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Understanding the law

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Keeping Confidence is a qualitative research study that explores the perceptions of criminal prosecutions for HIV transmission among those providing support, health and social care services for people with HIV. For further information about the study methods and sample please see Report 1 – *Executive summary*.

This report explores the understanding which participants had about the law relating to HIV criminalisation. This is important for clinical care providers because they may feel it appropriate and / or necessary to explain the law to those who are newly or recently diagnosed with HIV, and for social support providers who may be asked for information, advice or advocacy. The data suggest that although participants had a basic understanding of the conditions for imposing criminal liability, and of the ways in which liability may be avoided, there exists significant confusion. In order to provide some context, we first set out the law as it currently stands (as at January 2013).

CRIMINAL LAW AND HIV IN ENGLAND AND WALES

In England and Wales it is a criminal offence intentionally or recklessly to transmit HIV (or any other sexually transmitted infection) to another person. There is no liability where someone merely exposes another to the risk of transmission (unless there was a deliberate, but failed, attempt to transmit the virus). The prosecution has to prove beyond reasonable doubt that the defendant was the source of the complainant's infection. Where the person to whom HIV has been transmitted consented in advance to the risk of transmission, there is no liability. For consent to provide a defence, it has to be based on actual knowledge of the defendant's HIV infection at the time transmission occurred. In almost all cases that knowledge will be based on the defendant's prior disclosure of status, but there is no independent legal obligation for people with diagnosed HIV to disclose their status prior to sex.

Guidance published by the Crown Prosecution Service advises prosecutors that where a person has taken appropriate precautions against onward transmission (e.g. by using a condom), it is unlikely that recklessness will be established. The Guidance also advises that proving onward transmission may be extremely difficult, especially where the complainant in a case has – or has in the past had – numerous sexual partners.

The scientific evidence that is typically used in prosecutions (phylogenetic analysis) can exclude the possibility that the defendant was the source of the complainant's infection, but it cannot definitively prove that she or he was.

Criminal charges for intentional or reckless HIV transmission are brought under the Offences Against the Person Act 1861 ('OAPA 1861'). To date, the only convictions have been for reckless transmission under section 20 of that Act. A person convicted of reckless transmission may be sentenced to up to five years' imprisonment. The sentencing court may also impose a separate Order requiring the convicted person always to disclose his or her HIV status in advance to potential sexual partners, and / or always to practise safer sex.

PROVING TRANSMISSION

Most participants appeared to know that a prosecution would only succeed where it was proven that HIV transmission actually occurred.

I think the important thing is that transmission actually has to take place. So it is not just about unsafe sex – it is about transmission essentially happening. Somebody has to become positive. (clinical service provider)

Participants also recognised that proving transmission can be problematic, not only because of the diverse range of sexual relationships people have, but because discovering one's status during the course of a relationship with a particular person does not mean that person is the source of your HIV infection.

Another thing is, that just because you were tested first, does not mean you transmitted to the other person. A lot of misunderstanding around that. (community service provider)

The fact that transmission has to take place was not necessarily a source of comfort to people with diagnosed HIV, however. As one clinician explained:

For a lot of our clients and a lot of our patients, they feel that their very sexual activities are criminalised rather than it is the reckless transmission that's the criminalised bit. (clinical service provider)

FINDING FAULT

Under the law that applies in England and Wales, the prosecution will be able to establish that the defendant was reckless if s/he was aware of the risk of passing on HIV to the complainant. Here, recklessness is used in a technical sense, to describe the minimum degree of fault that has to be established by the prosecution. In most prosecutions under the OAPA 1861, where the injury is a wound or a broken bone and where the defendant accepts having caused that injury but denies having done so deliberately, proving recklessness will not be difficult: most of us realise that acts of violence risk harmful consequences.

In the context of liability for HIV transmission, however, the question of what amounts to recklessness is more complicated because most sexual contact carries some degree of risk and the point at which risk-taking becomes criminally culpable is far from straightforward. It is further complicated because it is not necessary for a person with HIV to have been diagnosed as having HIV for there to be a finding that s/he was aware of the risk of onward transmission. As far as the criminal law is concerned to “know” you are HIV infected, is not the same as having received, and understood the implications of, a positive HIV test result.

Recklessness and risk taking

There was wide variety in the way recklessness was understood by participants, and although there was an implicit recognition that it implies conscious risk-taking during sex (which is consistent with the legal definition), many associated it with kinds of behaviour and character traits which are, strictly speaking, irrelevant to a finding of fault. For example, some explained recklessness in terms of “high” partner numbers and / or non-disclosure of HIV infection.

I am just thinking that for someone who knows that he or she is positive, and just knew that he or she were supposed to have protected sex and refuses to have protected sex and does not inform her partners that she is positive, I think she is doing that recklessly. And she is having multiple partners, more than just one or two. That is my understanding. Yes, it might be difficult to prove it, but if somebody engages in that kind of behaviour, I think that's reckless. (clinical service provider)

So the way I understood it was, that the law is defined into an act and a mental state. And the original law applied to intention, which is to intentionally and to wilfully desire to do it. And it's kind of flowed out into recklessness, which is sort of omission, or by not caring, or not caring if you transmit. But not taking reasonable precaution, or by not telling people it's kind of evolved wider than what my understanding about what the original law was meant to be? (community service provider)

In contrast, some appeared to associate recklessness with a failure to heed advice and (although it is a different kind of fault in criminal law) described it in terms of deliberate, repetitive, risk-taking:

Reckless means doing it intentionally, repeatedly and ignoring any advice not to do it, and still putting the other person at risk. (clinical service provider)

These accounts suggest a basic knowledge of how the law actually defines recklessness, combined with a subjective, personal, evaluation of behaviour that is seen as characterising it (which may or may not be legally significant in a technical sense). In short, it was not always possible to determine whether participants were expressing their understanding of the law as it is, or their moral or ethical views on what it should be (such views are discussed further in Report 4), or even if they could differentiate between the two. This raises questions about the extent to which professionals' values should and do influence the way they frame advice to service users about sexual behaviour, and the way they discuss minimising the risk of prosecution.

Knowledge of HIV status

It is not only the behaviour of people with HIV towards others that is relevant to a legal finding of recklessness, but the knowledge they have of their HIV infection. There has been much speculation as to the impact of criminalisation on people's willingness to come forward for testing, the suggestion being that not having been diagnosed as having HIV provides a defence against criminal liability if you transmit your infection. Although there is little empirical evidence to support the claim that criminal law does create a barrier to testing, this was something which participants had direct experience of. One community participant gave the following example:

This happens many times when we go to do outreach to the places where the Latin Americans congregate. They say I'm not interested to know anything about HIV or sexually transmitted infection test, because if I don't know I cannot be punished. So many times the people they just decide not to learn anything about the test, or where to test, or how it works. (community service provider)

A nurse put it a little differently, suggesting that ignorance may enable a patient to have the kind of sex she or he wants, without the need to worry about disclosure or condoms.

We do have patients that that's why they don't test. I had a patient recently who's been active for twenty years, he'd had over 500 partners, and so refused to test because said he would have to disclose. He was negative, but he didn't know that at the time. [...] He didn't want to know, he hadn't kept himself up to date with advances in medicine so, and we said 'you've probably have syphilis, and we can treat that, and you may as well have an HIV test', but his argument was 'well, if I'm told I'm positive, I'm going to have to use condoms and I've never used them, and I've never had gonorrhoea, or anything and actually didn't have anything. He was very lucky. (clinical service provider)

It is not possible to know whether this patient's initial refusal to test was influenced by the law, or – if it was – to what extent. What is clear is that refusal to test by a person who has HIV and who subsequently does pass on HIV to someone else will not necessarily be able to rely on their lack of a positive diagnosis as a defence. The reason for this is that there are two ways in which knowledge is defined for the purposes of a legal finding that the defendant consciously took an unjustifiable risk of onward transmission. The most common is for a person to have a confirmed diagnosis. The second, as some participants recognised, is for a person to be 'wilfully blind' to the fact that she or he may be infected:

There is also the possibility of wilful blindness, so if you wilfully do not find out your status, then you will be prosecuted. If you simply do not know your status, then you will not be prosecuted. (community service provider)

In terms of advice and support, 'wilful blindness' means that clinicians may feel the need to address criminal liability not only when, or soon after, an HIV diagnosis is first communicated, but when the patient refuses a test having presented with a history or symptoms that indicate possible HIV infection. A person who has HIV, but who refuses to acknowledge this despite being advised to test, may be successfully prosecuted – something that clinicians understood in principle, even if the accuracy of their understanding varied. For example, one clinician stated:

It's also not just about patients and people who are known to be HIV positive but also those people who are in high risk category. It's about whether they should be aware of their high risk status and therefore take sufficient precautions. (clinical service provider)

And another said:

If you've got a reason to believe, or someone could assume, they are positive and they decline to test then it is no defence in the law. (clinical service provider)

This conflation of 'risk group' membership with 'wilful blindness' was also expressed in a community setting:

Through case law it's been developing to the point that it has gotten to someone should've known that they were HIV positive [...] but that's never been directly tested – that they should've known – which could potentially cause a lot of problems for African communities and men who have sex with men.

Why?

Because potentially then this 'should have known that' could become a legal test in itself of being from the community that is at high risk of contracting HIV, and therefore anyone from that community who has not tested the last three months should've expected that they'd be seroconverting any time soon. It's kind of homophobic and racist (community service provider)

The law does not make a sub-Saharan African migrant or a gay man with undiagnosed HIV liable for onward transmission merely on the basis that they are members of populations with high HIV prevalence. Rather, what is significant is that a person has actively chosen to remain ignorant of their infection, despite advice to test for HIV.

AVOIDING BLAME

Clinical and social care providers are primarily concerned with their patients' and clients' health and well-being. As this research will show, HIV criminalisation represents, for many providers, a disruptive phenomenon in the delivery and quality of the support they wish to give. If an accurate understanding of, and ability to communicate, the grounds on which prosecutions are brought is seen as an important dimension of care and support, we have seen that this is far from universal. The same is true of participants' understanding of the ways in which criminal liability may be avoided – which is arguably even more important. Such 'prophylactic' advice is made more difficult because the law here is less than straightforward.

We can say for certain that there can be no liability (if HIV is in fact transmitted) where the defendant was neither intentional nor reckless, or where – if there is proof of conscious risk-taking – there was a valid consent to the risk. However the findings above reveal that the meaning of these terms is not completely clear. For example, the Crown Prosecution Service guidance explains that recklessness is unlikely to be established if the defendant used a condom appropriately; but there has been no clarification in the courts on whether a person with an undetectable blood viral load who does not use a condom takes an unjustifiable risk. Research suggests that the likelihood of a person in this category actually transmitting HIV is extremely low, and so a prosecution in England and Wales is extremely unlikely; but viral load can change depending on other infections and treatment adherence. A person may believe that they represent so little risk as to not need to use a condom with a partner, but in fact be infectious. She or he might also believe that there is no need to disclose their status to a partner for the same reason, where doing so (and gaining consent to risk), would protect them from legal sanctions.

These considerations created understandable difficulties for participants in this study. It was recognised, correctly, that practising safer sex could preclude a finding of recklessness:

Where condoms have been used that's been taken as being not reckless. I am not aware that there have been any successful prosecutions of people that have used condoms. (clinical service provider)

Similarly, the contested significance of the emerging scientific consensus (based on studies of those having vaginal intercourse) that a person with diagnosed HIV who is on effective anti-retroviral therapy with an undetectable viral load, and is otherwise healthy, is not infectious – was acknowledged by participants:

The issue I have with that is, at the moment we have a lot of people who are basing their sexual lifestyle on the fact that they are taking antiretrovirals and therefore the risk of transmission is low. So coming back to the recklessness, how do you prove that that was their intention? So they may be coming from thinking they are on treatment and not that infectious. (clinical service provider)

There is now accumulating evidence that being on treatment, having an undetectable viral load and how that reduces the risks and the likelihood of passing it on is really low. Evidence is grey, and we are developing more evidence, more research, to try and find the answer to this. It is almost like there is degrees of recklessness you are describing. And what one person describes as reckless, the evidence can be interpreted differently. I think it is really difficult to make judgements about all sex where you have, you don't disclose, and you are positive, versus how many measures you have taken to not be reckless. (clinical service provider)

The relevance and importance of disclosure raised even more issues. As explained above, there is no legal obligation to disclose one's HIV status in advance to a sexual partner, but the defence of consent (which can be critical if transmission occurs) will almost without exception be impossible to raise if disclosure has not happened. One participant demonstrated his understanding of this when he said:

Based on that, that is where I go with my casework, that the only way you can be safe from the law is if you are completely honest with people, and telling any person you are having any sexual contact with about your status, because that's the only way that that person can fully consent and they can never have any comeback. (community service provider)

Another, however, was unsure. When asked if there was a legal obligation to disclose, she suggested:

I thought there wasn't a legal obligation to disclose as long as you're – as long as the positive person is having 100% safe sex, and if there's a condom accident they advise the person to have PEP [...] I don't know if that's right. (clinical service provider)

Perversely, as English law stands, disclosure *after* transmission has occurred (in order to enable PEP to be accessed) could amount to an admission of culpability rather than a defence (especially if the condom was not deployed correctly, or there was evidence of a history of condom failure). The clinician here is, for sound professional reasons, framing transmission risk in terms of protection from harm; but the law is concerned with whether the potential complainant was given a prior opportunity to determine the level of risk she or he was prepared to accept.

SUMMARY

The willingness and ability of participants to respond to questions about the criminal law, with relatively little prompting as to what the questions were seeking to elicit, indicates a broad and immediate awareness both of the topic in the abstract, and of the ethical and practical issues it raises for them as care providers, and for their patients and clients. The understanding which participants had of the law was, however, mixed. Some demonstrated accurate knowledge. It was particularly notable that many participants were aware of the complex ways in which recklessness – a technical criminal law term for the minimum degree of fault that has to be established by the prosecution in HIV transmission cases – was rendered more complex by the human behaviours associated with sexual risk-taking, managing one's own health, and intimate communication. As one clinician neatly put it:

It depends what you call reckless. Whether you say non-disclosure is reckless, whether you say not using a condom is reckless, or whether you say not taking antiretrovirals is reckless. (clinical service provider)

For the criminal lawyer, recklessness is essentially a mental concept (conscious awareness of risk), which is manifested in, or evidenced by, conduct. For clinicians and social care providers whose concern is the health and well-being of people with diagnosed HIV, and how that is assured in practice, there appeared to be a perfectly comprehensible focus not on the mental, but on the physical and behavioural. This difference in the way in which recklessness is conceived is not, in itself, significant or important.

However, some participants got the law wrong or a little bit wrong (which can be wrong enough in a context in which people may be prosecuted, convicted and imprisoned), while others elided their own subjective understanding of what they thought being reckless meant (or what they thought it should mean) with the technical legal definition. In the former category, the most striking (and potentially problematic) category of misunderstanding was the association of risk group membership / identity with “wilful blindness”; in the latter, there appeared to be a more or less implicit moralising towards those with diagnosed HIV who have multiple partners, and who repeatedly expose others to risk. Such people demonstrated ‘recklessness’ of a kind which might increase the blameworthiness of a person (and so increase their sentence if convicted), but it is irrelevant to the question of liability.

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