Case Study 7
Mitigating criminalisation of HIV transmission: England & Wales

General Information about Case Studies 6/7/8. These studies discuss tackling criminalisation of transmission & exposure in the European region.

Many countries across Europe have seen prosecutions of people with HIV for transmission, exposure or even just perceived exposure of HIV. Laws and responses have varied and are documented in the GNP+ Global Scan. Coverage of prosecutions and changes to the law can be found indexed by country at the HIV Justice Network's database. This set of three interlinked case studies looks at the very different approaches taken by people in three European countries in response to what they saw as the inappropriate use of criminal law to prosecute people with HIV for transmission-related "crimes". While each has an interesting story to tell in its own right, together they illustrate that there may be a number of different paths to tackling an issue, each with its own pitfalls and benefits.

General Criminalisation links:

GNP Global Criminalisation Scan: http://criminalisation.gnpplus.net/node/11
HIV Justice Network website: http://www.hivjustice.net
Global HIV Law Commission: http://www.hivlawcommission.org/index.php/working-papers?task=document.viewdoc&id=90
UNAIDS Policy Brief: http://data.unaids.org/pub/BaseDocument/2008/20080731_jc1513_policy_criminalization_en.pdf
Oslo Declaration on Criminalisation: http://www.hivjustice.net/oslo/
Aidsmap briefing on the issue: http://www.aidsmap.com/law

What was the issue?

England and Wales share a criminal law system. After an unsuccessful earlier charge, the first successful prosecution for HIV transmission came in 2003-4 through reinterpreting a Victorian law on physical assault. Multiple allegations and attempted prosecutions followed, many failing through faulty understanding of the law or of HIV itself but causing distress and fear. There was immense confusion amongst people with HIV, the communities most at risk of acquiring it and the police and Crown Prosecutors (CPS) themselves about what was, or was not, prosecutable.

Why was change needed?

There was widespread concern from leading HIV support organisations that such prosecutions and the media coverage of them increased HIV stigma, discouraged testing and disclosure and reduced joint responsibility for safer sex. It rapidly became clear that confusion about the law was causing considerable waste of police time and personal distress but resulting in very few cases going to court. People were also being induced to plead guilty, in the absence of genuine proof, by defence lawyers who did not understand HIV science. Services supporting people with HIV, including clinics, were confused about their responsibilities and how to act.

How could things be improved?

The movement against criminalisation was growing in Europe and the US at this time (2003-2010). Individual country campaigns chose different tactics. UK activists, believing that law change would take a long time and might end with a more restrictive HIV-specific law due to public attitudes, chose to concentrate their efforts on clarifying and restricting its use instead. They aimed to get clear guidelines from the police and CPS, based on legal precedent and scientific reality, which would mitigate poor practice and reduce prosecutions for all but intentional transmission.

What were the barriers to change?

The biggest barrier was HIV stigma, which meant that many people thought those prosecuted must have "deserved it" for being sexually active. Most of the early prosecutions were of migrants who had the least resources and least public support. There was also widespread ignorance of the facts of transmission and risk. With 43 separate police forces and 13 CPS offices and only light coordination, there was widespread inequity in practices. At the start, there was substantial disagreement between and within HIV organisations and clinician bodies, with some who believed no prosecutions were ever acceptable to others who fully supported them.

How long did change take and who was involved?

From the first successful English prosecution (2004) to the production of guidelines for the CPS (2008) and police (2010) took six years, but work has continued since then to revise the CPS guidance and monitor implementation. From a very early stage a wide group of NGOs, most notably the National AIDS Trust (NAT) and Terrence Higgins Trust (THT) were involved, as were clinicians and all worked with the CPS to produce their guidance. NAT led in producing police guidance with ACPO, the Association of Chief Police Officers, while THT, with a national helpline, collated case reports and produced a review of them with ACPO and Metropolitan Police support. BHIVA, the British HIV Association, produced ethical and practical guidance for clinicians.

How was change made?

Creating consensus: Widespread discussion at sector meetings meant most organisations took a similar line; for reform rather than legislation, against "reckless" (non-intentional) transmission but not "intentional" (malicious and deliberate) and sharing cases to obtain best support. Training sessions supported local organisations to manage cases and understand basic law, while referring actual ongoing prosecutions in to a smaller number of experts.

Documenting cases: From the start, THT logged all criminalisation calls to their helpline and policy team and many other organisations fed in case reports, all of which were collated. The resulting evidence of widespread poor and inequitable management was used in forming police and CPS guidelines, as well as feeding in to research and to online and printed guidance for people with HIV and the organisations supporting them.

Using human rights legislation: Alongside this evidence, the inequity of who was being prosecuted (largely black and ethnic minority people at this stage) convinced the CPS to act, but only after NAT said it would refer the issue to the Equality & Human Rights Commission for investigation if they did not.

Using precedents in good practice: The police agreed to work with THT and community advisors to review their case practice largely because they had already done this with homophobic hate crime, though they were wary of working with an activist community. Similarly, the CPS had already produced guidelines on managing domestic violence so they had a precedent.

***Collaboration not confrontation**:* Apart from NAT's invocation of human rights law above, made when the CPS were initially reluctant to engage, relations throughout with police and CPS were constructive and even sometimes cordial. Individual helpful officers were identified and relationships fostered. This led to NAT and THT being able to comment on CPS training and ongoing practice, and even to being able to flag up individual cases where local police and CPS were not following their own guidance.

***Involving legal expertise**:* Early on, one defence solicitor was used as a primary referral for cases that came through the helpline. He developed strong expertise in the detailed scientific arguments and was the first solicitor to identify the need to challenge the prosecution's doubtful "expert witness" evidence. He worked very closely with the key HIV activists and took over a number of cases where poor defence practice was identified. Case comparison research later suggested that those defendants who used his expert advice had more successful case outcomes overall.

***Using science and data**:* Since the English law only applied to cases where transmission had occurred, phylogenetic (virus typing) evidence became important because it could eliminate suspects. There were persistent attempts by CPS prosecutors to suggest that it could also show a link, but these were comprehensively demolished by defence experts. Court cases struggled to find good defence experts in this field, but this was instrumental in the dismissal or dropping of several cases. The anonymised case data collected by THT and others was used to inform campaigning and training priorities as well as the various guidelines.

***Clarifying confidentiality**:* Early on there were attempts to establish whether clinicians and social workers had a legal duty to report patients suspected of causing transmissions, or just unsafe sexual practices, to police. This would have been very damaging for public health. Considerable debate (and an expensive court case) established no such duty, but this became a central part of guidelines for clinics on the issue from BHIVA. Debates and case presentations on this helped inform doctors and nurses at their professional meetings. On the other hand, a few small support groups were reluctant to ask for help with cases because they feared this breached confidentiality – in one case despite the person concerned already being named and pictured in the tabloid press.

***Sharing information**:* In addition to training and discussion sessions, NAT and THT shared the production of basic information (see link below) on what to do if someone was being investigated and THT ran an awareness campaign so that people with HIV understood the situation, once it was clarified. This alongside information on their websites helped people to avoid and counter malicious or misinformed complaints.

Are there any ongoing issues?

Because the law was not changed, some prosecutions continue and there is a need for constant monitoring of practice to ensure that miscarriages of justice do not take place. Furthermore, it is possible that the CPS may seek to interpret this and other laws in new ways to bring further prosecutions. Guidance will need to be updated regularly in light of new scientific advances e.g. Treatment as Prevention (TasP) and Pre-exposure prophylaxis (PrEP). There is recent evidence of lengthy delays in investigating cases with no realistic chance of conviction and this needs to be tackled by improved police practice.

What lessons have been learnt?

Tackling an issue so complex and stigmatised needed community consensus to move forward successfully. A combination of centralised expertise with local support prevented a number of miscarriages and maintaining good relationships with justice agencies even when there were fundamental disagreements with them enabled change to happen more easily.

Links (see cover sheet for Case Studies 6-8 also)
Clinical guidance: http://www.bhiva.org/documents/Guidelines/Transmission/Reckless-HIV-transmission-FINAL-January-2013.pdf
NAT leaflet:
http://www.nat.org.uk/media/Files/Publications/May_2010_Prosecutions_for_HIV_Transmission.pdf
CPS legal guidance:
http://www.cps.gov.uk/legal/h_to_k/intentional_or_reckless_sexual_transmission_of_infection_guidance/
ACPO evidential flowchart:
http://www.nat.org.uk/Media%20library/Files/Policy/2010/EVIDENTIAL%20FLOWCHART%20HIV%202010.pdf

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