences specialist team) officers investigated this case instead of generalist CID officers, the management of the case might have been different. SOIT teams do not exist in all forces, and it is clear that ways of addressing this issue are likely to vary between forces, but the overall impression of the cases examined was that opportunities for understanding were missed and that sensitivities went unaddressed in a number of areas, in some cases causing unnecessary bad relations between professional parties.

Theme 5: Media interaction

This theme was chosen because of a small number of high profile cases, mainly those resulting in convictions, where police statements had appeared in the press or informed radio and televisual coverage. The CAP examined what, if any, information had been released to the media during cases or after court appearances and whether cases had considered any media strategy.

In most of the cases examined, particularly those which did not result in a trial, there was no record of any media strategy being considered and there was no evidence of media reporting of the cases. In one case, local media reporting was included in the case file but this was directly attributable to the local paper's court reporter and did not include any police involvement.

In one case, there was repeated mention of a media strategy in case notes and an interview transcript. This appeared to be aimed specifically at publicising the identity of the accused pre-trial in order to identify any further sexual contacts they had made and, as noted already, the idea was abandoned due to consideration of the rights of the suspect and as being disproportionate. However, although there was no mention in the case papers of media comment, both police and community members involved in this project were aware of a notification of dissatisfaction made directly to the Chief Constable of the force involved by NAT, following comments made directly by the investigating officer to members of the press upon conviction of the accused, including information identifying a minor and their address.

5.2 **Good practice identified**

During the course of the project, analysis of the case papers provided a number of examples of good practice which the CAP highlighted as noteworthy and useful examples for other forces.

- **Post exposure prophylaxis:** Of particular note was the prompt offer of PEP to the complainant in a case where sexual activity had taken place that night. PEP is a course of treatment which can be given to someone within 72 hours of contact, where there is a genuine risk of transmission of HIV. It is most frequently used in case of needlestick or other occupational injuries by healthcare workers, but is increasingly used following unprotected sex, or sex where a condom has broken, where one partner is known to have HIV. Guidance on the use of PEP should be available to all police forces, and Force Medical Examiners should receive training on the issue, but the current level of understanding is not uniform. Consideration of PEP in appropriate cases should be encouraged, especially given that time is of the essence.
- **Action to prevent inappropriate disclosure in the community:** In one case where anonymously-produced leaflets appeared in gay clubs during the course of an investigation, identifying the accused and publicising their HIV status, LGBT Liaison Officers from the local police force intervened to remove the inappropriate information from public circulation and explain the issue to the bar staff. They also spoke to individuals they considered potentially responsible for the leaflets. Actions of this kind have a positive effect beyond the immediate maintenance of the law, by increasing trust in police fairness.
- **Seeking specialist advice:** As previously noted, in another case police sought information from a doctor at the local GUM clinic in order to advise a complainant about getting an HIV test. In particular, if these cases are to be handled by general CID officers, rather than specially trained or SOIT Officers, it is imperative that they feel confident in seeking advice on medical and social aspects of HIV from clinicians and specialist voluntary organisations.
- **Use of SOIT Team even where not directly involved:** In one case, officers consulted their force's SOIT unit directly for advice. It is likely that officers trained and experienced in sexual offences work will have a better understanding, in general, of the motivations, difficulties and pressures involved for all parties in this area. Their advice or direct involvement is likely to improve management of such cases and may well avoid some of the more unfortunate examples of poor practice highlighted on the following page.

- **Use of tact and discretion in managing a case involving juveniles:** Members of the CAP were impressed by police initiative in the handling of one case involving juveniles where no transmission occurred. Case notes made it clear that aspects of this case had been handled with tact and sensitivity in what was undoubtedly a difficult situation. Both the carers and the young people involved had been listened to, the views of the victim considered and, in the absence of clear and timely CPS guidance, the Crime Manager had made a decision after some months and after consulting the records of previous cases to record "no crime". The CAP noted the need to be aware of difficult issues when engaging with minors, especially around offences of this nature where revelation of the minor's positive HIV status can also impact on other members of their family.

5.3 Concerns identified and opportunities for improvement

On the whole, the investigations considered by the CAP demonstrated professionalism and a commitment to policing sensitively within a complex, predominantly unknown area and a new use of an existing law. Nevertheless, and inevitably, there were shortcomings which we outline below to improve police practice in the future.

A number of general areas of concern were noted during the case reviews.

- **Poor understanding of HIV leading to inappropriate management of cases:** The panel felt, in particular, that there was evidence from some of the cases examined that the strength of the police reaction to the initial complaint, and the manner in which the case was then pursued, suggested a poor understanding of the realities of the virus and related assumptions which proved unhelpful. Areas of misunderstanding included how transmissible HIV is within specific acts, likelihood of transmission within a single act, expectations that HIV is still a death sentence in the UK and beliefs in the likelihood of people infected with HIV taking "revenge" on others. These beliefs led in turn to sometimes heavy handed management of cases, or to the drawing out of a case beyond any reasonable expectation of a conviction.

In fact, in the UK, with appropriate treatment it is now likely that most people with HIV will survive until old age and, if their virus is successfully suppressed by treatment, the possibility of the virus being transmitted in any one sexual encounter of any kind is greatly reduced (indeed, in many cases it is now considered to be zero). These and other issues were commonly poorly understood by officers in the investigations.

In discussion, the CAP agreed that the majority of problems arising in both the cases under review and others experienced by members of the panel arose from this lack of up to date knowledge of HIV on the part of investigating officers and colleagues. This observation is not surprising, since officers are unlikely to have any specific training beyond health and safety on blood-borne viruses and will therefore have the same range of understanding and potential prejudices as any other member of the public. HIV is a stigmatised and widely misunderstood condition, frequently reported in a sensationalised manner likely to induce fear, and police officers are as subject to these influences as anyone else.

This level of misunderstanding about HIV transmission was clearly illustrated in one case examined. The case log and interview transcripts show that the Investigating Officer appeared to hold the belief that HIV was likely to be transmitted in every single sexual encounter. From the case notes: "Urgent enquiries critical as suspect is alleged HIV carrier who is having unprotected sexual intercourse... early arrest critical to prevent further offences". The officer told the accused they were "putting a death sentence on other parties" and that they needed to "try and save their lives and the lives of their families".

These beliefs led to officers in the case repeatedly disregarding doctors and nurses in attempting to enter a health facility ("SIO met with hostility, staff were unable/ unwilling

to give further details despite my explanations"). Officers in this case felt it necessary to seize household linen and personal garments for DNA analysis and this was the only case examined where the accused's HIV status was revealed to people in their social circle by officers.

- **Lack of clarity about use of the Offences Against the Person Act (OAPA):** Other problems encountered in a number of cases primarily related to the Crown Prosecution Service but had an impact on the conduct of investigations. The courts and the CPS Policy Team were clear from an early stage that, under the OAPA, actual transmission (i.e. harm) is required to obtain a conviction for reckless transmission of HIV; it is not possible to attempt to be reckless. Unfortunately, this was frequently misunderstood by local CPS offices until Guidance was produced in 2008 and therefore it is not surprising that in a number of cases examined, considerable effort was expended on investigations before it was even clear whether a crime had been committed and, in others, after it should have been clear that no crime had been committed.

In one case, despite the complainant having received a negative test the requisite three months after the end of the relationship and two months before their initial complaint, officers continued a full investigation, with the local CPS then taking a further four months to find that there was no offence with which the accused could be charged, after intervention from senior CPS officers. This, in turn, led to the accused's HIV status being reported back to their local police force although no crime had been committed.

It is to be hoped that the publication of CPS Guidance in 2008 (Appendix 1) will go some way towards clarifying this and avoiding cases where police resources are expended unnecessarily, a situation which must leave the forces concerned as frustrated as everyone else involved.

- **Long drawn out investigations:** Another common difficulty observed was the length of time from complaint to resolution, either in court or by closing the case. This causes great strain on both complainant and accused. THT has experience of supporting both parties in such cases and the uncertainty and heightened anxiety over a period of months or even years can further damage both their mental and physical health. In some ways, this delay is to be expected with unusual or new forms of crime where clear procedures and CPS Guidance are not yet established but it is THT's experience that cases subsequent to this exercise have continued to take a long time. The cases examined by the CAP ranged from four to 12 months for cases which did not result in prosecutions and six to 34 months for those that did. CPS advice took from one month to ten months to obtain, including in some cases requests from the CPS for further enquiries by the police before final advice.
- **Difficulties in reconciling the realities of HIV transmission with the requirements of the charge:** One reason for the delay following initial charge is that, while GBH is an immediately arrestable offence, allegations of HIV transmission can often take months to prove or disprove. Police are having to manage cases brought under a law never designed for such scientific complexity. However, it would be useful for officers to have some sort of prioritised checklist to enable them to approach such cases in the most timely fashion, and this will be dealt with under Recommendations later.
- **Management of complex scientific evidence:** A further difficulty, again involving the CPS, was presented by the necessity of obtaining complex virological reports in order to attempt to establish a link between the viruses of the accused and complainant. These reports were provided in several of the cases examined by the CAP. To a lay person (in which we include both police officers and the CAP) they are impenetrable and confusing, being couched in highly scientific language. As a result, unwarranted assumptions were repeatedly made that, in conjunction with the histories of testing of both parties, they could prove that A had given HIV to B. It was not until a case at Kingston Crown Court in 2006 that the defence chose to call their own virological expert to dispute the meaning of these reports, most of which appear to have been written to a formula with details pertaining to each case inserted at key points.

These reports regularly feature in case logs as "proving" transmission in the eyes of investigating officers. In one case examined, the log reads "It needs to be established if (the accused) was responsible for infecting (the complainant) with the virus. This can be done by XXXX University... They can tell us if (the complainant) was infected by (the accused)". In fact, the careful phrase used in all the virological reports is "These results are consistent with transmission... between these two individuals", i.e. proof that transmission could have occurred between the two individuals, rather than it definitely did. However, the police were relying upon expert witnesses who, until challenged in open court, allowed them to repeatedly misinterpret the strength of the scientific evidence. This was no fault of any of the officers concerned, but it did lead to cases, including one included in this project, being drawn out at great length but eventually failing in court. Again, it is to be hoped that this will be less of a problem in future, but there is a need for guidance for officers which explains the issues in plain English and easy terms.

5.4 Recommendations to ACPO

5.4.1 Who should handle these cases within the police force?

The investigations examined by the CAP were all undertaken by ordinary CID officers without specialist training. This led to a number of misunderstandings about aspects of HIV detailed above, which in turn made the investigations more difficult for all concerned than was necessary.

Although the science and social issues involved in HIV can seem complex, there is a real need for each force to contain personnel with some basic understanding of key tenets and facts. It is clear that in order to use a very old law for a very new issue, **(A) training should be provided for designated officers in each force who can provide support in management of these cases.** This should not be limited to HIV, since the CPS makes it clear that the OAPA (1861) could be used for a number of serious sexually transmitted conditions.

There was general agreement that **(B) consideration should be given to all GBH allegations involving sexual transmission being handled, where possible, by SOIT-trained officers.** It should be noted, though, that the charge of transmitting HIV or any other condition, recklessly or intentionally, is not a sexual offence. However, there are links in how it may be investigated and SOIT officers are familiar with issues on mental health and sexual decision making which can be highly relevant in some cases.

As a parallel example, domestic violence cases are frequently charged as GBH, but are handled by specialists such as the Community Safety Unit in the MPS, which is also where LGBT liaison officers in forces link in to. It was also felt that **(C) ACPO should consider whether a national register should be drawn up of officers trained and experienced in managing such cases.**

The CAP recognised that individual officers were often doing their best in circumstances where they were inexperienced and trying to manage without expert support. It was agreed that **(D) "Critical Incident" status could help in accessing the resources to manage such cases,** where they are seen as having community sensitivity. Amongst other things, this would allow the use of Family Liaison Officers and other specialist practitioners in order to support the person bringing the accusation, some of whom had mentioned a wish for further personal and emotional support.

5.4.2 What information support do the police need?

There was a strong view expressed by the CAP that police working on these cases needed far better information and expert support on sexual health and HIV than was demonstrated in the cases examined. As basics, **(E) investigating officers need access to easy-to-understand**

guides to the law in this area and related CPS guidance, which could be provided on paper or via Internet which would avoid the considerable waste of resources currently spent pursuing cases where there was no basis in law for a prosecution. Early resolution of such cases would also improve community relations and reduce fear amongst people with HIV and those considering testing. **(F) Such guidance should also include accurate and up to date information on HIV and STIs including the actual risks of transmission in different acts and settings, and the implications of a positive diagnosis for someone's future health. (G) It would also be helpful for such guidance to include a list of expert external agencies from which officers could seek guidance about specific issues and circumstances,** such as the organisations listed in Appendix 3, who will be familiar with not only the science but also the relevant lifestyles and sexual behaviours of people involved in these cases. It was felt that this would be useful in helping officers to interrogate the sometimes misleading language of scientific evidence and put it into the practical context of everyday sexual lifestyles.

Given the depth and range of problems encountered in this area, it was agreed by the CAP that **(H) a checklist of consecutive actions should be constructed, helping officers to understand what needs to be proven or considered at each stage of the investigation in order to proceed appropriately. This should include Recommendations I-O.**

There was general agreement between CAP members and advisors that **(I) a series of standard questions should be developed, possibly as part of the checklist, to establish at an early stage whether a viable case exists and to ensure appropriate actions are taken.**

These could include:

- Has the complainant tested positive for HIV?
- Did they do so before they could reasonably have been infected by the accused (i.e. were already positive at the time of the alleged offence)?
- Has the accused tested positive for HIV?
- If the alleged offence is within the past 72 hours, has the complainant been offered post exposure prophylaxis (PEP) to prevent onward transmission?
- Did the accused know they had HIV at the time of the alleged offence and did they understand how it can be transmitted?
- Did the accused and complainant ever have unprotected sex without previous disclosure of the accused's HIV positive status?
- Does phylogenetic analysis of virus samples of complainant and accused produce a result consistent with HIV transmission between the two individuals concerned?
- Is the accused the only person who could possibly have infected the complainant?

One of the key issues for proper conduct of a number of the cases examined was having an understanding of transmission issues in relation to the need, or not, for immediate arrest. Officers are often completely reliant upon an allegation by a complainant and need more guidance on what can or cannot be proven, at what stage and by what means. For example, **(J) cases in which a complainant says that sexual activity has only taken place with the accused in the last few days would benefit from a timely HIV test for the accuser in order to establish whether they were already infected prior to the complaint.** Where someone has had unprotected sex without previously ascertaining the HIV status of their partner, they may have done so before and may already be infected. Cases where this has been a feature have been reported outside the UK. A test upon complaint, as well as later, would clear this issue before it becomes a disputed point during a court case.

The group also recommended that **(K) evidence of both parties HIV status should be obtained before any charge relating to transmission is made** (see above) and that

(L) where a complaint relates to sexual activity within the last 72 hours, post exposure prophylaxis should always be offered to the complainant alongside taking an HIV test in order to both minimise transmission and establish the absence of prior infection.

Furthermore, where any possibility of an offence is unclear at the point of a complaint being made, due to waiting for confirmatory tests, **(M) officers should consider waiting for confirmation of transmission before going ahead with arrest and investigation.**

This would considerably reduce wasted resources, individual misery and community tensions. In one 2008 incident, which occurred too late for inclusion as a full case study but which contributed one of the interviews to this report and which was corroborated by third parties, the accused was remanded without bail on three occasions. When finally bailed they were given stringent conditions which caused them to be suspended from work, initially without pay, only to have the case dropped without explanation once scientific reports were received. It should be noted that this was a person with no previous convictions and that the allegations concerned incidents two years prior to the accusations.

It was clear from examination of some of the cases that even where there was no charge possible from the original complaint, police continued to seek other potential complainants. It was the unanimous view of the CAP that this strategy was instrumental in causing fears amongst people with HIV about malicious or misguided complaints leading to wider disclosure of their status and disruption of their lives and possibly to reluctance in disclosing previous sexual partners in a clinical setting where notes could later be required as evidence. It was therefore felt that **(N) wider investigation beyond the original complainant should only proceed once it is clear that they are infected and that a charge is possible.**

5.4.3 Use of virological or scientific evidence

It was clear from a number of the cases examined that investigating officers had effectively been misled into believing that they could obtain scientific proof that A had infected B beyond reasonable doubt. As a "Submission of Case for Scientific Examination" form quoted in one case report stated *"It needs to be established if (the accused) was responsible for infecting (the complainant) with the virus. This can be done by XXXX University... They can tell us if (the complainant) was infected by (the accused)..."* While virological evidence will form part of any prosecution case of this kind, it is important that officers understand its limitations and the possibility of other sources of infection where a complainant has had multiple partners without regular testing.

Investigating officers in these cases need to be aware that the accused may feel guilty simply because they realise that they have put someone at risk. However, in itself this is not a criminal charge, and **(O) no plea should be accepted without virological checks and the taking of full sexual histories as outlined in the Crown Prosecution Service Guidance.** This is already contained in the CPS guidance but also needs to be understood by investigating officers. The group felt strongly that it needed to be made clearer to investigating officers that the scientific reports on virology must be used in cases in order to eliminate potential suspects but could not, of themselves, constitute full proof of transmission between two specific individuals, nor indicate which direction transmission was in.

5.4.4 Other issues

Alleged fear of HIV transmission has now been used on a number of occasions, including one of the cases included in this review, in an attempt to mitigate responsibility for violent assault. **(P) Care needs to be taken in cases where HIV transmission is a counter-allegation by someone accused of other crimes or misbehaviour.**

Similarly, **(Q) close attention should be given to any evidence of domestic violence or other forms of harassment within a case**, which may affect the dynamic within which risky behaviour or failure to disclose takes place.

(R) Guidance is needed for officers on the passing of sensitive information such as HIV status to others; in particular, to other forces as part of an Information Report where no crime has been charged. Like information on change of gender, as covered in the Gender Recognition Act, it should remain undisclosed unless it is relevant to the charge and even then should be put within the "protected" category of information which requires a higher level of permission to access. Police working on cases involving people with HIV should always be aware of the reasons why disclosure to third parties without consent may be problematic, and encouraged to consider whether any such disclosure is strictly necessary.

In one case the police exercised their discretion in deciding not to charge without waiting for CPS advice. Given the increasing clarity of some aspects of these cases, alongside the sometimes lengthy wait for CPS advice, (S) officers should be supported to make decisions in advance of a CPS response on case closure where appropriate; for example, where no transmission has occurred or where investigation has uncovered a number of potential but untraceable sources of infection, making a successful prosecution extremely unlikely.

5.5 Key learning points for clinicians and community support organisations

During the course of the project, members of the CAP were able to discuss cases in depth with ACPO and MPS representatives. This was of great value, particularly to those working directly on ongoing cases and providing advice to other organisations. Understanding was gained as to why police in the cases took certain decisions or behaved in particular ways and, although it was not part of the original plan, it was agreed that a section of the final report should address this and try to give some insight into police decision making in areas which had previously not been understood by some of the Panel.

Since this was not an aim of the original exercise, these observations do not form part of the formal recommendations but are included below.

5.5.1 Officer Training

Police training is extensive and all officers receive ongoing training. However, this has to cover a very wide range of subjects and cases involving HIV transmission are thankfully rare. Therefore, this is not an issue on which most officers have any expertise. Offering to provide awareness training on basic aspects of HIV and living with HIV to local police are likely to have a beneficial aspect all round, in improving understanding, increasing the sensitivity of community policing and decreasing the pursuance of inappropriate cases.

5.5.2 Police expectations of cases

The investigative process can engender a very different mindset to working in a hospital or a community group. In most cases, police can expect to receive a complaint, treat the complainant as a "victim" and pursue the person complained about as the "accused". Most police investigation, though complex, is much clearer than the average complaint of HIV transmission and it is unlikely to cross the mind of an officer that, say, a complainant may have an emotional certainty as to who infected them, but in reality have taken a number of other risks.

Additionally, press coverage of HIV transmission cases has in the past made them appear more straightforward than the reality and few officers who have not previously been involved in a transmission case enter into them with an understanding of the extreme complexities and confusions they will likely encounter.

It may be helpful to ensure that local police and all involved have an understanding of how such cases are likely to progress at an early stage or, even better, to discuss this with community liaison officers in advance of any local case arising. Such officers may also be able to help community groups understand the reasoning of officers in a case.

5.5.3 Reluctance to accept complainants dropping a case

There was extensive discussion at the CAP as to why police involved in such cases are so reluctant to allow complainants to withdraw allegations. However, it became clear in discussion with police representatives that this has in part evolved from domestic violence cases, where pressure can be put on complainants to withdraw by the accused. In any dialogue or training with local police, it may be useful to provide an understanding of why someone may experience internal conflict about bringing such a complaint, or may decide without such external pressure that it is not the best move for them.

5.5.4 Duty of care

When investigating a potential crime, police officers have a duty of care to ensure public safety. This arises from legal cases against them, and from a concern about criticism that if the police receive information that a person or persons are at risk then they have a duty to act to reduce that risk. Given misperceptions about the transmissibility of HIV, alongside widely-repeated urban myths about people with HIV who intentionally infect others as "revenge", it is therefore not surprising if some officers act on these anxieties in a way which many HIV community groups feel is inappropriate.

This was clearly illustrated in one case examined, and also evident in the way in which other investigations were handled. It is important, when liaising with the police, that groups understand this wider context when discussing police actions.

5.5.5 Disclosure of information

Police officers have legal obligations around disclosure of information in relation to criminal investigations. This mainly relates to disclosure of information between the police, CPS and defence representatives in prosecution cases. However, more recently, in response to criticism about the Soham case, where forces failed to notify others of allegations of paedophilia and which culminated in two murders of children, the expectation has arisen that forces will share information on allegations and investigations, not just convictions, in relation to serious offences.

Some officers may interpret this more widely than others but there is undoubtedly, as discussed above, some discretion in how the guidance is interpreted and it is always worth discussing how and when this might be done, once a relationship has been established between an HIV organisation or clinic and the local police.

5.5.6 Knowledge of HIV

One of the things which came through clearly during the examination of cases is quite how unsupported most of the investigating officers were around simple HIV facts and an understanding of living with HIV. While these cases were mainly from 2005-6, it remains true that most new allegations are still conducted by officers with no previous experience and no personal knowledge of HIV.

The most important and useful thing that any local HIV specialist organisation can do, in terms of supporting good practice policing and reducing inappropriate investigations, is to offer such information and support. It has been our experience that very few such offers are refused. While it is unhelpful to drown an officer in, say, the science of HIV, an offer of simple leaflets, the phone number of THT Direct or a local agency and direction to a few key websites may make a difference in how a case is pursued.

5.5.7 Complex cases

In one case examined, there was a confusing scenario of allegation and counter-allegation. It was noted that the officers involved chose to arrest all parties and remove them from the scene, before ascertaining what was really going on. Policing representatives pointed out the difficulty in sometimes being able to work out what is going on at a crime scene, particularly where there is violence or raised tempers and that sometimes, in short, "the simplest thing to do is arrest people and sort it out later".

5.5.8 Police procedure

Sometimes members of the public, especially if they are unfamiliar with police procedure, can misunderstand the seriousness or at least the urgency of certain police procedures. It is far from unusual, for example, for police to make an initial arrest, release someone on police bail and decide later on (sometimes months later on) that there is no charge to be made.

Often, someone suddenly and unexpectedly arrested for what they know is a serious offence can be distressed and alarmed by being arrested, not charged but put on "police bail". They may be asked to report back to the police at a date some time later and, in many of these cases, then be asked to come back again months later because investigations have not yet been completed. This can happen with very little explanation of what procedures are being undertaken, or what is causing the delay.

This can be particularly worrying and frustrating where they, or persons supporting them, have read the CPS guidance, understand the evidential requirements and believe that no offence has been committed. Where there is serious concern, from reading the CPS guidance and discussing the anonymised case with others who are experienced in the process, that the process is being extended but no charge is likely to be successful, it may be worth a tactful intervention by a trusted support organisation on behalf of the person charged.

This can often be done via community liaison officers with whom the organisation has an existing relationship. It may be possible to explain the situation and shorten the process – though only with the agreement of both the person charged and their solicitor.

5.5.9 Levels of support to complainant

In at least one of the cases examined, and in others with which the Panel were familiar, it often comes as a surprise to the complainant that they receive no independent legal advisor, access to legal aid or automatic source of emotional support.

It is important that both complainants and those in contact with them are fully aware of how the court and legal system works; that the police investigate, and that, in any serious crime, any decision to charge someone and go to court is made by the Crown Prosecution Service; that the CPS provide the prosecution legal team and that the complainant is effectively a prosecution witness. There is no legal requirement for the police to offer independent legal advice to a complainant or a witness. If they want personal legal advice, they will need to seek it separately.

Within the MPS and in many other forces, all complainants will be referred to Victim Support as a matter of policy. Dependent upon the case, they may also be referred to other generic counselling services. Some people have found this helpful, but others may prefer to see someone more understanding of their personal experiences, be they gay, African or just wanting someone who knows something about HIV. Several of the agencies on the Advisory Panel had found that both sides of a case may require emotional support and it is vital that this is offered in a manner which does not compromise the agency or the case.

5.5.10 CPS role and involvement

As stated above, it is the role of the CPS to decide whether there is enough evidence for a charge to be brought and, if there is, to prosecute in court. It is clear from the cases examined that this decision making process can take considerable time and has, in the past, not always resulted in entirely accurate advice. It was also evident that local CPS officers may not always be in harmony with CPS policy on these charges.

This will hopefully be resolved with the publication of relatively clear guidance from the CPS Policy Division in 2008 (included at Appendix 1), whereby local CPS officers are, in addition to following the Guidance, also required to notify cases to the Director's Principal Legal Advisor through the Area's Head of the Complex Casework Unit [where there is one] or through the Chief Crown Prosecutor where there is not. It is important for everyone involved to be clear about the separate responsibilities of the police and the CPS.

6. Further action

- 6.1 Following the findings of this report (and indeed prior to its publication) the Association of Chief Police Officers intends to develop Guidelines for policing transmission which will sit alongside those produced by the Crown Prosecution Service in April 2008. In this, they will be supported by NAT.
- 6.2 THT, working with them and other HIV and sexual health organisations, will use the findings of the report to inform both policy and practice. Further guidance for voluntary organisations, clinicians and people living with HIV will be produced by various partners and informed by this report.
- 6.3 Copies of the report will be circulated widely to all areas of the justice and the sexual health sectors and seminars held to support learning from it. Learning will also be communicated internationally in order to inform work in a wide variety of countries in Europe, Africa, Asia and the Americas where HIV transmission and the role of the criminal law are currently under scrutiny.

7. Appendices

7.1 Organisations/individuals involved in the Community Advisory Panel

Secretariat and report:

- Lisa Power, Policy & Public Affairs, Terrence Higgins Trust

Community Advisory Panel:

- Yusef Azad, NAT
- Eleanor Briggs, NAT
- John Dulieu, THT Direct, Terrence Higgins Trust
- Andrew Little, MPS Disability Advisory Group
- Chris Morley, George House Trust
- Rhon Reynolds, African HIV Policy Network
- Michael Verrier, MPS LGBT Advisory Group

Eleanor Briggs of NAT, Derek Lee and Bob Hodgson of MPS LGBT Advisory Group, CS Carl Bussey of MPS, John McKernaghan of the Brunswick Centre, Cheikh Traore of the Greater London Authority, Victoria Sheard of THT and Peter Kirkham all also gave advice or input at various stages for which we are thankful.

7.2 **Crown Prosecution Service Guidelines on Intentional Or Reckless Sexual Transmission Of Infection**

1 **Introduction**

- 1.1 This guidance sets out how prosecutors should deal with cases where there is an allegation that the accused has passed an infection to the complainant during the course of consensual sexual activity. It excludes other methods of transmission, such as shared needle usage.
- 1.2 Prosecutors will appreciate that this area of the criminal law is exceptionally complex.
- 1.3 The criminality of this offending lies in the mens rea. This means that the relevant offences will be difficult to prove to the requisite high standard, to satisfy the evidential stage of the Code test and in the court itself.
- 1.4 There are other sensitivities: the relationship between the criminal law and consensual sexual behaviour is delicate. The use of the criminal law in the most intimate of physical exchanges is always going to attract publicity and will invite strongly held and differing views.
- 1.5 The role of the prosecutor, however, is clear: it is to apply the criminal law and prosecute individuals where the two stage test set out in the Code for Crown Prosecutors are satisfied.

2 **Relevant Offences**

- 2.1 The courts have recognised that person-to-person transmission of a sexual infection that will have serious, perhaps life threatening, consequences for the infected person's health can amount to grievous bodily harm under the Offences Against the Person Act 1861: R v Dica [2004]. Therefore, the transmission of that infection can constitute the offence of inflicting or causing grievous bodily harm, which when intentional can attract a sentence of life imprisonment.
- 2.2 The relevant offences for a prosecutor to consider are under sections 18 and 20 of the Offences Against the Person Act 1861.

3 **General Propositions**

- 3.1 The application of the law in this area is not related to any particular characteristic of the defendant or the complainant. The sexual transmission of infections can take place between a man and a woman, between two men and between two women. The infection may pass from either person engaging in sexual activity and it is wrong to think that it can only be passed from the so-called "active" person to the so-called "passive" person.
- 3.2 Sexually transmitted infections may be bacterial or viral; the means by which infections are transmitted vary. Some sexually transmitted infections may be passed through semen, or blood, or saliva, or a combination of all of these. There may be different rates of likely infection depending on the characteristics of the particular infection and on the medium by which it is transmitted.
- 3.3 It follows therefore that an infection may be passed without the two people engaging in full sexual intercourse. Indeed, some infections are transmitted in other ways entirely. Prosecutors will need to have a clear understanding of the mediums by which and of the ways in which any particular infection can be passed when considering the evidence required to prove how the infection was in fact transmitted - and therefore whether it was passed by the defendant.
- 3.4 Prosecutors will also need to pay detailed attention to the totality of the evidence available to them when deciding whether there is sufficient evidence to prosecute. As the grievous bodily

harm cannot be seen in the same way as, for example a, stab wound, it is inevitable that detailed scientific and medical evidence will need to be adduced in court. The nature of this scientific and medical evidence will be dependant on the type of the sexually transmitted infection.

- 3.5 However, scientific and medical evidence will only ever form part of the case against the defendant. We must build up a strong factual case around the scientific and medical evidence in order to satisfy the evidential test in the Code. This is because scientific and medical evidence of this nature is not as precise as, for example, evidence of DNA matches.
- 3.6 In the case of some infections, the scientific and medical evidence can demonstrate with certainty that the defendant did not infect the complainant because the two people concerned have different strains of the infection. However, scientific and medical evidence cannot prove that the defendant did infect the complainant. In such circumstances, at best, the scientific and medical evidence may demonstrate that the strain of the infection in the complainant is consistent with the strain in the defendant and that the stages of the infection in each are compatible with the assertion that the defendant infected the complainant.
- 3.7 In the case of other infections, the medical and scientific evidence may be able to demonstrate that the physical symptoms that the complainant exhibits are the same as the symptoms of a particular kind of infection that the defendant clearly has.
- 3.8 The nature of the evidence will depend on the type of infection. Guidance on the weight and nature of the evidence required to be adduced by the prosecution is set out at paragraph 6.

4 Intentional Transmission: Section 18 Offences Against the Person Act 1861

- 4.1 The deliberate infliction of grievous bodily harm by one person on another is one of the most serious crimes under the law.
- 4.2 Consequently, where the evidential stage of the test set out in the Code is satisfied, it is likely that the public interest will require a prosecution.
- 4.3 However, prosecutors should never accept a plea to section 18 unless there is scientific, medical and factual evidence which proves the contention that the defendant intentionally and actually transmitted the infection to the complainant. The mere fact that the defendant says that they did and that they intended so to do is not sufficient to meet the evidential stage in the Code test. There has to be other factual evidence to demonstrate that the defendant's account is at least compatible with the scientific evidence available: see paragraph 3.5.
- 4.4 Where there is factual and compatible scientific and medical evidence and an informed plea by the defendant who admits intentionally seeking to infect the complainant, a plea to section 18 may be accepted, subject to the public interest stage of the Code test also being satisfied.
- 4.5 The consent of the complainant to sexual activity in the knowledge that the defendant is infectious does not amount to a defence for the defendant in cases of intentional infection: *R v Donovan* [1934] 2 K.B. 498; Attorney General's Reference (No. 6 of 1980) [1981] Q.B. 715, CA.
- 4.6 If the prosecution can prove that the defendant intended sexually to transmit an infection to a person but failed to do so, a charge of attempting to commit section 18 can be brought.

5 Reckless Transmission: Section 20 Offences Against the Person Act 1861

- 5.1 'Recklessness' in this context means that a defendant foresaw that the complainant might contract the infection via unprotected sexual activity but still went on to take that risk. Once the prosecutor is satisfied that the suspect has foreseen the risk of infection, the 'reasonableness' of taking such a risk must be considered. 'Reasonableness' is dependant upon the circumstances known to that person at the time he or she decided to take the risk.

- 5.2 It will be highly unlikely that the prosecution will be able to demonstrate the required degree of recklessness in factual circumstances other than a sustained course of conduct during which the defendant ignores current scientific advice regarding the need for and the use of safeguards.
- 5.3 Prosecutors should never accept a plea to section 20 unless there is scientific, medical and factual evidence which proves the contention that the defendant recklessly and actually transmitted the infection to the complainant. The mere fact that the defendant says that he or she did and that he or she did so recklessly is not sufficient to meet the evidential stage of the Code test. There has to be other factual evidence to demonstrate that the defendant's account is at least compatible with the scientific evidence available: see paragraph 3.5.
- 5.2 Where there is factual and compatible scientific and medical evidence and an informed plea by the defendant who admits recklessly infecting the complainant, a plea to section 20 may be accepted, subject to the public interest stage of the Code test also being satisfied.
- 5.3 The informed consent of the complainant to the assumption of risk of infection by engaging in sexual activity with a person who is infectious - in cases where the defendant cannot be shown to intend to pass on the infection - is a defence available to the defendant in cases of section 20 grievous bodily harm: *R v Dica*.
- 5.4 'Informed consent' does not necessarily mean that the defendant must disclose his or her condition to the complainant. A complainant may be regarded as being "informed" for the purposes of giving consent where a third party informs the complainant of the defendant's condition, and the complainant then engages in unprotected sexual activity with the defendant. Similarly, a complainant may be regarded as being "informed" if they become aware of certain circumstances that indicate that the defendant is suffering from a sexually transmitted infection, such as visiting the defendant while he or she is undergoing treatment for the infection in hospital, or the appearance of sores (etc.) on the defendant's genitalia.
- 5.5 Whether the complainant gave his or her informed consent is a matter for the jury.

6 **Evidential Issues**

- 6.1 In cases under section 18 and section 20, the prosecutor must be satisfied that there is sufficient evidence to satisfy the evidential stage of the Code test.
- 6.2 The first issue that needs to be addressed is the scientific and medical evidence. As stated in paragraphs 3.5 to 3.7, that evidence may be able to prove that the defendant did not transmit the relevant infection, and it is likely that, in such circumstances, that finding would be conclusive in terms of not proceeding with the matter.
- 6.3 As indicated earlier, the scientific and medical evidence in respect of other infections may indicate that the strain of the infection in the complainant is compatible with the strain of the infection in the defendant. Prosecutors will need to discuss with their expert witness all the ramifications of that finding and have clearly in their minds exactly how far they are able to rely on the scientific and medical evidence to support their case against the defendant. The proximity of the strains of infection in the complainant and defendant and the extent to which the scientific evidence supports other factual evidence in terms of when the infection was allegedly passed will be critical in helping to determine the weight that may be placed on the scientific evidence.
- 6.4 Prosecutors will always have in their minds the fact that the scientific evidence will only be evidence of the fact of infection - not of the identity of the person who infected.
- 6.5 Prosecutors are advised always to have a conference with their scientific or medical expert before reaching a final decision about the strength of the evidence as a whole so that that evidence may be placed in its appropriate factual context.

- 6.6 As scientific and medical evidence alone will be insufficient to satisfy the evidential stage of the Code, it is clear that, before a prosecution may be started, other evidence needs to be obtained.
- 6.7 Prosecutors will be alert to the need to proceed most carefully here. The prosecutor will need to be satisfied that the complainant did not receive the infection from a third party or that the complainant did not infect the defendant. This means that the prosecutor will need to know about any possibility which is compatible with the scientific evidence that the complainant was infected by a third party. This means enquiries will have to be made about the relevant sexual behaviour and relevant sexual history of the complainant. This is extremely sensitive and prosecutors must take enormous care to ensure that the complainant is treated with respect and dignity and is not made to feel any more victimised than they are likely to already. They will need to be made aware of the need to rule out the possibility that they became infected in a different way or by a person other than whom they allege. Not to rule out such a possibility will mean that there will be insufficient evidence to proceed.
- 6.8 Prosecutors must ensure that expert evidence is sought at an early stage in order to determine the likelihood of transmission in any given case, and the possibility of alternative sources of infection, in order to minimise unnecessary and protracted investigations and distress to all parties concerned. In particular, prosecutors must be fully aware of the ways in which the particular infection can be passed between two people. They will also need to be aware of the ways in which individuals can protect themselves against transmission of the particular infection. This information should be obtained from the scientific expert. In this way, prosecutors will be able to guide the investigating officer as to the information they need to elicit from the complainant in order to set the allegation in a factually provable context.
- 6.9 Once a prosecutor is satisfied that they are in possession of sufficient factual evidence to show that the defendant is responsible for passing on the relevant infection and that the scientific evidence is compatible with the allegation, they will need to move on to consider the way in which the element of recklessness may be proved.
- 6.10 In this regard, prosecutors will look for evidence that the defendant 'knew' that they had a sexually transmissible infection and were potentially infectious to others if they engaged in unprotected sexual activity. 'Knowledge' is a matter for the prosecution to prove to the criminal standard of proof and for the jury to decide. Evidence will have to be called and the best, and usual, evidence will be medical diagnosis, that is evidence to prove that the defendant had been tested and had been told of his infection and advised about ways of reducing the risk of transmission to others, and that he or she had understood such advice. But it is possible that, on rare occasions, a person can know that he or she is infected without undergoing the necessary medical tests. This will depend on all the circumstances and will be a matter for the jury to decide. Those who choose not to be tested will not necessarily avoid prosecution for the reckless transmission of a sexually transmissible infection if all the circumstances point to the fact that they knew that they were infected. 'Wilful blindness' by not undergoing testing may be a factor that a jury can take into account when deciding the question of the defendant's 'knowledge'.
- 6.11 Such evidence might be confirmation that the defendant has had a preliminary diagnosis from a clinician who has recommended that they have a formal confirmatory test for presence of the sexual infection but the defendant has failed to act on that recommendation; it might be evidence that the defendant is exhibiting clear symptoms associated with the sexual infection from which it is reasonable for the prosecution to infer that they must know that they have it; it might be evidence that one of their previous sexual partners has since been diagnosed with a sexually transmitted infection in circumstances which the defendant knows that this means that it is only he or she who is likely to have infected their sexual partner. Any of these factual circumstances may be sufficient to allow the prosecution and eventually the court to decide that the defendant did have the required degree of knowledge that should have led them not to take the risk of infecting another person. However, it will only be in exceptional cases that the Crown will be able to rely on 'wilful blindness' as proof of knowledge.

Policing transmission

- 6.12 Prosecutors will need to be aware that proof of knowledge is likely to be difficult. Even in cases where the defendant can be shown to have been told that they carry an infection, prosecutors will need further evidence to show that the defendant understood that he or she too was infectious to other people.
- 6.13 Prosecutors should bear in mind that there may be varying degrees of infectiousness during the cycle of an infection and therefore medical evidence is extremely helpful here and it should also include specific information on the degree of infectiousness of the defendant at the time of the alleged offence.
- 6.14 Prosecutors will also want to bear in mind that people who are informed that they have an infection which may possibly be life-shortening are likely to be in a state of shock at that time, and any further information that is given at the same time may be unlikely to have registered fully with the defendant. In such cases, prosecutors will need to be satisfied that the defendant really did understand that they were infectious to other people, and how the particular infection concerned could be transmitted.

Safeguards against transmitting infection

- 6.16 Prosecutors will need to have a thorough understanding of the means by which people can protect themselves either from passing on an infection during sexual activity or from being infected during sexual activity.
- 6.17 Prosecutors will need to ensure that their expert fully addresses these issues in their statement and in conference. Different considerations apply depending on the nature of the infection involved and prosecutors must be alert to the different forms of safeguards and any differing medical advice that may have been given to the infectious and the previously uninfected person regarding their use during their sexual activity.
- 6.18 Whilst in consensual sexual activity, public health considerations demand that it is the responsibility of both individuals to ensure safeguards are taken to mitigate the risk of transmitting infection, ultimately it is the responsibility of the person who is infectious to ensure that those safeguards are taken and, so far as they are aware, remain operative throughout the entire period of sexual activity when it remains a possibility that their infection might be transmitted.
- 6.19 Evidence that the defendant took appropriate safeguards to prevent the transmission of their infection throughout the entire period of sexual activity, and evidence that those safeguards satisfy medical experts as reasonable in light of the nature of the infection, will mean that it will be highly unlikely that the prosecution will be able to demonstrate that the defendant was reckless. Although infection can occur even where reasonable and appropriate safeguards have been taken, it is also of course possible that the infection took place because the safeguards and/or their usage or application were inappropriate. However, prosecutors will need to take into account what the defendant considered to be the adequacy and appropriateness of the safeguards adopted; only where it can be shown that the defendant knew that such safeguards were inappropriate will it be likely that the prosecution would be able to prove recklessness.
- 6.20 The extent to which safeguards remain effective during sexual activity will need to be considered by the prosecutor if the issue arises as a matter of fact. Clearly, the issue of recklessness only arises in circumstances where the defendant has not informed the complainant of their infectious status. When the safeguards cease to be operative, it is for the defendant to disclose their infectious status to the complainant, so that they can choose whether to assume the risk [R v Dica] and thereby provide a defence to the defendant.
- 6.21 Each case however will have to be considered on its merits, and prosecutors will need to take a reasonable and practical view about the extent to which recklessness remains provable in circumstances where the defendant took appropriate safeguards which in the event proved to become inoperative during sexual activity.

7. **Attempt to Commit Section 20 Grievous Bodily Harm**

- 7.1 It is not possible to attempt to commit an offence contrary to section 20 Offences against the Person Act 1861. Therefore, a prosecution cannot be brought for this offence unless transmission has actually taken place. It is not sufficient for a person to be put at risk of being infected by a partner who failed to disclose their medical condition.

8. **Rape**

- 8.1 A person who does not disclose the fact that they have a STI and then has consensual sexual intercourse with another without informing that person of their infectious state, is not guilty of rape (R v B [2006] EWCA Crim 2945, CA).

9. **Sexual Transmission of an Infection as an Aggravating Feature of Another Sexual Offence**

- 9.1 The sexual transmission of an infection may be the consequence of the defendant committing a serious sexual offence on the complainant, such as rape or sexual assault. The Sentencing Guidelines Council has indicated that where an offender knows that he or she has a sexual infection and commits a sexual offence on another, that fact can be taken into account as an additional aggravating factor for sentencing purposes. (Definitive Sentencing Guideline - Sexual Offences Act 2003, published 30 April

(http://www.sentencing-guidelines.gov.uk/docs/0000_SexualOffencesAct1.pdf).

10. **Public Interest Issues**

- 10.1 Where the prosecutor is satisfied that there is sufficient evidence to meet that stage in the Code for Crown Prosecutors, they must carry on to consider the public interest. The relevant considerations to be borne in mind are set out in the Code.

11 **Complainant and Witness Care Issues**

- 11.1 By its very nature, the sexual transmission of infection takes place during the most intimate of activities. Notwithstanding the physical impact that this form of grievous bodily harm may have on them, complainants are likely to have to attend court to give their evidence.
- 11.2 Prosecutors must do everything in their power to make sure that those who are infected do not become complainants twice over - once through the actions of the defendant and once more through the requirements of the criminal law for the prosecution to prove its case. Prosecutors should always have in their minds the traumatic circumstances in which the complainants find themselves: this may include coming to terms with the fact that someone well known and close to them has transmitted a possibly life-shortening infection to them. This in turn could have resulted in the breakdown of their relationship and disrupted the complainant's social, domestic and working life in a way that may cause them not to want to add to their situation by having to give evidence and face the prospect of cross-examination of their sexual behaviour.
- 11.3 As a result, the prosecutor may well arrive at a position whereby the complainant decides that they no longer wish to give evidence in any court case.
- 11.4 The prosecutor's duty is of course to the public interest rather than to the interest of any one individual and they will want to bear in mind that s18 and s20 offences are serious.

- 11.5 Where before trial the complainant indicates that they no longer wish to give evidence, the prosecutor will first consider whether it is possible for the prosecution to continue without the complainant. At the same time, the prosecutor will instruct the police to take a statement setting out why the complainant does not any longer wish to give evidence. The key issue is whether the decision to withdraw support from the prosecution is voluntary or as a result of pressure being brought to bear on the complainant.
- 11.6 Depending on the reason for the complainant's decision, prosecutors will need to consider whether it is appropriate to ask the police to conduct further enquiries with a view to instituting charges against the defendant or a third party.
- 11.7 Prosecutors should keep all possible options open for continuing with the prosecution – including the possibility of requiring the complainant to give evidence, and the possibility that the relevant provisions under the Criminal Justice Act 2003 may be invoked.
- 11.8 Prosecutors must ensure that the complainant is aware of the special measures that can be applied for at court to provide a more secure environment in which the complainant may give their evidence.
- 11.9 A combination of these factors may help in persuading the complainant to continue to want to give evidence for the prosecution.
- 11.10 Ultimately, prosecutors must ensure that the standards of witness and complainant care as set out in the Victim's Code and Prosecutors' Pledge are adhered to.

12 Internal Procedures

- 12.1 As these offences are highly sensitive and to ensure consistency of approach, all cases in which a charge of intentional or reckless sexual transmission of infection might be preferred should be notified to the Director's Principal Legal Advisor through the Area's Head of the Complex Casework Unit [where there is one] or through the Chief Crown Prosecutor where there is not. This includes cases where the local prosecutor does not consider there to be sufficient evidence. The reviewing lawyer must provide a synopsis of the evidence and a recommendation regarding the appropriate course of action to take which must be considered and endorsed by the CCU Head or CCP.
- 12.2 This procedure will be reviewed before the expiry of 12 months from the date of this guidance.

7.3 Further information links, useful organisations and websites

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Head office:
314-320 Grays Inn Road
London WC1X 8DP

T: (020) 7812 1600
www.tht.org.uk

THT Direct: 0845 1221 200

THT is the UK's national and local provider of HIV and sexual health services, including information and advice, testing, health promotion and support on legal issues from our 34 regional offices and THT Direct, national phone line.

NAT

New City Cloisters
196 Old Street
London EC1V 9FR

T: (020) 7814 6759
F: (020) 7216 0111
www.nat.org.uk

NAT is the UK's leading charity dedicated to transforming society's response to HIV. We provide fresh thinking, expert advice and practical resources. We campaign for change. Shaping attitudes. Challenging injustice. Changing Lives.

NAM/Aidsmap

Lincoln House
1 Brixton Road
London SW9 6DE

T: (020) 7840 0050
F: (020) 7735 5351
www.aidsmap.com

Provide high quality information on HIV and related issues including "Criminal HIV Transmission" aimed at educating the justice system on HIV.

Crown Prosecution Service Policy Team

50 Ludgate Hill
London
EC4M 7EX

T: 020 7796 8000
www.cps.gov.uk

African HIV Policy Network

New City Cloisters
196 Old Street

T: (0) 207 017 8910
F: (0) 207 017 8919
Email: info@ahpn.org
www.ahpn.org

AHPN is an alliance of African community-based organisations working on HIV in the UK.

George House Trust

77 Ardwick Green North,
Manchester
M12 6FX

T: 0161 274 4499
Email: ght@ght.org.uk
www.georgehoustrust.org.uk

HIV organisation for North West England.



POLICING TRANSMISSION

NE HIV CRIME SCENE

SCENE HIV CRIME SCENE

The HIV and sexual health charity for life

Website: www.tht.org.uk THT Direct: 0845 12 21 200

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Design Felton Communication 020 7405 0900 Ref: 11114