



ASSAULTS AND OTHER OFFENCES AGAINST THE PERSON - SENTENCING ADVISORY PANEL CONSULTATION

Submission from the National AIDS Trust and Terrence Higgins Trust

Introduction

This submission is made by the National AIDS Trust (NAT) and the Terrence Higgins Trust (THT). It is also supported by the African HIV Policy Network (AHPN).

The National AIDS Trust is the UK's leading independent policy and campaigning organisation on HIV. We develop policies and campaign to prevent the spread of HIV, ensure people living with HIV have access to treatment and care, and eradicate HIV-related stigma and discrimination.

The Terrence Higgins Trust is the largest sexual health charity in the country, providing services to over 50,000 people and campaigning around sexual health and HIV prevention, treatment and care.

NAT and THT welcome the consultation by the Sentencing Advisory Panel on assaults and other offences against the person. We wish to draw the attention of the Panel to a recent use of s20 of the Offences Against the Person Act 1861 (OAPA 1861), namely the prosecution of the reckless transmission of HIV. There have been five prosecutions in England and Wales since 2003, all of which have resulted in custodial sentences.

We believe that this extension of the use of the OAPA to consensual sexual behaviour raises a number of fresh issues for sentencing policy, including a much wider range of mitigating circumstances and questions over the appropriateness of a custodial sentence for someone living with HIV as a suitable response to HIV transmission.

At the time of writing there is the possibility that Mr Dica, the first man convicted of reckless transmission of HIV under the OAPA, might take his appeal to the House of Lords. The Crown Prosecution Service is also in the middle of a consultation with relevant professionals and affected communities on guidance for

prosecutors in this new area of law (NAT, THT and AHPN are all represented on the working group). We would suggest that the Panel might make some interim recommendations on the basis of submissions received on this issue but also, given the continuing uncertainty as to the application of the law, that the Panel agree to return to the question of sentencing for reckless disease transmission in the near future to allow more detailed consideration.

NAT and THT oppose the prosecution of reckless transmission of HIV. Some of the arguments relevant to this position should, at least whilst prosecutions continue, have a mitigating impact on sentencing.

This submission focuses on HIV but we note that there is a possibility that reckless transmission of other sexually communicable diseases could be successfully prosecuted in the future.

Seriousness of harm

HIV is a serious long-term condition. It does not, however, in the UK, with treatment available, result in death except in a very small number of cases (usually when someone is diagnosed at so late a stage of disease progression that treatments are ineffective). People can live with HIV for many years without any HIV-related illness or symptoms. HIV treatments can also allow people to live full and productive lives. Indeed recent research suggests that the large proportion of HIV positive people who respond well to anti-retroviral therapy have the same mortality rates as those of the general population.¹

There is, however, a great danger that prosecution, conviction and sentencing for HIV transmission take a view of seriousness influenced by the pervasive fear and stigma associated with the disease and by outdated medical information rather than by clear understanding of the current medical facts and the realities of living with this long-term but manageable condition. In trials to date, some of the comments made suggest an outdated or incorrect understanding of the implications of an HIV diagnosis. To give just one example, counsel in one case described HIV infection as no different from 'rushing down the street with a hammer and smashing someone's skull'.

If prosecutions are to continue, **the courts need as a matter of urgency to have consistent training and information**

¹ Lewden C. abstract PE18.4/8, 2005 10th European AIDS Conference

available on HIV to counteract the possible impact on sentencing of HIV-related stigma and misconceptions about the transmission and impact of the disease.

Culpability

Of course culpability in a case of transmission of HIV will vary from case to case.

No one has as yet been convicted of intentional transmission under s18 of the OAPA (and we would submit that such cases would be extremely rare).

With regard to the other three levels of culpability identified by the Sentencing Guidelines Council, there is evidence that the vast majority of those living with HIV are concerned not to pass the virus on to sexual partners. Unprotected sex may occur because of fear of the consequences of disclosure of HIV status, including loss of confidentiality or violence. The power balance in the relationship may make condom negotiation difficult. There are also many who have received little or no clear advice and support on safer sexual behaviour.

We submit that the vast majority of instances where someone diagnosed with HIV has transmitted the virus through unprotected sex without disclosure of status should fall into the category of negligence or, in some cases, 'knowledge' as defined by the Sentencing Guidelines Council.

Aggravating factors (Questions 2 and 3)

One of the aggravating factors referred to which is relevant to HIV transmission is 'Commission of an offence while under the influence of alcohol or alcohol or drugs'. There is evidence that high risk sexual behaviour is often associated with alcohol or recreational drug consumption (though the causal relationship remains unclear). But in the majority of these cases it will be both parties who are affected by alcohol or drugs in cases of consensual sex.

We submit that in such instances where both parties are intoxicated, both are responsible for any failures in safer sex, condom negotiation and disclosure of HIV status. It would be wrong to consider the influence of alcohol or drugs to be an aggravating factor in such cases since the circumstances are so different from other cases of assault.

Mitigating factors (Questions 2 and 3)

As stated above, in cases of reckless HIV transmission, there are a number of possible mitigating factors which should be taken into account.

Four factors are mentioned in the consultation paper. We agree that all four are relevant to HIV transmission cases.

The example of provocation has some particular relevance to HIV transmission cases. We note that provocation can include anticipated violence. We also note that CPS domestic violence policy considers 'outing' of HIV status to be a possible instance of harassment, actual bodily harm or blackmail. Fear of the consequences of disclosure in both heterosexual and homosexual relationships is one of the main reasons why people diagnosed with HIV continue to have unprotected sex with regular sexual partners without disclosing HIV status. **A reasonable anticipation of consequences of disclosure such as violence, eviction, denial of contact with children, and 'outing' of HIV status to others should be an important mitigating factor in sentencing.**

Another important area of mitigation relates to knowledge of possible harm and the extent and quality of safer sex advice and support given to the accused. In at least two of the five cases so far prosecuted there has been evidence that the accused had poor knowledge of risk of transmission. Post-test discussion of the implications of a positive diagnosis varies significantly both internationally and within the UK. Some people living with HIV in England are denied access to HIV treatment because of their residency status and are thus denied access to the HIV counselling and support many need to develop safer sex behaviours. Some HIV prevention messages are now recommending risk reduction strategies within unprotected sex, which people may act on in a genuine attempt to be responsible and avoid reckless HIV transmission. **Mitigating factors in sentencing should include poor or inadequate understanding of risk of HIV transmission and lack of advice and support available on safer sex.**

Safer sex information advises consistent condom use or less risky sexual behaviours such as oral sex to be safer alternatives to unprotected intercourse. HIV transmission does, however, remain possible, even if much less likely. If prosecutions are brought in cases where infection could only have occurred despite condom use or less risk sexual behaviours, **condom use or the choice of less**

risky sexual behaviours should be an important mitigating factor in sentencing.

A further issue relates to who in the relationship has decision-making power and responsibility for condom use. In many instances control of condom use is not equally shared between sexual partners and this should be recognised in sentencing. There are many instances where requests to use a condom by someone with HIV are refused by the sexual partner, leaving the person with HIV with the choice of disclosure or refusal to have sex, both of which can be fraught with danger and difficulty. **In sentencing, consideration should be given to the lack of control the accused had over condom use in the particular relationship as a mitigating factor.**

There are cases where a positive person only realises that possible infection of a sexual partner may have occurred after sex has taken place, for example when condom breakage occurs. It is important that the sexual partner is advised to go immediately to request a course of Post-Exposure Prophylaxis (PEP) to prevent HIV infection. Of course this would be to disclose HIV status and run the risk of future prosecution. Such a possibility should not act as a disincentive to advise PEP. **Disclosure of HIV status after sex has taken place and advice to take PEP should be mitigating factors in sentencing.**

Compensation (see Question 10)

We submit that compensation orders are inappropriate in cases of reckless transmission of HIV, given that the 'harm' took place as a result of consenting sex between two adults.

The Panel's proposals for s20 offences (see Question 13)

For reasons outlined above, **we submit that the section at para.113 on starting point sentences for s20 offences does not adequately address instances of reckless transmission of HIV during consensual sex.** One reason for this is the need for a fuller list of mitigating factors. Another, which we discuss further below, is the inappropriateness of custodial sentence for those living with HIV. A third and fundamental objection is that the mode of transmission involves the complainant consenting to unprotected sex in a society where safer sex messages inform the public of the need to use condoms to avoid HIV infection - in other words, there is some shared responsibility for the fact of HIV transmission. The complexities with regard to trust and assumptions of HIV status in sexual relationships, and the stigma surrounding HIV in society

which can make disclosure extremely difficult - all these circumstances mean that reckless transmission of disease is, we submit, a very different order of offence to those ordinarily prosecuted under s20 of the OAPA.

HIV infection does of course require extensive medical treatment but we submit that the three year starting point proposed is unduly harsh given the very specific and widely differing circumstances of this kind of case.

The inappropriateness of custodial sentences

To date, all those convicted of reckless HIV transmission have received significant custodial sentences, and in two cases a recommendation of subsequent deportation.

There is both UK and international evidence that prisons are places where there is increased risk of HIV transmission, where there are significantly higher rates of HIV prevalence, where confidentiality of HIV status and treatment are usually compromised, and where there are high levels of HIV-related stigma, discrimination and abuse. Condoms in English and Welsh prisons remain extremely difficult to get hold of, with serious implications for unsafe sexual behaviour and onward transmission of the virus. We would refer the Panel to the recent report published by NAT and the Prison Reform Trust 'HIV and hepatitis in UK Prisons'. It is currently unlikely that anyone convicted of reckless transmission of HIV would receive any kind of support in English prisons which would mitigate the possibility of re-offending, both inside prison and after release.

Since HIV treatment is not universally available in many other countries, a recommendation for subsequent deportation of a person with HIV to such a country will, in effect, be condemning them to an early and highly unpleasant death. Deportation in such cases constitutes a stronger sentence than any prison term, and an inappropriate response where the offence has arisen within consensual sexual activity.

We submit that prison is not ordinarily an appropriate form of punishment for someone with HIV convicted of reckless HIV transmission. Non-custodial alternatives should be considered. Deportation orders for these offences should not be made to countries where appropriate HIV treatment is not available.

**National AIDS Trust/Terrence Higgins Trust
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