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Re: BHIVA reply to the Crown Prosecution Service draft policy for prosecuting cases involving sexual transmission of infections which cause grievous bodily harm

The British HIV Association (BHIVA) is grateful for the opportunity to comment on the Crown Prosecution Service (CPS) draft policy for prosecuting cases involving sexual transmission of infections which cause grievous bodily harm, including HIV.

BHIVA is a national organisation committed to excellence in the care of HIV-infected individuals. Membership is multidisciplinary and includes doctors from a wide range of specialities involved in HIV/AIDS, pharmacists, clinical psychologists and other professions allied to medicine. BHIVA has partnerships with the Children's HIV Association of the UK and Ireland (CHIVA), National HIV Nurses Association (NHIVNA) HIV Pharmacy Association (HIVPA) and Dieticians in HIV/AIDS Group (DHIVA). Patients and patient organisations are also represented within the Association. BHIVA's activities include educational conferences, provision of national clinical treatment and adherence guidelines, clinical audit, and publication of an academic journal, *HIV Medicine*.

Members of BHIVA work directly with people who fall within the scope of the proposed CPS policy and have extensive experience of the needs and concerns of people affected by, and infected with HIV.

BHIVA understands that the CPS wishes to issue a clear statement that the intentional or reckless sexual transmission of infections including HIV is not acceptable, and that the CPS will, where it considers it appropriate, prosecute individuals through the criminal courts. Reflecting both patients' and clinicians' anxiety and confusion, BHIVA wishes to draw attention to the fact that this process is running in parallel with the Department of Health policy consultation on disclosure of information and sexually transmitted infections (STIs), including HIV. Clarification on the separate nature of these processes would be helpful and clearly each may inform the other.

This reply is structured around the questions raised in the consultation document, and focuses on medical and medical-legal aspects of the policy.

1) *What relevance, if any, should be given to the defendant's reliance on medical/clinical advice that he/she received?*

- a. BHIVA wishes to express concern that the CPS appears to consider that lack of a clear understanding of HIV infection and its transmission could be construed as an adequate defence against a charge of reckless transmission. The risk of HIV transmission in any particular circumstance is not absolute and depends on multiple factors relating to both the 'donor' and the 'recipient'. The science is not black and white and, importantly, the advice given to patients is likely to have evolved over time reflecting scientific advances and changes in the patient. For example, there is a small but definite risk of HIV transmission during unprotected oral sex even if condoms are used for vaginal/anal penetration. Patients are usually told that risk of transmission through oral sex is "minimal". Furthermore, they are generally advised that the risk of transmission is "lower" if no ejaculation occurs. Patients are also made aware that successful antiretroviral therapy "significantly reduces" the risk of transmission. At the same time, couples who wish to conceive may be given advice about ways of "minimising" the risk of transmission if they do decide to engage in unprotected intercourse. Language and education level will substantially influence the way in which the advice is understood and interpreted.
- b. In general it will be extremely difficult to assess the level of a patient's understanding retrospectively. Relying on clinical records may not clarify whether the advice given was full and appropriate, given that entries are usually brief summaries of discussions rather than a precise, verbatim record of what was said. What will be the health care professionals' legal position if a defendant denies having received "appropriate" information on the risk of HIV transmission? What will be the health care professionals' legal position if no records are available?
- c. If ignorance can be used as a defence, we believe that this will have a serious negative impact on regular clinic attendance and engagement of people with HIV with a range of appropriate services. This serves neither the interests of the individual, nor those of the wider HIV infected population. Indeed people with untreated HIV are likely to be more infectious to others and this may be of detriment to the general UK population.
- d. There may be several possible routes of HIV transmission between sexual partners, including, but not limited to, sexual intercourse. Contact with infected blood or other infected body fluids (e.g., semen) may occur through accidental injuries or through an open wound or splashes in the

eyes or the mouth. Once the infection has occurred there is no way of determining the route of transmission. How will the prosecution deal with this uncertainty?

- 2) *When determining whether it is in the public interest to prosecute what weight, if any, should be given to a defendant's limited ability to ensure use of protection?*

BHIVA wishes to caution CPS about over-reliance on a history of condom use. Published evidence indicates that histories of condom use are often unreliable. This also impacts on the overall validity of estimates of condom effectiveness (Sexually Transmitted Diseases, 2004;31:588-95). Nonetheless, BHIVA agrees that the ability of a defendant to ensure protection should be taken into account when assessing responsibility, in the context of cultural and social determinants of sexual behaviour.

- 3) *Should the context in which sexual behaviour occurred be a relevant factor when determining whether it is the public interest to prosecute; and if so, why?*

For years the ethos of the medical advice and public health campaigns has been that responsibility for HIV transmission is shared. Nearly all persons having sex also know that HIV is sexually transmitted. In addition, HIV-negative persons who are perceived to be at risk receive counselling about risk reduction when they access health services. Engaging in unprotected sexual intercourse with casual partners is a recognised risk factor for the acquisition of STIs, including HIV. There is also widespread awareness that in England and Wales the risk of HIV infection is particularly high for certain behaviours (e.g., unprotected anal intercourse). The current understanding is therefore that there must be a balance between the defendant's and the complainant's level of responsibility. It is BHIVA's view that it is not the sole duty of the person with diagnosed HIV to ensure that consensual sex occurs with protection (International Journal of STD & AIDS 2006; 17: 315-8), and epidemiological, social and behavioural factors must be taken into account in determining the level of responsibility.

- 4) *Should the defendant's age, vulnerability or understanding of the nature of the infection be relevant to the public interest considerations?*

BHIVA believes that these factors should be taken into account, although as discussed above it may be difficult to ascertain retrospectively the level of understanding at the time of the alleged transmission. It is likely to be against the public interest to prosecute in general, and especially the very young, ethnic minorities and other vulnerable groups, as this will increase fear of stigma, potentially reduce the uptake of HIV testing and access to healthcare and ultimately result in an increased risk of HIV transmission.

- 5) *Are there any other relevant public interest factors that should be taken into considerations?*

1. There is growing disquiet among clinicians that regarding HIV transmission as a possible criminal act will impact negatively on not only the individual but

also the HIV-infected population at large, acting against the public interest. In particular, BHIVA wishes to express concern that:

- a. Criminalisation will impact negatively on efforts to de-stigmatise HIV infection. Public health officers have called for increasing efforts to de-stigmatise HIV infection allowing more people to be tested early in the disease process. Early diagnosis of HIV infection benefits the individual by ensuring that appropriate treatment is started before the onset of life-threatening disease. It also benefits the population at large as persons with a diagnosed HIV infection can be counselled about risk reduction. Furthermore, effective treatment reduces the risk of HIV transmission to others by lowering the amount of virus present in blood and genital tract.
 - b. That ignorance of HIV status would represent an adequate defence. If persons who are infected but remain undiagnosed can transmit HIV with impunity before the law, criminalisation will reduce testing as a way of circumventing the issue of disclosure. This may be especially relevant for persons who engage in high risk sexual practices and therefore perceive themselves as being at risk of HIV infection. It has been estimated that at least a 25% reduction in HIV testing may occur, which could lead to a parallel rise in HIV transmission.
 - c. Surveys of persons with HIV have indicated that nearly half would be less frank in their discussions with health care professionals for fear of criminalisation, which will negatively affect the way people with HIV engage with health services, potentially reducing clinic attendance and opportunities for counselling on risk reduction and appropriate management of the infection.
 - d. Partner notification, and therefore diagnosis of new cases earlier in the disease spectrum, is likely to be less successful if there is a perceived threat of prosecution.
2. BHIVA would like to pose the questions:
- a. What is the CPS position about the start of responsibility? Is it to be the date of first ever HIV positive test, or could there and should there be a retrospective assessment of when the alleged source first suspected that he/she might be infected?
 - b. What will be the difference between not having been diagnosed with HIV and not wanting to know about a possible infection in persons that engage in high risk practices?
 - c. If this must not be seen as an HIV specific law, how will it apply to other STDs?

- d. How will the law apply to persons who share paraphernalia for intravenous drug use?
3. BHIVA would like to draw attention to the reliability of scientific evidence. This is crucial given its great potential weight on the outcome of prosecutions. The reliability of virological investigations (“phylogenetic trees”) to prove HIV transmission must be addressed in some detail. BHIVA believes that the CPS and courts should be made fully aware of the limitations of phylogenetic trees before using such evidence as conclusive or even suggestive of transmission between two individuals.
 - a. Phylogenetic trees are used to determine relationships between virus strains, usually in the context of research on populations rather than individuals. As a result, for scientific purposes the building of phylogenetic trees can and does tolerate a certain degree of approximation and error.
 - b. Phylogenetic analyses are generally carried out in research settings rather than forensic laboratories. Sample tracking is likely to be less robust and errors may occur.
 - c. The correct interpretation of the phylogenetic trees is closely related to the size and source of the dataset analysed and in particular to the source of the “control” sequences (i.e., the other branches of the tree) included in the dataset. To allow appropriate interpretation of phylogenetic trees, controls should be drawn from an epidemiologically relevant context and ideally from the same geographical origin, social context and potential transmission network as the parties under investigation. In addition the controls should be collected around the time of the alleged transmission event. This is crucial in the setting of the often complex sexual networks that exists among homosexual men. It will be in most cases difficult and often impossible to obtain samples from the appropriate controls. As a result, interpretation of the findings will have to be cautious. Using inappropriate controls will emphasise any relatedness detected between two viruses as strikingly unique. However HIV sequences may be shared by more than two individuals if they are part of a wide transmission network. For example, phylogenetic analyses of HIV sequences obtained in 1999-2003 from British homosexual men showed six large groups of related viruses, each group comprising between 26 and 62 related viruses (Proc Natl Acad Sci U S A. 2005; 102:4425-9).
 - d. Even with the appropriate controls, phylogenetic trees cannot prove transmission. They are reliable in excluding transmission. When results of simple phylogenetic trees show a relationship between two parties however, they do not exclude the possibility of infection by a common party, infection of one by the other via several third parties, or

superinfection of one by the other directly or via third parties. All of these circumstances can yield similar results in phylogenetic analyses and very sophisticated virological investigations are required to obtain even an indication of possible direction of transmission.

- e. Given the above considerations, evidence from phylogenetic trees must be seen in the context of the totality of other evidence and never be the starting point of an investigation.

In summary it is BHIVA's view that people with HIV should not be stigmatised and discouraged from testing and accessing medical care as this will affect both the infected individuals and the population at large. We further believe that pursuing people with HIV through the criminal courts will be counterproductive to both public health and clinical endeavours to contain the HIV epidemic in the UK. The clear relationship between treated HIV and reduced infectiousness supports the role of health professionals serving the interest of both the individual and the public. The context of the alleged HIV transmission should be evaluated taking into account personal circumstances as well as the widely publicised information about risk of HIV infection among persons engaging in unprotected sexual intercourse. Confidence on history of condom use should be tempered. Likewise, excessive reliance on scientific evidence should be avoided and the limitations of the scientific investigations acknowledged. Finally there is a significant need for education amongst all clinical staff and patients to understand the constraints and protections of current legislation. BHIVA recognises its role in contributing to this process.

We hope our comments are of value and look forward to hearing from you with the outcome of the consultation in due course.

Yours sincerely

A handwritten signature in black ink that reads "Margaret Johnson". The signature is written in a cursive, flowing style.

Professor Margaret Johnson
Chair
British HIV Association (BHIVA)