Developing guidance for HIV prosecutions: an example of harm reduction?

Extensive discussion of the global trend towards the prosecution of individuals for HIV transmission has tended to focus on arguments of principle for or against such prosecutions. There has been less examination of how, where prosecutions are taking place, the community, the voluntary sector and relevant professional bodies (hereinafter the "HIV sector") can mitigate ensuing harm and maximise fairness and understanding in the criminal justice process. In England and Wales, where prosecutions for reckless HIV transmission have been taking place since 2003, the HIV sector persuaded the Crown Prosecution Service (CPS) to consult on the production of Legal Guidance for CPS prosecutors and caseworkers (hereinafter "Guidance") in this area of law, as well as an accompanying Policy Statement.[1] In this article, Yusef Azad describes both the process and the outcome, and attempts an initial assessment of whether this intervention has benefited people living with HIV.[2]

The law in England and Wales in relation to prosecution of HIV transmission

In an earlier article for the HIV/AIDS Policy & Law Review, Matthew Weait and I set out the application of the law in England and Wales to HIV transmission as it had emerged from the four cases which had at that point come to court and, in particular, as had been set out in two Court of Appeal judgments.[3] In summary, since 2003, Section 20 of the Offences Against the Person Act 1861 (OAPA 1861) has been used to prosecute reckless HIV transmission as serious bodily harm. To date (March 2008), there have been 13 prosecutions under Section 20, 10 of which have resulted in conviction and three in acquittal. Prosecutions for intentional transmission are also possible under section 18 of the OAPA 1861, but none has as yet taken place.[4]

The Court of Appeal made clear that HIV infection was a serious harm; that causing such harm whilst aware of the risk of so doing constituted recklessness; that a possible defence was that the person infected had consented to the risk of that infection occurring; but that such consent could not be inferred simply from the fact of having unprotected sex, but rather had to be on the basis of the infected person's specific knowledge of the defendant's HIV-positive status.

The two Court of Appeal judgments left many key questions unanswered for people living with HIV, faced for the first time with the prospect of police investigation and possible prosecution if they passed on HIV to another person. Amongst the areas of concern and uncertainty were: What sort of sexual behaviours will the courts consider "reckless" for the purposes of HIV transmission? Is condom use a defence? Can transmission of other infections be prosecuted or is this only about HIV? What knowledge of one's HIV status and infectiousness is necessary for one to be considered reckless (the second man convicted had never had an HIV test)? Is exposing someone to the risk of HIV transmission a crime?

In July 2004 the National AIDS Trust (NAT) and the Terrence Higgins Trust (THT), two key NGOs in the U.K. HIV sector, convened a seminar to discuss how the sector might best respond to the prosecutions. Participants included community activists, voluntary sector representatives, clinicians, academic researchers and lawyers. There was particular concern about the many issues where there was no clarity as to how the law applied. This is not surprising given a nineteenth-century law was being used to prosecute these cases, a law which had certainly not been drafted with HIV (or any other disease) transmission in mind.

Guidance for clinicians, for HIV support organisations and for people living with HIV were all identified as priorities, as was engagement with the media. But clarity as to the detailed circumstances of prosecutions could only be secured from the CPS itself. There was agreement that the CPS should be approached with

a request for clarity and guidance in this area of law.

By contrast, there was at the seminar, and there continues to be in the HIV sector, wariness about attempting to persuade Parliament and government of the need to amend the law and end prosecutions for the reckless transmission of disease. Newspapers reported in 2006 that the Labour Government had in its then nine years of power created over 3000 new criminal offences, twice the number of the previous Tory administration.[5] The fashion, in other words, is not to decriminalize anything, and there was a consensus that inviting legislative review of HIV transmission carried a serious risk in the current political climate of making matters worse rather than better.

Consultation process

Recent CPS practice encouraged a view that there might be willingness to work with the HIV sector on guidance for prosecutors in this new area of law. Since 2002, a process of public consultation by the CPS, with the support also of an expert working group of "practitioners," had been used to agree policy and guidance in a number of areas of social sensitivity, including homophobic crime, domestic violence, and racial and religious hatred.[6]

Initial attempts to persuade the CPS of the importance of the issue met with no success. This changed in October 2004 when the chief executives of NAT and THT wrote directly to the Director of Public Prosecutions, head of the CPS, drawing his attention to this new area of prosecution, the fact that the first three people convicted were all African migrants, the social vulnerability of the communities most affected by HIV in the UK (gay and African), and the need to ensure prosecutions were conducted in a non-discriminatory manner and with a good understanding of the biological and social facts around HIV.

The letter was very deliberately copied to the Chair of the Commission for Racial Equality. This brought a prompt response and a commitment to engage with the HIV sector in a consultation process to identify appropriate policy and guidance for prosecutors.

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The process had all of the key elements which, according to the CPS, attend all their consultation exercises of this sort — a working group was established with key community stakeholders; it was made clear that the final policy and guidance would be that of the CPS alone, albeit "community informed"; a draft of the policy and guidance was produced for discussion and refinement within the working group and then sent out for a three-month public consultation process; qualitative exercises were held to complement the discussion process;[7] based on the consultation responses, a revised draft was produced for further discussion with the working group; and the policy and guidance was submitted to the Director of Public Prosecutions and Law Officers for final clearance, and then publication.

The working group for this consultation process included, from the HIV sector, representatives from NAT (the author), THT, the U.K. Coalition of People living with HIV and AIDS, the African HIV Policy Network and a senior clinician representing the British HIV Association. In addition, there were a number of CPS officials, someone from the Metropolitan Police, and representatives of both the Ministry of Justice (the department's current title) and the Department of Health. The group worked both through meetings and email correspondence. Four meetings were held in total — three in advance of the public consultation and one soon after the consultation period had closed.

Two points should be stressed. First, the final policy and guidance was the responsibility of the CPS alone. The HIV sector advised and persuaded but, in the end, were not asked to agree any policy or guidance. This was important. The representatives from the HIV sector on the working group are all opposed in principle to the prosecution of reckless HIV transmission. It is one thing to advise on prosecution guidance to minimise harm and quite another to own and author it. Any requirement to agree would have produced no end product at all, and thus an opportunity to influence for the better would have been lost.

The second point is that the CPS could not question the interpretation of the law as set out in the two Court of Appeal judgments. There is a "public interest" test for prosecutions, and there were early attempts

to argue that given the claimed pubic health harm, it was not in the public interest to prosecute at all. It became clear, however, that the public interest test was in relation to whether or not a given individual should be prosecuted and was not about giving the CPS an effective public policy discretion to overrule the courts and Parliament. Inevitably, engaging the CPS on guidance for prosecutors meant managing expectations within the HIV sector — i.e., this was never going to be about ending prosecutions.

One of the earliest points made to the CPS was that it was discriminatory to single out HIV transmission alone for prosecution and not any other serious communicable disease. The CPS agreed to include within its terms of reference the sexual transmission of any serious infection. Thus, ironically perhaps, the result of the HIV sector's concern that HIV should not be stigmatized was that the CPS developed guidance for the prosecution of a wider group of infections, broadening the scope of the consultation. (There has not yet been a prosecution for any infection other than HIV.)

The public consultation itself, which took place from September to November 2006, excited great interest and resulted in over 60 submissions, almost all of which set out arguments against prosecutions for HIV transmission and identified issues that had to be borne in mind in any prosecution. Although it was not in the CPS's power to end prosecutions completely, in my view the arguments against prosecutions were not wasted. I believe that the force of these arguments helped to secure a minimal take on the scope for prosecutions.

A key development which occurred during the course of the consultation was the growing disquiet with respect to how scientific evidence and, in particular, phylogenetic analysis had been used by the prosecution ostensibly to "prove" responsibility for infection. The first effective challenge from an expert virologist to this misuse of evidence took place in August 2006 in a case at Kingston Crown Court and resulted in the first acquittal in one of these cases. In February 2007, NAT with NAM[8] and a number of the experts involved published "HIV Forensics," which set out the value and limitations of phylogenetic analysis in prosecutions for reckless HIV transmission.[9]

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In response, the CPS also established a separate clinicians working group. This group made an important contribution, both confirming the arguments made on the limitations of the scientific evidence but also making helpful points including, for example, on the need to be aware of varying stages of infectiousness and on the shock of diagnosis undermining the ability to understand fully behavioural messages. Of course, such points had been made by others, but a doctor's voice caries weight and there is real value of making as much common cause as possible with HIV clinicians in addressing prosecution issues.

Whilst normally the published government response should have occurred three months after the close of the consultation period (which would have been March 2007), the CPS actually spent most of 2007 deliberating internally on the consultation responses and the evidence from the clinicians working group. It was only in the Autumn of 2007 that a new draft emerged for consideration by the community working group.

It was immediately apparent why the process had taken so long: The documents had been completely rewritten. They were, however, much improved, and input from the working group in the final months resulted in the vast majority of the group's suggestions being accepted and included. The Guidance document and the Policy Statement were published on 14 March 2008 on the CPS website.

Content of the Guidance

The CPS concluded that attempting to set down detailed criteria for prosecution for all possibly relevant sexually transmitted infections, with their varying degrees of seriousness and modes of transmission, was impossible. As a result, the Guidance is generic — the reader will note immediately that neither HIV nor any other infection is mentioned by name.

The following is a discussion of some of the key issues addressed in the Guidance. Readers are encour-

aged to go directly to the two CPS documents in question to consider their content in more detail. Whilst the interpretation in this article is the author's alone, it reflects the shared initial understanding of the CPS documents amongst colleagues in the HIV sector. It remains to be seen whether prosecution practice will be consistent with this interpretation.

Scientific evidence and infection

The Guidance makes clear that in all cases, and even where the defendant is thinking of pleading guilty, scientific evidence is crucial to determine the likelihood of the defendant having infected the complainant. Early cases had involved guilty pleas and convictions without any corroborative scientific evidence of the defendant's responsibility for the complainant's infection. The requirement that evidence must always corroborate even a guilty plea for either reckless or intentional infection is an important provision.

Even where a close match between the two samples is demonstrated, there may be other explanations for what happened — for example, the complainant could have infected the defendant, or they both could have been infected by a third party. Thus, the Guidance requires that even where samples are closely linked, other evidence needs to be obtained, for example detailed sexual histories of the complainant as well as the defendant, to prove the likelihood that the defendant was responsible for the complainant's infection.

The Guidance states that scientific evidence can demonstrate that the defendant was *not* responsible for the complainant's infection. Whilst the Guidance does not explicitly state this, the relevant scientific evidence in relation to HIV will ordinarily be phylogenetic analysis of HIV samples from complainant and defendant.

In summary, the scientific evidence alone cannot conclusively prove the responsibility of the defendant for the complainant's infection, but it has to be part of any prosecution case. This position might be somewhat paradoxical, but it reflects both the importance and the limitations of the scientific evidence, and has been central to the recent decline in the number of cases going to court and the recent increase in acquittals.

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Knowledge and recklessness

The second case prosecuted in England involved the conviction of someone who had not had an HIV test but had been informed by his wife of her own HIV-positive diagnosis and of her doctor's advice that he also be tested. This raised the question of what knowledge was required for someone to be prosecuted for recklessness in transmitting HIV.

The Guidance contains a strong subjective test of knowledge as it relates to recklessness — "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." The implication is that someone who "should" or "ought to" have known" that they were or could be infected cannot be prosecuted when actual, subjective knowledge of infection is absent.[10]

The Guidance states that the "best, and usual, evidence" of such actual knowledge is a medical diagnosis — i.e., "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."

An important argument used by many in the HIV sector against prosecutions was the possible deterrent effect of prosecutions on willingness to test for HIV, if criminal liability was so closely linked to diagnosis. The CPS notes in its introduction to the Policy Statement that "the strong public interest in encouraging testing amongst those who may be at risk from any sexually transmissible infection". The Guidance states that "[t]hose 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."

In the Guidance, the examples given of knowledge without diagnosis — or "wilful blindness" as the CPS perhaps unhelpfully terms it — include "where the defendant has 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." Other examples where knowledge could be present in the absence of diagnosis are "clear

symptoms associated with the sexual infection" from which knowledge could reasonably be inferred, or the diagnosis of a sexual partner who could only have been infected by the defendant.

The Guidance emphasises, however, that such cases without diagnosis will be "rare" and "exceptional." It is important to be clear that these examples of knowledge without diagnosis are not instances of "should" or "ought to" have known. The prosecution still has to prove actual, subjective knowledge by the defendant of his/her infected status. Whether this could ever be proved in a court of law in the absence of a diagnosis may be open to doubt. But this is nevertheless one issue to watch with care.

The discussion of knowledge in the Guidance was clearly influenced by submissions from the HIV sector. The Guidance requires not only evidence of a diagnosis having been delivered but of it having been understood. Referring to the shock of a positive diagnosis and the difficulty in understanding all that may then be communicated, the Guidance states that "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"; and that "proof of knowledge is likely to be difficult."

In summary, the emphasis on proof of subjective knowledge of infection and infectiousness, and the acknowledgement of some of the social factors which compromise such knowledge, result in a high evidential threshold for prosecution. As the CPS states in the introduction to the Guidance, "The criminality of the offending lies in the *mens rea*. This means that the relevant offences will be difficult to prove to the requisite high standard…."

Behaviour and recklessness

The Guidance states that "recklessness" means the defendant foresaw the risk of infection to his or her sexual partner but still went on to take that risk, and did so unreasonably. The requirement of subjective knowledge is thus complemented by a more objective evidential requirement linked to the concept of "reasonableness." There is a theoretical and remote risk of infection from a very wide range of sexual behaviours but in many cases, whilst foreseeable, the risk is so low as to make taking that risk reasonable. For an objective view of which behaviours involve a relevant degree of risk to possibly be prosecuted, the Guidance refers the prosecutor to "current scientific advice regarding the need for and use of safeguards."

One important result of keeping the Guidance at this generic level is the absence in the document of any explicit statement as to what sexual behaviour would constitute recklessness in relation to HIV transmission. Instead, the prosecutor has to ensure that s/he understands the nature of the sexual infection in question, how it is transmitted, the varying degrees of infectiousness possible, and the place of "appropriate safeguards" in preventing transmission risks. In all these areas the prosecutor should get advice from an expert.

There are undoubted difficulties in this approach for those who wanted clarity from the CPS. The judgement for the purposes of prosecution as to whether a particular behaviour was reckless or a particular safeguard appropriate is one for individual experts and prosecutors.

It appears that the expert would ordinarily be a clinician. Whilst clinicians might be able to provide expertise on degrees of risk, it is not necessarily the case that they have a single or objective view as to what behaviour might be reckless, a very different sort of judgement. There is the possibility of both prosecution and defence calling clinicians as expert witnesses to argue the point, and of inconsistency of approach. We still do not know, for example, whether a prosecution might be attempted for HIV transmission from oral sex.

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It could be argued, on the other hand, that the lack of stipulation, whilst not excluding any behaviour from prosecution, does not unequivocally include any behaviour either — i.e., we have avoided an unhelpful list which puts beyond doubt that a particular behaviour will be deemed reckless. This allows for development in scientific understanding and consensus, and also for a nuanced approach which could take more account of risk reduction or different stages in infectiousness. It could even be argued that the CPS have effectively given back to the HIV

sector the responsibility to establish the consensus as to what constitutes behaviour with a serious risk of harm.

Safeguards as a defence

As striking as the absence of the word "HIV" from the Guidance is the absence of the word "condom." Again, this arises from the decision to provide generic advice applicable to the range of sexually transmissible infections. It is possible that the term "safeguard," which is used in the Guidance, might be interpreted to mean not only a device or technology but also an aspect of behaviour which reduces risk. The main kind of safeguard in relation to HIV will nevertheless be the condom.

The Guidance states that evidence of consistent use of safeguards (read condoms) will make it "highly unlikely that the prosecution will be able to demonstrate that the defendant was reckless" even though infection has nevertheless occurred. This statement, which is effectively about condom use as a defence against prosecution, is, of course, very welcome, and reinforces public health messages. The Guidance goes on to state that even if the safeguard employed is inappropriate or incorrectly used, "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."

Other issues

The Guidance restates the position of the Court of Appeal that a possible defence is that the person infected (the complainant) had consented to the risk of that infection occurring. This involves specific knowledge of the defendant's HIV status when the HIV transmission took place. But the Guidance makes clear that whilst disclosure would be the most usual way for the complainant to be informed, there are other routes for the information, such as from a third party, a hospital visit or "the appearance of sores" — and this is clearly not an exhaustive list.

With respect to intentional transmission, the Guidance states that an offence of "attempted intentional transmission" is possible, but also explicitly says that there is no offence of "attempted recklessness." In other words, there is no crime of recklessly exposing someone to the risk of HIV transmission. Nor is someone guilty of rape who has consensual intercourse without disclosing his/her infection.

There is no guidance on the sensitivities around the application of the law to young people living with HIV reaching adolescence and becoming sexually active. As well, there is only a brief, and inadequate, account of how the law applies in cases of condom breakage during sex.

Next steps

The CPS is requiring that its local offices refer these sensitive cases to headquarters, which should establish some expertise and consistency. There is also to be a review of the Guidance and Policy Statement in a year's time, which will be an opportunity to revisit uncertainties or continuing concerns.

A seminar for the HIV sector is being jointly organised by NAT and THT to discuss collective understanding of the CPS documents and next steps. There is clearly a need to communicate to individuals, professional bodies and organizations the implications of the Guidance. Tailored resources will need to be produced for different audiences. Given the significant role envisaged for expert clinical evidence, it will be important to review the helpful guidance on prosecutions produced for clinicians in March 2006.[11]

Also important will be to work with police forces to establish some consistent best practice in the investigation of these cases. A review is being undertaken of selected cases by the Metropolitan Police and THT to identify examples of both good and bad practice in investigation. NAT will draw on the results of this review to work with the Association of Chief Police Officers on the development of nationally applicable best practice guidelines for police investigation.

Conclusion

Judging success depends a lot on one's initial expectations. The CPS were not in a position to end prosecutions for reckless transmission or disagree with the interpretation of the OAPA 1861 as set out by the Court of Appeal. What they could do — and what they did do — was consider in greater depth, and on the basis of detailed evidence, what is required to prove responsibility for infection, knowledge, recklessness and appropriate use of safeguards. An informed understanding of these elements has, even in the context of current criminal law, resulted in fewer and fairer prosecutions. As the CPS says in its Policy Statement, "[O]btaining sufficient evidence to prove the intentional or reckless sexual transmission of infection will be difficult … accordingly it is unlikely that there will be many prosecutions."

Therefore, we should consider this to be a successful example of policy intervention as harm reduction. It was not without its risks. Success

was due to a number of factors, not least of which was a CPS that was already committed to taking seriously the concerns and experiences of affected communities when considering prosecutions in socially sensitive areas of law. Some jurisdictions will not have such an enlightened prosecution service, and so the HIV sector will need to start further back in terms of engaging with the authorities. But it may be possible, even given the different legal contexts of different countries, to use the CPS Guidance to help bring about improvements in practice elsewhere.

The process was helped immensely by the commitment from an extraordinarily wide range of partners within the HIV sector, encompassing NGOs, academics, clinicians, virologists and, above all, people living with HIV.

Although harm may be reduced, it has not been ended — prosecutions for reckless HIV transmission remain and will continue. There is an urgent need to restate the ethical and policy case against such prosecutions and to consider freshly how and when we might engage with political decision-makers on this issue.

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[1] The Policy Statement' is designed for a general readership; its full title is "Policy for Prosecuting Cases Involving the Intentional or Reckless Sexual Transmission of Infection." Available at www.cps.gov.uk/publications/prosecution/index.html. The Legal Guidance for prosecutors and caseworkers is more detailed; its full title is "Intentional or Reckless Sexual Transmission of Infection." Available at www.cps.gov.uk/legal/section7/chapter_h.html. The two documents contain very similar text. In this article, the Guidance is cited except where the Policy Statement states something additional.

[2] The description is not exhaustive and, in particular, cannot capture the broader and sustained level of community and sector engagement on the issue, which included publications, surveys, information dissemination, challenging stigmatizing coverage and engaging on sentencing policy and on public health law reform.

[3] M. Weait and Y. Azad, "The criminalization of HIV transmission in England and Wales: questions of law and policy," *HIV & AIDS Policy & Law Review* 10(2) (2005): 1, 5–12.

[4] There have been two or three attempts to charge individuals with intentional transmission, but they have never reached the courts.

[5] "Blair's 'frenzied law-making': a new offence for every day spent in office," *The Independent*, 16 August 2006.

[6] See www.cps.gov.uk/publications/prosecution/index.html for documents concerning CPS prosecution policy and guidance.

[7] In this case, the CPS held a wider focus group in December 2005 for people from the HIV sector to feed in to the preparation of the document for public consultation.

[8] NAM (formerly 'National AIDS Manual') is a leading UK HIV NGO which provides treatment and other HIV-related information. See www.aidsmap.com.

[9] NAT/NAM, *HIV Forensics*, 2007, at www.nat.org.uk/document/230; see also, E. Bernard, *Criminal HIV Transmission*, NAM, 2007.

[10] For a helpful account of the English legal context on recklessness, see M. Weait, *Intimacy and Responsibility: The Criminalisation of HIV Transmission* (London: Routledge-Cavendish, 2007), pp.158–160.

[11] British HIV Association, *HIV Transmission, the Law and the Work of the Clinical Team*, 2006, at www.bhiva.org.