

# Grievous harm?

**Use of the *Offences Against  
the Person Act 1861* for  
sexual transmission of HIV**

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**Briefing Paper**

# Preface

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This briefing paper is part of a series that forms one strand of the research and development programme supporting CHAPS, the HIV prevention programme for Gay men, Bisexual men and other homosexually active men in England and Wales. It is intended to explore use of the *Offences Against the Person Act 1861* to prosecute people who have transmitted HIV infection to sexual partners in England, Wales and Northern Ireland. The topic was chosen by CHAPS partners as an area of interest to their organisations and others engaged in HIV prevention and sexual health promotion.

This briefing paper examines available evidence regarding the use of the judiciary in cases of sexual HIV transmission and considers the likely impact that criminalising HIV transmission has on public health, especially HIV prevention. It strives to provide an overview of academic and policy debates and responses to the topic, to make recommendations across a range of relevant agencies and organisations, and reviews all known cases (as of 31<sup>st</sup> August 2005).

A number of people have given considerable time and energy to the development of this paper. We would like to thank Matthew Weait of Keele University and Daniel Monk of Birkbeck College for checking the discussion of the law and of legal principles. We would also like to thank the following for their helpful comments on earlier drafts: Yusef Azad (National AIDS Trust), Edwin Bernard (NAM), Carl Burnell, Barrie Dwyer and Tim Molloy (GMFA), Sarah Clarke, Will Devlin, Gerard McGuickin and Lisa Power (all of Terrence Higgins Trust), Tom Doyle (Yorkshire MESMAC), Bernard Forbes (UK Coalition of People Living with HIV & AIDS), Chris Morley (George House Trust) and Rhon Reynolds (African HIV Policy Network).

This document does not provide legal advice. If information is required about a specific situation, we recommend that advice is sought from a fully qualified and experienced legal professional. The information here is provided in good faith, and contains details of the legal situation as far as it is known and understood at the time of writing. However, the use of the law in this area is continually evolving and it is certain that future events will change the implications of this issue.

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# 1 The criminalisation debate: policy, prosecutions & response

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In many countries, increasingly punitive responses to the sexual transmission of HIV have emerged in recent years. A wide array of legal jurisdictions in Africa, Australasia, Europe and North America have implemented criminal penalties under existing or specially drafted legislation (see R Elliott 2000, R Elliot 2001, Worth *et al.* 2005). A recent review of such prosecutions in forty five signatory countries to the European Convention on Human Rights (Nyambe & Gaines 2005) demonstrates that convictions against those who have transmitted HIV to sexual partners is increasingly common across Europe.

In many countries, including UK jurisdictions, the implementation of these criminal laws bears no requirement to prove intention in order to convict individuals for transmitting HIV. In 2001, a conviction for reckless endangerment was made under Scots law against a man who had transmitted HIV to his female sexual partner, with a similar case pending in Edinburgh at the time of writing (see Section 7.2). In Canada, the Supreme Court decision in *Cuerrier* meant that where it was established that a person with diagnosed HIV had not disclosed their status to a sexual partner and had exposed that partner to the risk of transmission, they had vitiated that partner's ability to consent to the act of sex itself (*R v Cuerrier* 1998, Canadian HIV/AIDS Legal Network 1999). A number of sexual assault convictions have followed from this Canadian ruling.

Moreover, in some places there is no requirement to prove that HIV transmission occurred. Included here are a number of well-documented cases in the United States where individuals with HIV have been sentenced up to life imprisonment for biting or spitting at others (Bray 2003). In addition, in the USA, federal funding provided to individual states for HIV treatment and care under the *Ryan White Care Act (1990)* has been made reliant on the existence and enforcement of criminal penalties against HIV exposure.

In 1998, discussion regarding the criminalisation of HIV transmission came to the fore in the context of the criminal justice system in England, Wales and Northern Ireland. The Home Office initiated a process of consultation (both leading up to and after publication of) a document titled, *Violence: Reforming the Offences Against the Person Act 1861* (Home Office 1998). It sought advice on the extent to which a revised Act should apply to those who knowingly or intentionally transmitted serious disease, as well as whether a separate law should be created in relation to HIV transmission (Dine & Watt 1998, Earle 1998, Home Office 1998). Individuals and AIDS service organisations responded with arguments against a specific law for HIV transmission, arguing that general legislation was sufficient to deal with those rare cases where individuals purposely caused a threat to public health (Terrence Higgins Trust 1998). The case was also strongly made against the criminalisation of reckless HIV transmission in many of these responses. In the recommendations put forward in their consultation document, the Home Office determined that no HIV specific law should be developed, and that only prosecutions for extreme cases of intentional transmission of HIV should be sought under Section 18 of the *Offences Against the Person Act 1861* (henceforth *OAPA 1861*) in the three UK jurisdictions where this Act applies: England, Wales and Northern Ireland. The Home Secretary at the time was absolutely explicit that reckless transmission of disease should not be pursued under the provisions made in Section 20.

The focus of the proposals is deliberate intention to transmit disease. While there is sometimes a fine line between negligence, recklessness and intent the proposal focuses on such cases in which a person knew how to transmit disease and deliberately set out to do so. Very few prosecutions are anticipated.

Jack Straw MP, then Home Secretary

Minutes of a meeting of the All Party Parliamentary Group on AIDS, 1<sup>st</sup> April 1998

This decision was based on an explicit desire to balance the need to intervene where serious harm is caused with intent, while not rendering individuals liable for prosecution for reckless acts leading to the transmission of disease. Thus the government made a clear decision against the use of the recklessness provision (Section 20) of the *OAPA 1861* in cases of disease transmission because of the damaging public health consequences of such a wide-ranging prosecution policy.

*The Offences Against the Person Act 1861* is an Act of Parliament that defines the situations in which a person may be held criminally liable for harming other people in England, Wales and Northern Ireland.

There are specific sections of the *OAPA 1861* that relate to causing (sometimes referred to as 'inflicting') Grievous Bodily Harm. In the context of this Act, 'grievous' means serious. Sections 18 and 20 of this Act can apply to the situation where it is established that one person has infected another with HIV.

***Section 18 – Wounding with intent to do grievous bodily harm (intentional provision)***

"Whosoever shall unlawfully and maliciously by any means whatsoever wound or cause any grievous bodily harm to any person...with intent,...to do some...grievous bodily harm to any person, [or with intent to resist or present the lawful apprehension or detainer of any person,] shall be guilty of an offence, and being convicted thereof shall be liable...to imprisonment for life."

***Section 20 – Inflicting bodily injury, with or without weapon (recklessness provision)***

"Whosoever shall unlawfully and maliciously wound or inflict any grievous bodily harm upon any other person, either with or without any weapon or instrument, shall be guilty of a misdemeanour, and being convicted thereof shall be liable...to imprisonment...for not more than five years."

The offence of intentionally causing grievous bodily harm under Section 18 would be extremely difficult to prove in relation to the transmission of serious disease (unless HIV was used as a weapon – in a syringe of blood, for example). To date, convictions in relation to the sexual transmission of HIV have only been under Section 20, often referred to as the 'recklessness provision'.

However, in some of the existing convictions, the initial charge has been made under Section 18 (intent), and subsequently reduced to the less serious offence set out in Section 20 (recklessness). The law says that a person is reckless if they consciously take an unjustifiable risk – which in this context would mean being aware of the risk of causing harm to the person they infected.

An issue of this importance has ramifications beyond the criminal law, into the wider considerations of social and public health policy. The Government is particularly concerned that the law should not seem to discriminate against those who are HIV positive, have AIDS or viral hepatitis or who carry any kind of disease. Nor do we want to discourage people from coming forward for diagnostic tests and treatment, in the interests of their own health and that of others, because of an unfounded fear of criminal prosecution.

Home Office 1998: §3.16

The legislative change recommended in the Home Office consultation document (1998) was never enacted by Parliament, yet many of the agencies and individuals contributing to the consultation probably believed that the spirit of those recommendations and the resulting draft Bill would be upheld, and that prosecutions would only be undertaken for extreme instances of intentional transmission. This approach was consistent with the concerns raised by many at the time (and since), who argued that extensive use of prosecutions (ie. including the charge of recklessness) would impede the goals of HIV prevention, treatment and care (Power 1997, Dine & Watt 1998, Earle 1998, Harrington 1999, Moran 2000, Bird & Leigh Brown 2001, Weait 2001, Weait 2004, Terrence Higgins Trust 2005, National AIDS Trust 2005).

However, with the conviction of Mohammed Dica in November 2003 (see Section 7.1.1) it became clear that prosecution for the transmission of HIV under the recklessness provision (Section 20) of the *OAPA 1861* was not only feasible but had become a priority for the Crown Prosecution Service (hereafter, the CPS). In a press statement following this conviction, René Barclay, the head of London's Serious Casework Section stated that:

This was a ground-breaking prosecution, which was the result of a massive team effort. The implications are that in the future people who are reckless in this way will be vigorously prosecuted.

Crown Prosecution Service 2003: 1

### ***Objectives of using the criminal law (criminal legal theory)***

In theoretical terms, the criminal law can be considered to serve a number of different social functions. However, there remains a considerable amount of debate about the extent to which these aims are met.

Four commonly cited objectives of criminal sanctions are: incapacitation, rehabilitation, retribution and deterrence (R Elliott 2002).

Imprisonment is said to **incapacitate** the offender, rendering him or her unable to harm others for the duration of imprisonment. It is also argued that a prison sentence can provide an opportunity to **rehabilitate** offenders, although the extent to which this occurs is questionable.

A key justification for criminalising specific behaviours is **retribution**, relating to the notion that harmful or blameworthy behaviour deserves punishment. This is particularly salient in relation to the 'victim' who may desire to see a sentence passed that bears a particular weight in response to the crime committed.

Further to this, it is argued that by setting out the criminal law and its penalties in relation to specific acts, most people will be **deterred** from engaging in such behaviour because of the risk of criminal conviction and sentencing that may ensue. Yet it is also argued that in circumstances where reasoning is outweighed by other less rational considerations (for example, addiction, compulsion, desire, or fear) that the deterrent function of the criminal law is seriously compromised.

As a non-governmental body, the CPS is not constrained by Home Office policy recommendations (Weait 2005a). In the two years following the initial prosecution, Feston Konzani was convicted and failed in his appeal, and three others were convicted after pleading guilty (see Section 7 for a detailed description of all known cases). All of these convictions have been secured under the recklessness provision (Section 20) of the *OAPA 1861*. These events have revitalised debate about whether HIV transmission should be criminalised under any circumstances, and if so, in what particular situations it may be justified for a person with HIV to be held criminally liable for onward sexual transmission of the virus.

There are those who advocate that prosecutions of reckless and intentional sexual transmission of HIV are a proportional means of curbing dangerous behaviour and securing punishment for harm caused by HIV infection. In contrast, others maintain that criminal prosecutions for the transmission of HIV have a negative impact on public health, and as such should only be used in the most extreme circumstances (ie. where intentionality can be established). Some have said that the negative public health outcomes are so profound that criminalisation of HIV transmission is inappropriate under any circumstance, as it fundamentally impedes HIV policy objectives. The remainder of this briefing paper will examine these positions in some detail, particularly focussing on sexual transmission of HIV and use of the *OAPA 1861* as it pertains to England, Wales and Northern Ireland.



## 2 Evidence relating to public health impact

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Research evidence on the public health impact of criminalisation of HIV transmission is very limited. There are very few research studies that consider the issue from the perspective of the person with diagnosed HIV and none that focus on the perspective of the uninfected individual.

Aside from Sigma's study of HIV-related stigma and discrimination that included some coverage of criminal prosecutions (Dodds *et al.* 2004a, Dodds & Keogh 2005), it was only possible to find two investigations examining the responses of people living with HIV to the issue. One was based on a questionnaire on criminalisation produced and distributed by the UK Coalition of People Living with HIV & AIDS (UK Coalition 2005), and the other consisted of qualitative interviews conducted by psychiatrists in three US cities where individuals were asked about the impact of a range of legal and regulatory interventions including criminalisation of HIV transmission (Klitzman *et al.* 2004).

In the American study, when asked if they thought that criminalisation would lead to behaviour change among people living with HIV, many thought that condom use and disclosure would increase as a result. This finding is significantly different from the majority of responses on this topic arising from the investigations conducted by Sigma Research and the UK Coalition, and this may be explained by a range of factors. There are very different national and cultural histories in the US and the UK regarding public health imperatives, legal interventions and the epidemiology of HIV, and respondents' ideas about the criminalisation of sexual transmission are likely to be expressed differently as a result. While the sample size and self-selection bias inherent in the UK Coalition quantitative sample limits the extent to which those findings can be generalised across the population, it should be noted that almost half of respondents with diagnosed HIV reportedly said that the recent prosecutions would not change the way in which they made decisions to disclose HIV status to new sexual partners (UK Coalition 2005: 18). The phrasing of questions may also explain the difference in responses. Where those taking part in the American study were asked how they thought 'people living with HIV' would behave in response to criminal prosecutions, the UK Coalition survey asked individuals to reflect on their *own* behaviours. As the study undertaken by Sigma Research used focus group methodology, group discussions on this topic were centred on respondents' perceptions of media coverage of the cases, and how the cases themselves might impact on people living with HIV, without raising personal aspects of sexual behaviour as a specific point.

Comparison of the qualitative research findings demonstrates that all of the key themes that emerged from the American data (Klitzman *et al.* 2004) were identified in the research conducted in England (Dodds *et al.* 2004a, Dodds & Keogh 2005). Respondents in both projects qualified their support for criminalisation by stipulating that it was only appropriate in specific circumstances, such as rape or deception. Other comparable themes included notions of shared responsibility between sexual partners, the need to reinforce the primacy of the 'safer sex' message, the possibility that such policies might dissuade people from testing for HIV, and the extent to which such application of the law could be abused. A sizeable proportion of respondents in both studies were also unclear about the types of evidence that would be necessary to secure a conviction, often conflating the legal distinctions between intent, recklessness and non-disclosure.

Turning our attention to those comments made on criminalisation in the qualitative investigation in England, the overwhelming majority expressed strong concerns and criticisms regarding prosecutions of people living with HIV (Dodds *et al.* 2004a, Dodds & Keogh 2005). Of these, the largest proportion felt that criminal proceedings would confer all blame on the individual

diagnosed with HIV infection, substantially undermining health promotion messages concerning shared responsibility.

**The first image that came in my mind when I saw the Dica case was fear. This case will lead to partners pointing the finger. All of us got it from somewhere. This was a waste of resources and money which should be put into prevention instead because all of us are responsible for ourselves.**

**African man with HIV (quoted in Dodds et al. 2004a: 33)**

This study also found that the prospect of criminal convictions increased fears about being open about having HIV. This effect was most pronounced among African men and women living in the UK, a group already very vulnerable to social exclusion and xenophobic abuse (Weatherburn *et al.* 2003, Dodds *et al.* 2004a, Fortier 2004).

**Once you talk about this, you fear everybody! You can't do this or that.**

**African man with HIV (quoted in Dodds & Keogh 2005)**

Experiences of stigma and discrimination impact on people's self-perception and mental health as well as their sexual risk behaviour. A significant number of respondents in this study argued that in social and sexual contexts many people find it very difficult to disclose their HIV status due to concerns about the negative repercussions that such disclosure can bring. Respondents clearly expressed their view that the way to make up the shortfall between aspiration and 'safer sex' behaviour should not be sought through criminal prosecution (Dodds *et al.* 2004a, Dodds & Keogh 2005). The strongest concern emerging from this group was that criminal conviction would reinforce constructions of people living with HIV as irresponsible and dangerous. This is supported by the UK Coalition finding that 84% of research respondents with diagnosed HIV (and 62% of others) felt that criminal convictions increased HIV-related stigma and discrimination (UK Coalition 2005: 2). One such respondent added:

**The law should focus on positive things it can do to protect people with HIV, not criminalise us and marginalise us further.**

**Respondent (cited in UK Coalition 2005: 11)**

We already know that the stigma and discrimination associated with HIV mean that some populations at substantial risk are unlikely to test for HIV, seek treatment or make behavioural changes (Chinouya *et al.* 2000, Flowers *et al.* 2000, Weatherburn *et al.* 2003, Mayisha II Collaborative Group 2005). Criminalisation increases the perception of HIV infection as a highly stigmatised condition – a situation that hampers HIV health promotion. It should be reiterated that the *Offences Against the Person Act 1861* is not HIV-specific, and the provisions made in Section 18 and Section 20 have been interpreted by the courts to relate to the transmission of serious disease more broadly. However, HIV remains the only disease to result in a successful conviction under the *OAPA*. The exclusive application of the *OAPA 1861* for disease transmission against those who have sexually transmitted HIV is interpreted by many of those within vulnerable populations as reinforcing the environment of fear, shame and stigma that is attached to the virus (Dodds *et al.* 2004a).

In the absence of any more specific evidence, general studies of people with HIV have something to contribute. Most Gay and Bisexual men living with diagnosed HIV in one sample expressed a strong feeling of responsibility to avoid transmission of HIV to any sexual partner (Stephenson *et al.* 2003). However, there is a disjuncture between the behavioural aims to which individuals might aspire and their sexual practice. In a UK national survey of homosexually active men, more than one third of men with diagnosed HIV infection reported that they had participated in unprotected anal intercourse (UAI) in the past year with a partner who was probably or definitely HIV negative (Hickson *et al.* 2003b). Similar behavioural data are not available for heterosexual African people living with HIV infection in the UK.

While the lack of concrete public health evidence impedes our assessment of the potential impact of criminalisation of sexually transmitted HIV infection, we do not believe that it is feasible to wait for the establishment of a coherent evidence base. Even if we knew now that the majority of people with diagnosed HIV opposed the criminalisation of onward transmission and the majority of uninfected people supported it, this would not settle any of the substantial and complex arguments that follow. The problem is not amenable to complete resolution via public health or social scientific investigation. Moreover, it seems unlikely the CPS would be willing to await the accumulation of further research evidence.

The problem posed by this lack of evidence is profound. While a raft of further evidence may not bring consensus between those with strongly held and vastly different views, the need to base such views on existing evidence, public health expertise and accurate information is important. All those who take a position on the criminalisation of sexually transmitted HIV infection essentially ground their arguments in some form of ethical framework. Problems ensue when these masquerade as factual assertions. Classic examples are to be found across the spectrum of positions held on this topic; from one extreme where some oppose criminalisation in the belief that it will reduce *everyone's* willingness to test for HIV, to those who advocate prosecution in the belief that it will directly curb HIV incidence via a deterrent effect. The veracity of either of these claims has never been established and perhaps never could be. Yet, there *is* a difference between making an unsubstantiated claim, and taking a position based on knowledge and expertise in the HIV prevention / health promotion field.

The ethical intention of health promotion is to find the best means of achieving the highest possible degree of individual and collective physical, mental and social well-being in a given society (World Health Organisation 1981). As such, those working in health promotion (whether or not this is specific to HIV) are oriented towards a broad critique of political and structural factors that impede health.

**Health promotion goes beyond health care. It puts health on the agenda of policy makers in all sectors and at all levels, directing them to be aware of the health consequences of their decisions and to accept their responsibilities for health.**

**World Health Organisation 1981: 2**

The following sections attempt to summarise key arguments and unpick the limited evidence base as equitably as is possible, with an open ethical stance that firmly places the goal of reducing onward HIV transmission at the centre of any legal or policy intervention.

# 3 Arguments for criminalisation

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There seems to be a significant degree of popular and press support for the prosecution of people who sexually transmit HIV. Recent research also suggests that almost half (47%) of 165 UK-residents with diagnosed HIV surveyed by the UK Coalition (2005), agreed with the view that the Crown should prosecute intentional HIV transmission, while 11% felt that both intentional and reckless transmission should be prosecuted.

When we examine the professional and expert literature on this issue, unequivocal support for the application of criminal law to both reckless and intentional sexual transmission of HIV is most common among those working in the criminal justice system alongside academic law colleagues. Arguments against prosecutions for reckless HIV transmission (under Section 20 of the *OAPA 1861*) tend to be found in academic and policy literature produced by HIV voluntary organisations, social science researchers and those with experience in the HIV sector more broadly. It is perhaps most accurate to say that there is a lack of consensus in the field about the prosecution of intentional HIV transmission (under Section 18 of the *OAPA 1861*). While some HIV organisations argue that it might be acceptable in relatively rare circumstances where it can be proven that harm was intended (Terrence Higgins Trust 2005, National AIDS Trust 2005, UK Coalition 2005), others contend that criminalisation is not justified under any circumstances (Reid 2003). Despite some exceptions to these observations, they remain important in what follows.

As the ongoing accumulation of convictions attests, the criminal justice system in England and Wales currently treats sexual transmission of HIV without prior disclosure as being contrary to the recklessness provisions of the *OAPA 1861*. This interpretation is supported by some legal academics who maintain that any individual who transmits HIV to sexual partners without telling them of their own known (or suspected) infection, has betrayed a trust and caused a physical harm that justifies the intervention of the criminal courts (Strickland 2001, Spencer 2004a, 2004b, Warburton 2004). Those who advocate criminalising the sexual transmission of HIV variously rely on the argument that this application of the criminal law will reduce onward HIV transmission by a) disabling the individual defendant from exposing others to the virus and b) deterring others with (diagnosed) HIV from engaging in behaviours that risk transmission. That the infected person can be threatened with removal from the 'general population' via incarceration (**incapacitation**) implies that this fulfils the public interest aspect of legal intervention.

**It will help to assure the public that the criminal law is there to protect them in those situations where there is a real risk of the transmission of HIV.**

**Strickland 2001: 7**

Proponents of the criminalisation of sexual transmission frequently cite it as both an effective **deterrent** and an appropriate means of seeking **retribution** on the part of those who feel wronged.

**To infect an unsuspecting person with a grave disease you know you have, or may have, by behaviour that you know involves a risk of transmission, and that you know you *could easily* modify to reduce or eliminate the risk, is to harm another in a way that is both needless and callous. For that reason, criminal liability is justified unless there are strong countervailing reasons. In my view there are not.**

**Spencer 2004b: 471, italics added**

Spencer's assumption that sexual risk behaviour can be 'easily modif[ied] to reduce or eliminate the risk' arguably ignores all the complexities of human sexual interaction in general, and the challenges facing HIV prevention in particular. He also raises the spectre of prosecutions in the absence of a defendant's HIV diagnosis. This latter point raises significant questions about the way in which charges could be targeted at those who *may* have HIV and therefore '*should know*' their status, and

how this classification will be defined by the judiciary. Spencer's published views made a significant impact on the Court of Appeal in the matter of *Dica*, with the above passage being quoted in the text of their written judgment (*R v Dica* 2004: § 55).

Spencer's rhetoric is important because it demonstrates the importance of **retribution** or punishment as a motivation for criminalising the reckless sexual transmission of HIV. From what we know, this has probably been the over-riding imperative of the complainants in the criminal prosecutions to date (see Section 7). This argument for criminalising sexual HIV transmission is the one that probably divides the opinion of commentators most sharply, and has contributed most to the lack of an unequivocal position among HIV organisations. It is undeniably true that to pass HIV to another person does them harm – few people want HIV and most people with the virus would undoubtedly rather they did not have it. Hence, it is argued that people who pass on HIV under any circumstance should face criminal sanction. In support of much earlier calls for HIV-specific legislation in the United States, Hermann takes the view that punishment for behaviour that risks HIV exposure helps to clearly demarcate the boundaries between desirable and undesirable behaviours.

**According to the [Presidential] Commission, an HIV specific statute can provide clear notice of socially unacceptable standards of behaviour specific to the HIV epidemic and can facilitate tailoring punishment to the specific crime of HIV transmitting behaviour.**  
Hermann 1990: 370

Among other arguments for criminalising the reckless sexual transmission of HIV, **deterrence** is commonly cited. It is asserted that prosecutions will have a positive impact on the HIV epidemic by encouraging behaviour change. In his detailed argument supporting the development of new criminal legislation to better address the sexual transmission of HIV, Ormerod takes this approach.

**If the public has become complacent about HIV this suggests that education and health campaigns are proving ineffective, at least in reaching those who knowingly expose partners to the risk of HIV. Perhaps the criminal law could supplement these initiatives, without its introduction reducing resources available for health and education, as might be the case in the developing world. Invoking criminal law in this way could be regarded as a considered response after decades of experience; not an over hasty reaction to a moral panic. A new criminal offence would overcome the deficiency in the present law. In addition, a new criminal offence could promote specified objectives that could be consistent with the objectives of the public health laws: to regulate behaviour in an AIDS-aware society. This includes a desire to signal the boundaries of appropriate behaviour and, where necessary, to re-educate people regarding their mutual sexual responsibilities.**  
Ormerod 2001: 142

Those who share this view hold that the threat of prosecution will encourage individuals to avoid behaviour that leads to transmission (ie. unsafe sex and non-disclosure of HIV infection). While delivering the sentence for the first conviction in England and Wales, Judge Philpot reportedly said that the lengthy sentence partly reflected "the need to deter others from acting in a similar fashion" (Bowcott 2003). Such a statement contains the assumption that people living with HIV will have a clear and detailed understanding of the precise ways in which such convictions are obtained (ie. what constitutes liable activity and what does not). It also presumes that people living with HIV will prioritise concerns about legal liability ahead of sexual impulse, privacy, and a desire to not be defined by, or discriminated against because of their HIV infection.

Some of the commentary offered by legal academics betrays a severely limited understanding of health promotion approaches to HIV prevention alongside basic facts of transmission. Arguments supporting deterrence are sometimes based upon presumptions which are themselves grounded in misinformation, as the following passages exemplify:

While it is not suggested here that HIV+ individuals ought not to be permitted ever to engage in sexual intercourse, that there may be a public interest in sanctioning unprotected contact is unconvincing. Furthermore, whether it truly is a 'positive social purpose' for HIV+ people to procreate, given the significant likelihood of subsequent foetal infection, must be a subject open to debate.

Warburton 2004: 9

Since the determination of what amounts to *serious* injury is to be left to the jury, it is highly likely that the jury would deem the actual transmission of HIV to another to be serious injury since death always results from the infection.

Strickland 2001: 10, italics in original

It is likely that some of the momentum in favour of wide-ranging criminal prosecutions arises from frustration with the ongoing growth of the epidemic while also misunderstanding the significance of treatment advances. This in turn leads to accusations that public health approaches such as awareness raising, HIV health promotion and targeted harm reduction messages are not working. This allows legal commentators to present the criminal law as the 'last bastion' of defence against further infections (Kromm 1999, Ruby 1999, Strickland 2001).

... the current policy of educating people about the risks they are taking with their lives is not convincing them to act more cautiously. Education, counselling, and testing should still be promoted and encouraged as methods of maintaining public awareness and knowledge, but cannot be relied on to stop the spread of the HIV virus... Criminalisation may force people to think twice before acting, and to be more responsible in their decision making.

Ruby 1999: 334-335

There is limited foundation for assertions about deterrence, since there is no evidence from any jurisdiction that has criminalised HIV transmission that incidence is reduced as a result. However, it is almost certainly true that some acts made illegal tend to become less common in the population as a whole (not wearing a seat-belt in a car, for example). Whether the criminal law could have the same impact on sexual behaviour between two consenting adults is a complex matter of ongoing debate.

# 4 Arguments against criminalisation

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This briefing paper rests on the overriding principle that any legal or policy development related to HIV must prioritise effective health promotion principles. This is the same position advocated by the Joint United Nations Programme on HIV/AIDS (UNAIDS) in a policy options paper on this topic.

**On the broader level of public health, it is also not clear that criminalisation is the best policy approach. Policy-makers must consider, in light of the best evidence that is available, what the impact of criminalisation of government policy may be on HIV prevention efforts or on access to care, treatment and support.**

R Elliott 2002: 27

It has long been argued that responses to HIV are most effective when they prioritise the rights and dignity of people who have been diagnosed with HIV or are at risk of infection (Watney 1994, Altman 1994, Mann *et al.* 1996, Gostin & Lazzarini 1997, United Nations High Commissioner for Human Rights and the Joint United Nations Programme on HIV/AIDS 1998, Hickson *et al.* 2003a). This rights-based approach to HIV prevention underlies efforts to support people to realistically evaluate their risk of infection and to engage in behaviours that reduce the risk of HIV exposure and transmission. It is also crucially important that individuals understand the importance of early HIV diagnosis and treatment, should they become infected.

*Making it Count [MiC]*, the planning framework for collaboration and action in the CHAPS partnership, asserts that simply telling people what to do is inappropriate in light of the complexities of sexual behaviour. The partnership collectively stands behind the framework's advocacy of *You Decide* rather than *We Decide* approaches to HIV health promotion (Hickson *et al.* 2003a: 16). Considering the issue of criminalisation alongside the framework of health promotion provided by *MiC* demonstrates a considerable contrast of potential approaches. *MiC* asserts that the role of people living with diagnosed HIV in the prevention of transmission is crucial, but that simply telling individuals to always disclose their positive status to sexual partners is not helpful, not least because it overrides aims pertaining to the health and well-being of people living with diagnosed HIV. Bringing criminal liability into matters concerning disclosure of HIV status in sexual encounters interferes with the freedom of an individual with diagnosed HIV infection to freely choose if, when and to whom they make their infection known.

HIV remains a highly stigmatised disease and many people with HIV experience discrimination in their daily lives (Weatherburn *et al.* 2002, 2003). As a result, those at highest risk of infection often distance themselves from the disease in public, social and intimate settings (Dodds *et al.* 2004a). As long as the stigma associated with HIV continues to pervade social responses to the epidemic, the resulting fear and shame will hamper efforts to undertake HIV prevention, treatment and care (Aggleton *et al.* 2005). Public health theory and research suggests that punitive responses to HIV are counterproductive, largely because they foster the stigma that drives the epidemic (Landsdell 1991, Bennett 1997, DeBruyn 1998, Harrington 1999, Lange 2003). It is widely held that a holistic response that accounts for contextual factors (such as the impact of stigma) is the best means of meeting the goal of reducing HIV transmission (Gostin & Lazzarini 1997, UN High Commissioner for Human Rights and the Joint UN Programme on HIV/AIDS 1998, United Nations 2001).

Those who are critical of the criminalisation of sexually transmitted HIV infection frequently make the argument that it is a punitive response that reinforces the substantial stigma and discrimination that contribute to ongoing HIV transmission.

**Appealing to a desire for retribution in making policy runs the risk of appealing to prejudice and reinforcing discrimination, particularly in the context of the heavy stigma that already often surrounds HIV / AIDS and those individuals or groups associated with it.**

**R Elliott 2002: 6**

No one has ever been successfully convicted of transmitting any other serious disease under the *OAPA 1861*. It is argued that criminal prosecutions contribute to the further demonisation of *all* people living with HIV infection with no regard for their actual behaviours or personal circumstances (Reid 2003). This is exacerbated by the media attention that such trials attract. As Rhon Reynolds of the African HIV Policy Network has pointed out, the ethnicity and migration status of appellants in these cases also contributes to the general increase in hostility toward migrants in the UK, as out of the five current convictions, three have been against African men who were seeking or had already obtained refugee status and another was against a migrant from Portugal (Reynolds' contribution in A Elliott 2005). It has been clearly documented that migrants and members of ethnic minorities are disproportionately prosecuted (and subsequently deported) for HIV transmission and exposure throughout a range of European jurisdictions (Nyambe & Gaines 2005), with similar concerns being noted elsewhere (R Elliott 2002, Bray 2003, Miller 2005).

The evidence raised in court and the attendant media attention that these cases bring fail to give any indication of the practical, emotional and social implications that influence the difficult decision to disclose HIV infection (Dodds *et al.* 2004a, 2004b, National AIDS Trust 2005). In court cases to date little or no account has been taken of the defendants' psychological state in relation to their HIV diagnosis, nor has it been satisfactorily clarified in any of the cases that the defendant had sufficient knowledge about HIV and its transmission in order to predict the outcome of their actions. The defendant's own understanding of the meaning of their own HIV diagnosis and the risk they might pose to others has not been taken into account by the courts. Evidence collection seems to be restricted to a limited number of factors: *Did the defendant know their own HIV positive status? And did the defendant disclose this to the complainant before engaging in sexual behaviour that carried a risk of HIV exposure and transmission?*

There are also a host of intervening issues that mean disclosure of an HIV positive status is not as straightforward as the legal system might infer. Those from the HIV sector who have had some insight into the details of particular cases raise questions about whether the criminal justice system is equipped (both in terms of structure and knowledge) to sufficiently understand the complexities of the current HIV epidemic (National AIDS Trust 2005). This mirrors similar longstanding debates about the difficult interface between the law and complex human activity more broadly, but this should not impede us from raising the matter in relation to sexually transmitted HIV infection.

Instead of alleviating this situation, or helping to manage some of this complexity, media coverage concerning criminalisation makes the stigma associated with having HIV far worse. African people living with HIV in particular are concerned about the impact of these prosecutions on their own lives, especially those who see gender and racial bias in the criminal prosecution system and the media (Dodds *et al.* 2004a).

The media representation of convictions through the criminal process reinforces the prejudicial perceptions that have historically been attached to HIV, strengthening the stigma and discrimination associated with infection. In their persistent and sometimes erroneous use of phrases such as 'deliberate infection' and 'biological GBH' (see for example, BBC News Online 2003), news agencies and broadcasters have blurred the boundaries between intentionality and recklessness that are clearly delineated in Sections 18 and 20 of the *OAPA 1861*.



An asylum seeker dubbed the *Aids Assassin* was jailed for four-and-a-half years yesterday for *deliberately* infecting his lover with HIV. Mohammed Dica, 38, was sentenced at the Old Bailey for *biological* grievous bodily harm after failing to tell the 39-year-old mother-of-two he had Aids. She will now be on medication for the rest of her life. Dica, from Mitcham, south London, was convicted in October, 2003. He appealed, and there were two retrials, forcing his victim to give evidence three times.  
Daily Star 2005: 18, italics added

Media coverage is characteristically sensationalised and inaccurate, and its demonisation and vilification of people living with HIV exacerbates HIV stigma and contributes to a belief that such convictions are a successful means of HIV prevention (see Petty 2005, for a review of media coverage in the Canadian context). It is implicit in much of the press coverage that criminalising sexual transmission of HIV would reduce incidence by means of incapacitation and deterrence.

The imprisonment of four men and one woman with HIV for 'recklessly' transmitting their infection will probably deter some people living with diagnosed HIV from having sex that carries a risk of exposure without their partner's knowledge of that risk. However, based on prosecutions to date it remains unclear what sexual activity has been criminalised and what 'behaviour change', short of abstinence, would ensure that infected individuals do not face criminalisation in the future. In such an uncertain environment the anguish that arises among those who are concerned about prosecution can be immense, and the harm done to their mental and sexual health could be argued to outweigh any benefit to the wider population, particularly as successful prevention is partially reliant on the attitudes, skills and well-being of people living with diagnosed HIV. While this uncertainty currently affects African people living with HIV most acutely (Dodds *et al.* 2004a, Dodds and Keogh 2005), it is clear that prosecutions against heterosexually and homosexually active White British men and women are imminent (see Section 7). Such factors have led some commentators to argue that the pursuit of retribution or deterrence through the criminal justice system will be considerably outweighed by the negative outcomes of increased stigma and discrimination that may in turn lead to increases in ongoing transmission (Bird & Leigh Brown 2001).

It also seems likely that criminalising the sexual transmission of HIV may lead some people at risk of infection to erroneously believe that the law affords the 'public' a degree of protection from HIV exposure, thereby reducing the need for vigilance about 'safer sex' (R Elliott 2002). In a UK survey of Gay and Bisexual men, 65% of those who tested HIV negative and 77% of those who were untested said they would expect a sexual partner with diagnosed HIV infection to disclose to them before sex (Hickson *et al.* 2003b). In this type of close-ended survey question, it is impossible to determine the extent to which those responding in this way were indicating a belief that others *would*, or that they *should* disclose a known HIV positive status. Regardless of this, both interpretations of respondents' high degree of expectation indicate HIV prevention need. It can be argued that ongoing awareness of criminal prosecutions will increase expectations of HIV-positive disclosure among those at highest risk of exposure, and hence exacerbate HIV prevention need.

The public health message of shared responsibility for 'safer sex' is obscured by the belief – among those who are HIV negative or untested – that people who know they are positive will always disclose their status before sex that carries a risk of transmission (Dodds *et al.* 2004b, Henderson *et al.* 2001), while those who do not will get locked safely away. Past qualitative research among Gay men living with HIV who participated in unprotected anal intercourse demonstrated that many believed that sexual partners who did not insist on the use of condoms for intercourse must also be HIV infected (Keogh *et al.* 1999). It remains unclear to what extent such prosecutions will impact on the behaviours of people living with diagnosed HIV. As noted earlier, a significant proportion of those taking part in a recent small-scale survey indicated that they would be unlikely to change their own sexual behaviour in response to criminal prosecutions – however survey respondents were not asked about their existing risk-management practices (UK Coalition 2005).

The logic that imprisonment (**incapacitation**) operates as a solution to ongoing HIV transmission neglects to take into account that prisons are places where both infected and uninfected individuals are seriously curtailed in their ability to exercise control over HIV exposure (Weild *et al.* 2000, R Elliott 2002, Prison Reform Trust and National AIDS Trust 2005). It also makes assumptions that prisons are not places where HIV transmission routinely occurs and that prisoners *per se* do not merit the protection afforded to the rest of the population. This is reinforced by the fact that the first man to be convicted for sexual transmission of HIV in the UK was himself infected in Glenochil Prison in Scotland (see Section 7.2.1). Yet this crucial issue is crowded out by the overriding portrayal of HIV positive 'predators' who pose a threat to a 'vulnerable' public.

An interview statement made by one of the female complainants in the *Konzani* case exemplifies a number of problems with the use of incapacitation as a rationale for criminalising HIV transmission.

**I feel happy he's been sent to prison. At least I know he's not going to go out and give some other girl HIV. He could have done it to my little sister or to anyone. I think he got what he deserved.**

**Flynn 2004b: 20**

The comment expresses the belief that by being sentenced to prison, the defendant was rendered incapable of transmitting HIV to 'some other girl', 'my little sister', or indeed 'anyone'. However imprisoning individuals with HIV does not halt the likelihood of onward transmission, it only transfers that risk to other prisoners in a setting where condoms and clean injecting equipment are rarely available (R Elliott 2002). Nowhere in these arguments are there any grounds to believe that the convicted individual will encounter an intervention that will assist him or her in the successful management of future HIV risk. **Rehabilitation** simply does not figure in this approach.

It is inevitable that some people will feel wronged by a sexual partner who has exposed them to a risk of HIV infection – where HIV transmission has occurred these feelings may be especially powerful. **Retribution** is a powerful argument for criminalising intentional sexual transmission of HIV, though what precisely intention could and would mean in such instances is severely contested. People with HIV are the population of potential complainants as well as defendants in all such cases. Everyone alive with HIV infection today was infected by someone, and it is only a tiny proportion of the HIV infected population that has pursued a criminal legal 'solution' to their infection. It has been surmised that a regulatory focus emerges in those environments where "so called irresponsible and unrespectable" people living with HIV are isolated from others living with the virus (Kinsman 2005: 102). Those agencies who engage with individuals involved in legal proceedings should seek clarity about the motivation for a complaint, preferably before charges are laid. Extraneous factors such as relationship breakdown, child custody, and third party pressures should be explored with complainants in order to determine if prosecution is the appropriate way forward.

When making the choice to contact police, it is unlikely that individuals are made fully aware of the limits of the criminal justice system in relation to the pursuit of personal retribution. Giving evidence about sexual relationships can be a gruelling experience, and complainants may find that the outcome of the process does not afford them the closure they sought. It is similarly unlikely that many complainants are given adequate support to deal with the increased surveillance that publicising one's own HIV positive status can bring, nor is it likely that much consideration is given to the way in which retributive responses can contribute to the overarching climate of stigma and discrimination related to HIV.

**Throwing people in prison can only happen after the virus has been transmitted. It may serve to fulfil the anger of an individual, but it seriously undermines the efforts we are all making to end discrimination against HIV positive people.**

**Reid 2003: 5**

The ideal outcome would be for newly-diagnosed individuals to seek support from voluntary and statutory HIV services rather than the police, at least as a first point of contact. In order to ensure that this is the norm, appropriate protocols for referral are needed between the point of diagnosis and ongoing psychological, behavioural, social and emotional interventions. Where concerns have been raised about the extent to which health professionals have actively encouraged complaints to be made at the point of diagnosis (see Section 7.1.3), the need for referral protocols appears most acute.

One of the most significant functions of the criminal law is to ensure that the power to remove an individual's liberty does not rest with the masses, but with a restrained judicial system which is governed by the rules of due process (Kennedy 2005). As such, criminal statute-making and the entire system which serves to uphold the rule of law is engaged with drawing a clear line between morality and illegality – while some behaviours may indeed be '*wrong*' it is not always in the best interests of society to make all of them criminal. It is in light of this fundamental tenet of the law that a careful distinction must be made between recognising the moral wrong done by the HIV positive person who puts another at (unknowing) risk of infection, and determining the public harm that will follow on from pursuit of retribution through the criminal law in such instances (Bennett *et al.* 2000).

**... the existence of a moral duty is a necessary but not a sufficient condition for invoking the criminal sanction. The legal duty should not be as extensive as the moral one.**

**Chalmers 2002: 450**

Among those who are critical of the outcomes of criminalising sexual HIV transmission, some have concluded that there are not any justifiable circumstances where such prosecutions are warranted, as the costs are simply too great (Reid 2003, A Elliott 2005, Worth *et al.* 2005). According to this view, the law is regarded as being fundamentally ill-equipped to tackle a complex HIV epidemic, and the difficulties and misunderstandings that such convictions provoke ensure that such application of the criminal law damages core HIV policy objectives. As such, the criminalisation of sexually transmitted HIV, be it under reckless or intentional provisions, is not judged to be useful based on the balance of available evidence and logic. Where legal systems are understood to operate for the common good, those who hold this position argue that criminal prosecutions should only be applied where they contribute to an overall outcome that benefits, rather than detracts from the public interest. Some analysts who take this position have warned that those who simply seek to draw limits around what should and should not be criminalised have already been drawn into a 'liberal regulatory approach' which bolsters the view that some people living with HIV are 'the problem' (Kinsman 2005: 102).

**A wise nation would consider whether in [prosecuting individuals who put others at risk of contracting HIV] we advance the public health... If, on the other hand, criminalisation serves to undermine our overall public health response to the HIV epidemic, then we must seriously question whether the gains from criminalisation are worth it.**

**Dalton 1993: 255**

Some commentators believe that the principled distinction between intentionality and recklessness that was so hard-fought at the time of the Home Office consultation in 1998 has since been manipulated as a means of securing prosecutions. As Bernard Forbes, the chair of the UK Coalition of People Living with HIV & AIDS (UKC), has said:

**UKC's support for prosecution of people who intentionally transmit HIV infection was arrived at a time when we were involved in protracted debates with the Home Office on a new *Offences Against the Person Act*. But as the recent Appeal Court judgment makes clear, intention can be bounced down to reckless, so our position is not necessarily of any use.**

**Forbes cited in A Elliott 2005: 24**

These sections of the briefing paper have aimed to set out the diverse arguments made in relation to the criminalisation of sexual transmission of HIV from a wide range of sources. Before moving on, it should be noted that this debate in the UK mirrors exchanges that take place elsewhere.

**Around the globe and across professional lines, even if they do not favour the anti-criminalisation stance of the authors of this article, a large number of experts concerned with the issue of HIV/AIDS and criminalisation find fault with the current legal provision to address HIV transmission in many countries. Commentators on the application of criminal law to acts related to transmission of HIV have reached somewhat of a consensus on the need to rethink and revamp existing legislation and policies dealing with such cases. Worth *et al.* 2005: 18.**

# 5 Unanswered questions ... Uncertain futures ...

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It is two years since the first conviction relating to the sexual transmission of HIV in England. However, there remains a severe lack of clarity on many of the key issues including what precisely is criminal, how criminal liability can be avoided, and what the Crown Prosecution Service aims to achieve through their actions. Clarification may slowly be achieved with each successive prosecution, yet this is a far from ideal means of informing people living with HIV how they should conduct their lives (see Smit in A Elliott 2005).

In this section, we highlight some of the problems that the criminalisation of sexual HIV transmission poses to the daily lives of many people living with HIV, and the vast majority of people that seek to meet their needs. While this list is far from exhaustive, all these questions need some resolution as a matter of urgency. We also outline some of the potential legal means to move towards clarity on the law and its relationship to sexual transmission of HIV.

## 5.1 NOT HAVING TESTED POSITIVE FOR HIV IS NO DEFENCE?

There is no clarity relating to prosecutions where it is deemed that a person *should have known* their positive status, even if they have not tested positive for HIV. While no evidence was heard in the Kouassi Adaye case because he pleaded guilty, there did not appear to be any evidence that he had ever tested positive for HIV. Those present at the sentencing hearing report that a doctor from Africa had been willing to offer testimony to the effect that she had recommended Mr. Adaye should have an HIV test due to his history of sexually transmitted infections, a recommendation that Mr. Adaye apparently never took up (Chalmers, personal communication). It has been pointed out that the law has a facility for 'wilful blindness' in relation to these types of recklessness charges (Chalmers 2002). That is, a person can be deemed to be reckless under the law even where they are not fully apprised of the necessary information that would help them to determine the likely outcome of their actions.

As such, we may see future prosecutions where sex workers, Gay men, or African people resident in the UK are convicted because they *should have* been aware of their HIV infection (even though it had not been diagnosed). This raises some serious questions about the policing of populations at highest risk, assumptions of the meaning of group membership, and the standard of evidence required to charge and convict.

## 5.2 NON-DISCLOSURE VERSUS ACTIVE DECEPTION – IRRELEVANT IN THE LAW?

Another issue that remains unresolved within the HIV sector is the extent to which it is desirable to make a distinction between remaining silent about an HIV diagnosis and lying about it in answer to a direct question (National AIDS Trust 2005, A Elliott 2005). It is possible that there is a moral distinction to be made between keeping quiet and seeking to deceive, however in its current state, the *OAPA 1861* does not afford us with a means of addressing these subtleties. This is partly the case because this statute was never designed to cope with the vagaries of risk, consent and negotiation. Therefore, no matter how desirable it may be to imagine that those who engage in active deceit are more culpable than those who were not asked their HIV status and did not reveal it – on the face of it, the *OAPA 1861* does not seem to recognise any such distinction.

### 5.3 DOES USE OF CONDOMS PROTECT AGAINST PROSECUTION?

The way that the criminal justice system interprets HIV transmission risk stands in stark contrast with harm reduction approaches to prevention. Many people living with HIV decide that if they are engaging in penetrative sex with a person to whom they have not disclosed their HIV status, they will use a condom. This is regarded as a simple means of protecting a partner from exposure while also protecting against the potentially negative outcomes of disclosure (Keogh *et al.* 1999). However, there is currently no clarity about whether a prosecution could be successfully brought in an instance where condoms were used, but HIV transmission still occurred.

The Court of Appeal decision in the Konzani case failed to make a clear distinction between protected and unprotected sex, and in relation to Lord Templeman's comments in the judgement of *R v. Brown* (1994), there is a possibility that the use of a condom could be interpreted by a jury as demonstrating a defendant's awareness of the risk of transmission (see Weait 2005b). In the future we might see cases where condom failure occurs and the HIV positive partner discloses their status so that the other person can access post exposure prophylaxis (emergency treatment) immediately. Should the person who has disclosed their infection after the fact be held legally liable for engaging in sexual behaviour that resulted in HIV exposure or transmission?

### 5.4 UNCERTAIN IMPACTS ON HIV RESEARCH, CARE AND SUPPORT

Practitioners across the HIV sector have raised a number of concerns about the professional and ethical implications of an increased regulatory environment surrounding HIV. The question of partner notification has been raised by those working in genito-urinary medicine. Some have expressed concern about the potential for legal liability being sought against medical staff who 'should' have informed known sexual partners about a patient's HIV infection. Clarification on this matter has been sought by legal and clinical experts (Chalmers 2004).

The use of blood samples that had been collected as a part of an MRC epidemiological investigation as evidence in the *Kelly* case (see Section 7.2.1) continues to raise questions about the moral and ethical implications of research engagement. Can researchers continue to ensure confidentiality to respondents who take part in HIV (or other sexual health) related projects?

It is also likely that increased regulation relating to HIV infection and transmission will mean increased legal intervention among people living with diagnosed HIV more broadly (Ormerod 2001). The Scottish Executive recently proposed new legislation which would compel individuals involved in possible exposure incidents (such as rape, car accidents, needlestick injuries) to submit to mandatory screening including HIV and hepatitis (Scottish Executive 2005a). This proposal will now be revisited through a public debate following on from a strong response by HIV organisations and public health bodies (McDougall 2005, Scottish Executive 2005b).

HIV care providers in New Zealand have reported on the impact that police seizure of their files, and personal threats of arrest for obstruction of justice had on their working practices and client confidence.

**The impact of the seizure of client files brought into question the ability of professionals and their organisations to provide a confidential service, to both potential defendants and complainants. In Christchurch, the national media hinted at cover-up conspiracies by health authorities... Alistair McDonald, in his position as a counsellor working for the NZAF at the time, observed the effects of the Christchurch prosecutions as being an exacerbation of the fear and anxieties HIV positive (and some HIV negative) people already have regarding surveillance and possible future prosecution.**

**McDonald & Worth 2005: 55-56**

As these authors point out, the actions taken by the police in these circumstances have probably caused significant damage to the capacities of a number of institutions that rely on an environment of confidentiality to meet government-contracted outcomes (McDonald & Worth 2005: 56). The New Zealand experience offers a stark warning to those working within HIV clinical and social care in many countries.

## 5.5 POTENTIAL ROUTES TOWARD LEGAL CLARITY

There are a number of means through which it may be possible to achieve differing degrees of clarity regarding the use of *the OAPA 1861* in England, Wales and Northern Ireland to prosecute such cases. Formal changes to the law and clear interpretation of the existing law achieved via a House of Lords ruling are two of the longer-term interventions that will be discussed below. In the shorter-term, engagement with the Crown Prosecution Service has resulted in the initiation of a designated working party consisting of representatives from the CPS and the HIV sector. The work of this group will contribute to the CPS aim of putting in place “a policy and guidance to inform future prosecutions in this area” (Crown Prosecution Service 2005: 29). However this endeavour comes with its own built-in limitations. First, no matter what the outcome, prosecutors will not be bound by the recommendations made in policy guidance. Second, prosecutions against those accused of recklessly infecting sexual partners with HIV will continue in the interim.

Some have argued that the best way to establish clarity around the criminalisation of sexually transmitted HIV is for Parliament to enact a new law that addresses the transmission of serious disease (Ormerod 2001, Chalmers 2002), or even one that is specific to HIV alone (Strickland 2001, Warburton 2004). This is an approach taken in many jurisdictions including Australia and some states in the USA, although it has been ruled out in other countries, such as South Africa (Mokgoro 2001). United Nations guidelines recommend that:

**Criminal and / or public health legislation should not include specific offences against the deliberate and intentional transmission of HIV but rather should apply general criminal offences to these exceptional cases. Such application should ensure that the elements of foreseeability, intent, causality and consent are clearly and legally established to support a guilty verdict and / or harsher penalties.**

**United Nations High Commissioner for Human Rights and the Joint United Nations Programme on HIV/AIDS 1998: para 29(a)**

It has also been suggested that the implementation of HIV-specific legislation will add to the burden of stigma on people living with HIV, because their infection alone would give them ‘potential criminal’ status (R Elliott 2002).

Those who call for a new Act of Parliament need to be clear about the likely implications of such a process. Law-making is generally used to clarify the specific circumstances under which a particular behaviour will be criminalised. Therefore, the request to establish a new Act in this instance amounts to a demand to specify when and in what contexts the transmission of HIV should be a criminal offence. The Home Office recommendations for reform of the *OAPA 1861* were welcomed by many in the HIV sector in 1998 as a fair means of consultation. However, such consultations are simply one aspect of the process of reform, and as is clear from experience since 1998, Home Office recommendations do not always result in legislative change. It is also necessary to recognise that once the process of law-making is underway, the outcome can be radically different to the one originally imagined by those calling for reform. There is little assurance that the initiation of reform at this time would result in a Bill that imposes any less duty on people living with HIV than the *OAPA 1861* as it is currently interpreted. In fact, there is a distinct possibility that a new Bill could result in harsher restrictions imposed on people living with HIV and other serious diseases. It should be pointed out that some hold a less ambivalent view on the potential involvement of Parliament on this matter (Ormerod 2001: 154-155).

Apart from the initiation of legal reform, there is another means by which public interest arguments in relation to the criminalisation of HIV transmission can be taken forward. If, for example, one of those individuals convicted under *OAPA 1861* for the transmission of HIV were to take his case forward to be considered by the House of Lords, then this would be an opportunity to ensure that concerns about the public health impact would be considered. In general terms, the role of the Crown Courts and the Court of Appeal (in criminal matters) is to determine the facts of a case to the extent that the actions of an individual can be considered to amount to a criminal offence. There is little opportunity at such hearings to introduce discussion about the broader public interest. At these stages, the relevant information is restricted to the facts of a specific case, or in the case of appeal, the procedural problems that bear questioning. However, when an appellant is given leave to appeal before the Lords, one of the central issues for consideration is the extent to which the application of a specific offence is appropriate within its broader social context. One of the explicit functions of appeal hearings held at the Lords is to clarify the broader appropriateness of making a specific activity illegal. Therefore, in the context of the criminalisation of HIV transmission, an appeal heard by the Lords would be an important opportunity to ensure that all of the relevant evidence and expertise relating to public health impact is heard. At the time of writing, Mohammed Dica's request to seek leave to appeal to the House of Lords has been certified, so it is possible that his case will be heard by the Lords in the near future.



# 6 Recommendations

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HIV health promotion specialists, sexual health care providers and AIDS service organisations have a duty of care to all those infected with HIV and those at greatest risk of infection. The criminalisation of sexually transmitted HIV infection is not an issue that any such organisation can justifiably ignore. However, responsibility for the maintenance of public health does not only rest with these organisations. Therefore this chapter makes recommendations to a range of organisations and institutions that collectively contribute to the reduction of HIV transmission while simultaneously ensuring that additional social and legal interventions do not interfere with that primary mandate.

## 6.1 RECOMMENDATIONS FOR HIV AND SEXUAL HEALTH ORGANISATIONS

1. **Provide accessible, accurate and up-to-date information about the state of the law in relation to sexual HIV transmission.** This will require the use of print and electronic media and training events to help people to understand how these convictions could impact upon them (as potential complainants, witnesses or defendants). Do not use the fluctuating and complex state of the current situation as an excuse for inaction.
2. **Develop and make known an organisational policy** on the use of the *Offences Against the Person Act 1861* for the criminal prosecutions of sexual transmission of HIV.
3. **Invest in organisational capacity to respond** to ongoing prosecutions of individuals for the sexual transmission of HIV (and other serious disease) including increasing knowledge and awareness among staff and clients.
4. **Determine and implement protocols for data management and confidentiality** in light of the possibility that named records from service sessions could be used as evidence in a court case and make clients aware of the limits of the confidentiality. As such, agencies will need to implement clear protocols for dealing with police enquiries relating to such cases.
5. **Increase support to people with HIV to manage status disclosure** to sexual partners and to reduce behaviours that carry a risk of HIV transmission. This is especially important for people who have been recently diagnosed.
6. **Encourage people without diagnosed HIV not to make assumptions about their sexual partners' HIV status.** Increase their awareness of the reasons why HIV positive sexual partners may not disclose their status and help to develop the skills required to negotiate sex that does not result in HIV transmission.
7. At both local and national levels, **monitor and respond directly to media stories** about such prosecutions, being particularly vigilant that language used is accurate and non-discriminatory and is in accordance with National Union of Journalists guidelines on HIV and AIDS and their code of conduct (1993, 2004). News media do respond to direct complaints, especially if from more than one organisation.
8. **Actively support existing communications networks regarding new criminal proceedings.** Share information (with due respect to the strictures of confidentiality where necessary) about arrests, prosecutions, court dates and convictions. This will also help to ensure that those working within the HIV sector attend such court hearings as observers, thus contributing to an approximate picture of ongoing developments. The MSN bulletin board on this topic that is managed by Matthew Weait and Catherine Dodds is one example of such a network (contact [catherine.dodds@sigmaresearch.org.uk](mailto:catherine.dodds@sigmaresearch.org.uk) if you are interested in joining). Another is the Positive

Voices message board hosted on the website of the UK Coalition of People Living with HIV & AIDS ([www.ukcoalition.org/cgi-bin/discus/discus.cgi](http://www.ukcoalition.org/cgi-bin/discus/discus.cgi))

9. Become familiar with **databases of specialist and experienced solicitors, barristers and expert witnesses** that are currently being developed with regard to prosecution of HIV transmission and ensure their use to assist clients requiring specialist legal advice. Once such databases are established, they will be publicised via the communications networks highlighted above.
10. **Write to the Crown Prosecution Service** and ask them to stop using Section 20 of the *Offences Against the Person Act 1861* to prosecute people for the sexual transmission of HIV until there is accessible and clear information about the specific conditions under which such charges can be brought. Write again each time you hear of a new prosecution.
11. Draw on available resources to **implement existing practical basic HIV training packages and reference materials** for police services, the Crown Prosecution Service, criminal solicitors and barristers, and members of the judiciary, covering HIV transmission and virology facts, the difficulties of positive disclosure, HIV-related stigma and the implications of treatment advances.
12. **Pro-actively develop relationships with civil society agencies** involved in the criminal process (particularly the CPS and police services) to develop and ensure access to reference and training resources, to establish a collegial culture across agencies, and to encourage referral and 'cooling off' periods supported by specialist counselling when criminal complaints arise.
13. **Maintain an active and public profile in the development of policy and law reform.** Ensure ongoing discussion of the impact of criminalising sexual transmission of HIV within the HIV sector, in news media and among Members of Parliament, the Law Society, legal and social science academics, police, health professionals and their representative bodies. Ensure that people living with HIV have a central role in planning, policy and legal reform recommendations in this area.

## **6.2 RECOMMENDATIONS FOR PROFESSIONAL ASSOCIATIONS OF CLINICAL SERVICE PROVIDERS**

**(eg. *British HIV/AIDS Association, British Association for Sexual Health and HIV, Society of Sexual Health Advisors*)**

14. Seek clear guidance from the Department of Health in relation to **the legal and ethical implications of clients' disclosure of behaviours that carry a risk of HIV transmission** (both for the sake of the NHS provider and the patient). This should include the development of clear protocols on the circumstances under which medical confidentiality can be broken, and how to manage police enquiries in such cases.
15. **Develop and issue guidelines on health professionals' roles and responsibilities** in relation to the prosecution of people for HIV transmission and support them with training. Health care professionals need ongoing advice, support and information about these prosecutions and the impact they may have on service delivery.

### **6.3 RECOMMENDATIONS FOR NHS STAFF**

**(including health advisors, HIV consultants, general practitioners)**

16. **Determine and implement protocols for data management and confidentiality** in light of the possibility that named records from service sessions could be used as evidence in a court case and make clients aware of the limits of the confidentiality.
17. **Increase support to clients with HIV to manage status disclosure** to sexual partners and to reduce behaviours that carry a risk of HIV transmission. This is especially important for people who have been recently diagnosed.
18. **Encourage clients who are engaging in behaviours that risk the transmission of HIV not to make assumptions about their sexual partners' HIV status.** Increase their awareness of the reasons why HIV positive sexual partners may not disclose their status, and why those who are not diagnosed may not endeavour to negotiate sex that reduces the risk of transmission.
19. **Develop or consolidate referral pathways** for HIV positive, HIV negative and untested clients to specialist HIV services and legal advice.

### **6.4 RECOMMENDATIONS FOR THE POLICE**

20. **Establish a collegial culture across agencies** to encourage referral protocols including 'cooling off' periods supported by counselling when criminal complaints arise.
21. **Police Diversity Officers liaise with HIV and sexual health organisations** to develop training materials that will be most useful to the police services. Diversity officers play a key role in the delivery of such training and in making referrals from the police services to the HIV sector.
22. **When HIV transmission comes to light during unrelated investigations, immediately refer to an HIV service provider.** Do not pressurise individuals to pursue charges relating to the sexual transmission of serious disease.

### **6.5 RECOMMENDATIONS FOR THE CROWN PROSECUTION SERVICE**

23. **Make clear the circumstances under which an individual will currently be prosecuted for sexual HIV transmission** in contravention of the *Offences Against the Person Act 1861*.
24. **Ensure that people living with HIV and representative agencies are engaged in any process of community consultation** that follows on from the meetings of the working group assembled for this task.
25. As a reviewing authority, **pursue prosecutions under Section 18 of the OAPA only where there is clear *prima facie* evidence** of intentional transmission. Do not charge Section 18 (intentional transmission) in the hope of achieving a guilty plea to a lesser charge under Section 20 (recklessness).

### **6.6 RECOMMENDATIONS FOR LEGAL PROFESSIONALS AND THE JUDICIARY**

26. **Seek out information about the current state of HIV** including transmission probabilities and the impact of treatment on infectivity.
27. **Ensure the use of appropriate language** during court cases and when speaking to the media. Judges have a specific obligation to ensure that language used in relation to HIV within the court is non-discriminatory and accurate. Do not allow HIV to be referred to as a 'death sentence' or people with HIV as 'AIDS victims'.

## 6.7 RECOMMENDATIONS FOR THE DEPARTMENT OF HEALTH

28. **Clarify the legal and ethical implications of clients' disclosure of behaviours that carry a risk of HIV transmission** (both for the sake of the health service provider and the client). The Department of Health has a duty of care to all NHS staff to support their capacity to feel competent when complaints or revelations about sexual transmission of HIV arise.
29. **Clarify the circumstances under which medical confidentiality (ie. as defined by the General Medical Council Guidelines) can be broken and when third parties (including sexual partners) should be notified of an individual's HIV positive status**, and what role health service providers may or may not play in that process.
30. **Provide guidance to NHS staff on protocols for data management and confidentiality** in light of the possibility that named records could be used as evidence in a court case. This is particularly prescient with the development of electronically stored health records that are held on a national database.

## 6.8 RECOMMENDATIONS FOR JOURNALISTS AND MEDIA EDITORS

31. Meet the ethical and professional obligations **to ensure accurate reporting of prosecution cases**. Stop using the phrase 'deliberate transmission' in relation to recklessness cases.
32. **Ensure the use of appropriate language** in media reports. Do not refer to HIV as a 'death sentence' or to people with HIV as 'AIDS victims'. Do not use xenophobic language in relation to migrants, refugees and asylum seekers involved in such cases. Editors have a specific obligation to ensure that the vocabulary used is appropriate, non-discriminatory and accurate as outlined in the National Union of Journalists HIV and AIDS guidelines and their code of conduct (1993, 2004).
33. Media aimed at Gay, Black and/or HIV positive communities should **offer some degree of balance** to sensationalist and hyperbolic coverage when covering stories about HIV generally and about these cases in particular. This should include help to individuals to understand the impact that prosecutions for sexual HIV transmission could have on them.

# 7 Appendix: Summary of cases to date

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## 7.1 ENGLAND, WALES AND NORTHERN IRELAND

In the jurisdiction of England, Wales and Northern Ireland, five people have been convicted of recklessly inflicting grievous bodily harm, contrary to Section 20 of the *Offences Against the Person Act 1861* after having transmitted HIV to sexual partners. Four of these convictions took place in England and one in Wales.

The authors are aware of three other pending cases. In two charges have been made against men by male sexual partners, and in the third a White British woman is facing charges made by a male complainant. It is likely that if these cases proceed, they will come up on the court schedule before the end of 2005. It is also likely that other charges have been made that have not made it to the attention of the authors, as information on such matters is collected on an *ad hoc* basis. In the main, where cases are known about within the HIV sector in advance, that has been because someone involved in a case (either complainant, defendant, or both) has discussed the matter with an HIV service provider who then shares basic information about the existence of the case with others in the sector while simultaneously protecting client confidentiality.

### 7.1.1 *Mohammed Dica*

Mr. Dica is a Kenyan who was living near London, with refugee status, with his wife and children at the time of his arrest. He was originally prosecuted and convicted on two counts of recklessly inflicting grievous bodily harm, contrary to Section 20 of the *Offences Against the Person Act 1861* after having transmitted HIV to two female sexual partners in South London (for a summary of this section of the Act, see the text box on page 2).

When Judge Philpot was directing the jury at the end of the trial in November 2003, he said that the issue of whether they believed that Mr. Dica had disclosed his HIV status prior to unprotected sexual intercourse was immaterial, as the complainants could not have consented to the harm of HIV transmission even if he had done so. In so ruling Judge Philpot relied on the decision of the House of Lords of *R v Brown* (1994), often referred to as the 'Spanner' case. This decision affirmed the criminal convictions of a number of men who had injured each other in the context of sado-masochistic sex on the basis that they could not legally consent (on public policy grounds) to the harm caused. Mr. Dica was convicted and sentenced to eight years imprisonment.

Subsequently, Mr. Dica launched and won an appeal in March 2004. In a majority judgment, the Court of Appeal agreed with the arguments put forward by Jeremy Carter-Manning QC, defence barrister, and held that the original trial judge should not have removed the issue of consent from the consideration of the jury. A retrial of the Dica case was ordered (*R v Dica* 2004). The Court of Appeal made it clear that juries should have the freedom to convict for the transmission of serious sexually transmitted disease, thus abolishing the prior authority of *R v Clarence* (1889). However, the Court of Appeal overturned Judge Philpot's interpretation of the issue of consent to harm. In their written judgment, the Court held that while those in *Brown* were participating in activities certain to induce harm, and that prohibition against such behaviour on public policy grounds remained justified, it did not feel that the courts should prohibit the ability to consent to *the risk of harm* between people engaged in sexual intercourse. To do so would, in its view, result in an unjustifiable diminution of personal autonomy. Thus, while one cannot consent to harm (apart from exceptional

circumstances such as injury consequent upon surgery, or inflicted during contact sports), the Court of Appeal held that one can consent to *the risk of harm*, and that a defendant may rely on such consent (or an honest belief in it) in his defence. As such, the Court determined that the question of the complainants' knowledge and consent in relation to Mr. Dica's HIV status should have been put before a jury.

A retrial was initiated in June 2004, but soon came to a halt when questions were raised about the validity of documentation that one of the complainants, known as 'L' had submitted in support of her testimony. Subsequent to an investigation and expert report on the matter, 'L' decided that she did not wish to give evidence again. In December 2004 another retrial took place with only the complainant known as 'D'. In that retrial the jury was unable to reach a verdict. At his third retrial in March 2005, Mr. Dica was convicted on one count of recklessly inflicting grievous bodily harm contrary to Section 20 of the *OAPA 1861*. He was ordered to serve out the remainder of his four and a half year sentence on that conviction. At the time of writing, while Mr. Dica was refused leave to appeal a second time to the Court of Appeal, it has been certified that he can request such leave to have his case heard at the House of Lords.

In the Dica trials there was no claim that the defendant had actively deceived his sexual partners as to his HIV status; rather, it was that he had failed to disclose it before participating in protected and unprotected sex. According to court testimony given by 'D', she met Mr. Dica in December 2000. 'D' made arrangements to leave her long-term partner as she initiated a sexual relationship with Mr. Dica. On the first two occasions of sexual intercourse, 'D' said that she provided condoms and ensured that they were used, but they subsequently stopped as Mr. Dica said he did not like using them. They subsequently had unprotected sexual intercourse together on numerous occasions until April 2001. 'D' testified that she was in love with Mr. Dica, and said he had wanted to start a family together.

After April 2001 Mr. Dica stopped contact with 'D' and it took her some months to find him. By that time she had already been diagnosed with HIV infection. They resumed contact after she located him at St. George's Hospital undergoing treatment. She told Mr. Dica of her own HIV positive infection and urged him to get tested. It was in later conversations with friends of Mr. Dica that 'D' said she learned of the many untruths he had told her over the course of their relationship, and that he had been diagnosed with HIV many years earlier. In an interview following on from the original trial, 'D' said:

**I was never going to let this go and let that man get away with what he did to me. It was not just for me but for other people as well. I thought if he's done this he needs to be stopped.**  
Flynn 2004a: 18

Mr. Dica did not testify at his original trial nor at any of the retrials. In his statement to the police upon arrest he said that he and 'D' had started a sexual relationship together in 1995, before his HIV diagnosis. He also said that when he later resumed a relationship with her in 2000, he told her that he was HIV positive and said that at the time she declared she was HIV positive as well. This latter point would appear to have been disproven by medical evidence that 'D' had an HIV negative test result in 2001, experienced the symptoms of seroconversion illness in the spring of that year and then subsequently had an HIV positive test result. Scientific evidence comparing a voluntary sample of blood given by Mr. Dica and that of 'D' demonstrated a high degree of similarity between their viral strains.

### **7.1.2 Kouassi Adaye**

There is very little reliable detail about the conviction of Kouassi Adaye as he pleaded guilty to a charge of recklessly inflicting GBH for the HIV infection of a woman living in Liverpool, alongside a number of unrelated charges including fraud and bigamy. The guilty plea for all charges meant that there was no courtroom trial of the evidence pertaining to this case. However, it would seem that

four years of his total six year sentence relates to the GBH conviction. Newspapers reported that Mr. Adaye was an asylum seeker from the Ivory Coast (Chapman 2004). He lived in the UK on his own, as his wife remained in South Africa.

It would appear that Mr. Adaye did not have an HIV positive diagnosis based on a blood test before his arrest, nor is it clear that there was any scientific evidence demonstrating any similarity between the viral strain of the complainant and the strain carried by Mr. Adaye. It has been erroneously and widely reported in the local and national press that Mr. Adaye's wife had telephoned from South Africa to inform him of her own HIV positive diagnosis in April 2002. Apparently the judge ordered that newspapers correct this misinformation, but there is no evidence that any correction was ever published.

Those present at the sentencing hearing report that a doctor from Africa had been willing to offer testimony to the effect that she had recommended Mr. Adaye to attend for an HIV test given that he was determined to be at 'high risk', a recommendation that Mr. Adaye apparently never took up (Chalmers 2005, personal communication). The judge felt that in light of this information, Mr. Adaye should have recognised the likelihood of his own infection, and called his ensuing sexual behaviour 'despicable'. It is expected that he will be deported after serving out his sentence.

### **7.1.3 Feston Konzani**

Feston Konzani arrived in England from Malawi in 1998, and was settled in Middlesbrough by the asylum service at the time of his arrest in 2003. He was convicted on three counts of reckless HIV transmission contrary to Section 20 of the *OAPA 1861*, and sentenced to a total of ten years imprisonment. Judge Fox who presided over his case commented that it would be likely that Mr. Konzani would face a deportation order once he had served his sentence. Mr. Konzani did not testify in court in his own defence, and said very little to police at the time of his arrest. Therefore, like in the *Dica* case, most of the trial evidence consists of testimony offered by the female complainants.

The first of these, referred to as 'DH' was fifteen years old when she met Mr. Konzani, and she had not previously had sexual intercourse. They began a relationship and she soon moved in with him. They participated in unprotected sexual intercourse over a number of weeks while living together. As the complainant described the situation, Mr. Konzani allowed her less and less contact with others over the course of this relationship. Eventually she left by climbing out of a kitchen window in the house they shared and returned to live with her mother. 'DH' later began a sexual relationship with another man, and subsequently went to the doctor because she thought she may have been pregnant. Her blood was tested for HIV, and it was at this time that she became aware of her HIV positive status. Her current, and another previous, sexual partner were tested for HIV infection and they tested negative. With 'DH's' consent, her doctor contacted police and registered a complaint against Mr. Konzani. 'DH' testified that Mr. Konzani never told her that he was infected with HIV, and that she was aware that unprotected sex could lead to pregnancy or a disease. When asked in re-examination if she thought having sex with Mr. Konzani put her at risk of catching a serious sexually transmitted disease, she replied: 'No. If I'd have known that I wouldn't have went with him' (*R v Konzani 2005*: para 14).

The second complainant was 'RW', a Kenyan woman who met Mr. Konzani at church in December 2002. They met at a number of church-related events, and she subsequently moved in with him and they had protected and unprotected sexual intercourse on a number of occasions. About the time that their relationship ended, 'RW' discovered that she was pregnant. An HIV test administered by her doctor at that time resulted in a positive diagnosis. She subsequently gave birth, and the child is HIV negative. 'RW' testified that as she trusted Mr. Konzani, she had no concerns about the fact that they had not discussed the use of contraception or the risk of HIV infection before engaging in protected sex. She said that she recognised the risk she had taken when looking back on the situation, but none of this had occurred to her at the time.

The third complainant, 'LH' met Mr. Konzani in connection with her community voluntary work relating to Africa. They discussed the situation of AIDS in Africa, and she testified that Mr. Konzani said that HIV was not very common in his home country of Malawi, and he did not disclose his own HIV positive status to her. She said that after the first time they had penetrative sex using a condom, she said to Mr. Konzani, 'I hope you haven't got any disease' and that he replied, 'Don't be stupid'. Further into their sexual relationship, Mr. Konzani stopped using condoms. 'LH' testified that rather than having a responsibility to ask him if he had taken an HIV test, that it was Mr. Konzani's responsibility to tell her of his infection. When the relationship later ended she had an HIV test, which is when she was diagnosed positive.

When Judge Fox directed the jury at the end of the trial he said:

**I leave you with this acid test which you may find of practical use. If a little bird had whispered in her ear as she was about to have unprotected sexual intercourse with Feston Konzani, "Would you be doing this if you knew he was HIV infected?" and that little bird went on to describe what that meant ... would she reply, "No, I wouldn't" or would she reply, "It doesn't matter, I'll be alright"? If you are sure she would say, "No, I wouldn't", then that would lead you to a guilty verdict. If it is your judgment that she should have said or may have said, "It doesn't matter", then he is not guilty.**

*R v Konzani 2004: Trial Transcript: 53 at lines 11-21.*

In March 2005 the Court of Appeal heard arguments from Mr. Konzani's defence barrister, Mr. Tim Roberts QC, about the problematic way in which Judge Fox handled the question of consent in his direction to the jury where he specified that in order to convict Mr. Konzani, they would have to determine that the complainants had not 'willingly' or 'consciously' consented to the risk of HIV transmission. Mr. Roberts argued that the trial judge should have considered the likelihood that in the mind of Mr. Konzani, the fact that the complainants had agreed to have unprotected sexual intercourse meant that they were consenting to the risk of any outcome that might follow from that action, including the transmission of HIV. This raised the question as to whether the judge had allowed the jury to consider whether Mr. Konzani had a guilty mind in relation to the offences. In response to these arguments put forward by the defence, the Court of Appeal judgment states:

**There is a critical distinction between taking a risk of the various, potentially adverse and possibly problematic consequences of sexual intercourse, and giving an informed consent to the risk of infection with a fatal disease.**

*R v Konzani 2005: para 41*

It then goes on to say:

**If an individual who knows that he is suffering from the HIV virus conceals this stark fact from his sexual partner, the principle of her personal autonomy is not enhanced if he is exculpated when he recklessly transmits the HIV virus to her through consensual sexual intercourse. On any view, the concealment of this fact from her almost inevitably means that she is deceived. Her consent is not properly informed, and she cannot give an informed consent to something of which she is ignorant.**

*R v Konzani 2005: para 42*

In its *Konzani* ruling, the Court of Appeal made a clear distinction between *running* a risk, and *consenting* to a risk. The complainants testified that they had been aware they were running a general risk in having unprotected sex. However, the Court of Appeal upheld the conviction on the basis that the complainants were unable to specifically consent to the risk of HIV transmission in the absence of disclosure by Mr. Konzani of his HIV positive status. This meant that Mr. Konzani could not successfully defend himself with the claim of an honest belief of a sexual partner's consent in the absence of disclosure (Weait & Azad 2005). This judgment therefore has a significant impact on the way in which people living with HIV should now consider disclosure of their HIV status to sexual partners. It means that where a person who knows their HIV positive status does not disclose this to



a partner prior to sex that carries a risk of transmission, and transmission occurs, that individual will be potentially liable to prosecution.

#### **7.1.4 Paolo Matias**

Mr. Matias entered a guilty plea on a charge of reckless grievous bodily harm (GBH) relating to the transmission of HIV to one female sexual partner in Leicester. He was sentenced to a prison term of three years in April 2005. It was reported that after more than a year of platonic friendship, Mr. Matias and his female partner began a sexual relationship where condoms were initially used and then abandoned at the request of Mr. Matias (Gibson 2005). It would appear that Mr. Matias was diagnosed with HIV in May 2002, once he was already friends with the female complainant, but prior to the start of their sexual relationship. During the sentencing, the Judge Michael Stokes QC noted that Mr. Matias might be in need of further information about the issues relating to HIV, and he hoped that he could be provided with relevant education in prison (A Elliott 2005, personal communication).

#### **7.1.5 Anonymous female**

In July 2005 a twenty year old woman in Newport, Wales entered a guilty plea on a charge of reckless grievous bodily harm (GBH) relating to the transmission of HIV to a male regular sexual partner. Her identity cannot be revealed by an order of the court.

She was sentenced to two years' youth custody after pleading guilty to a Section 20 charge contrary to the *OAPA 1861* for the transmission of HIV to a long-term male sexual partner (Bernard 2005). The reliability of widespread media reporting on this conviction was poor, after a Press Association press release stated that the conviction related to a Section 18 offence, because a PA reporter had used the word 'deliberate' in her report on the sentencing (G Patterson 2005, PA editor, personal communication). As in other cases where a guilty plea has been entered for a Section 20 offence, it is only possible to rely on media reporting of the alleged events. No courtroom testimony was heard.

A report in *The Sun* alleged that the young couple met when they were both 18 years old, and that the woman had been diagnosed after the relationship with the complainant had already begun (Coles 2005). Apparently she did not immediately disclose her HIV diagnosis to her boyfriend, and it is unclear at what point disclosure did happen, if at all. It was also reported that while the couple had initially used condoms during sexual intercourse, these were later abandoned as they wanted to (and did) have a child together. It would appear that in a letter composed by the young woman read out on the day of the sentencing, she said that she had not known how to disclose to her partner, and that she had trusted advice given to her that it was difficult for HIV to be sexually transmitted from women to men (Coles 2005).

## **7.2 SCOTLAND**

### **7.2.1 Stephen Kelly**

As an inmate at Glenochil Prison in Scotland in the early 1990s, Stephen Kelly contracted HIV while sharing syringes to inject drugs. Glenochil Prison experienced a significant outbreak of HIV among its drug injecting prisoners at that time, with molecular tests from a subsequent research investigation demonstrating that thirteen shared the same strain (Yirrel *et al.* 1997). Mr. Kelly voluntarily underwent HIV testing and counselling and he was diagnosed HIV positive in 1993. After leaving prison, Stephen Kelly began a sexual relationship with a female partner that included unprotected penetrative vaginal and anal intercourse over the course of two months (Bird & Leigh Brown 2001). During his trial for recklessly causing injury, the female complainant testified that she had known of Mr. Kelly's history of injecting drug use and imprisonment, and that when she

asked if he had AIDS he said that he had been tested as a matter of routine in prison, and that he had tested negative. She said that in March 1994, Mr. Kelly told her that she might be infected, as he had recently found out from a former girlfriend that he may have HIV. The female complainant subsequently tested positive for HIV, and continued in her relationship with Mr. Kelly. She said that Mr. Kelly later revealed that the story about the prior girlfriend had been a lie, and that he had known all along that he was HIV positive. Their relationship continued for some months, and in a later interview with the press, the complainant said that Mr. Kelly had intended to infect her with HIV so that he could manipulate her to stay in the relationship. She said, "there's no doubt in my mind at all that he went out of his way to deliberately infect me, which is why the prosecution took place" (BBC News Online 2001).

There were no arguments presented for the defence over the course of this trial. In his statement to police, Mr. Kelly first said that he had informed his girlfriend of his HIV positive diagnosis before the start of their sexual relationship. Later in the police interview he said that he had not discussed it with her before having sex. The jury found Mr. Kelly guilty of reckless endangerment and he was sentenced to five years in prison.

The *Kelly* judgment was the first time anyone in the United Kingdom had been convicted of a criminal act relating to the transmission of HIV. As the indictment faced by Mr. Kelly was specific to Scots Law, it was unclear at the time of his conviction whether prosecutions for the transmission of HIV would proceed in the criminal courts in England, Wales or Northern Ireland with the use of different charges. The *Kelly* judgment raised significant concerns within the research community about the criminal courts' use of information arising from medical research. Kelly had voluntarily taken part in a molecular epidemiology research project into the Glenochil prison HIV outbreak. Test results from this research were seized with the use of a police warrant and used as forensic evidence in the case against Kelly (Bird & Leigh Brown 2001: 1176). This raises the question of researchers' capacity to assure confidentiality for research participants when potentially incriminating evidence can be demanded for use in the courts.

### **7.2.2 Giovanni Mola**









In April 2005 a Scottish newspaper reported that an arrest warrant had been issued in Edinburgh against Mr. Mola after allegations that he concealed his health conditions from his female sexual partner who developed HIV and hepatitis C infection (Robertson 2005a). The couple engaged in unprotected sex between September 2003 and February 2004. It would appear that Mr. Mola is currently in Italy, having had some involvement with the Italian court system on separate charges. The Scottish courts are seeking clarification as to when Mr. Mola can be returned to Scotland to face the charge of reckless endangerment for the transmission of disease.









### **7.2.3 Christopher Walker**







A haemophiliac with HIV infection was declared unfit to stand trial by reason of insanity in Paisley, Scotland in May 2005 (Robertson 2005b). He had been facing a charge of culpable and reckless conduct in relation to repeated acts of sex (newspaper coverage did not stipulate if this referred to unprotected intercourse) with a female partner, while he knew or believed he was infected with HIV. The court ordered his detention in a medium-security psychiatric facility, after hearing reports that Mr. Walker's condition had begun to improve with the use of anti-psychotic drugs. A psychiatrist at the facility has said of Walker: 'He says he has no intentions of entering any further intimate relations again,' adding that if he did he would inform his psychiatrist and would take precautions against the risk of transmission (Robertson 2005b).











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