

Investigation Guidance relating to the Criminal Transmission of HIV

for police forces in England, Wales and Northern Ireland



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Police Investigations relating to the Criminal Transmission of HIV

NAT has worked with the Association of Chief Police Officers (ACPO) to produce 'ACPO Investigation Guidance relating to the Criminal Transmission of HIV'. The Guidance aims to end inappropriate police investigations and ensure, when they are considered necessary, that police forces and officers investigate allegations of criminal HIV transmission in a way which is:

- consistent with CPS prosecution policy,
- appropriately informed about HIV from both a clinical and a social perspective
- respectful of human rights and confidentiality, and
- which does not prolong an investigation longer than necessary.

The Guidance is available to all police officers in England, Wales and Northern Ireland via the [College of Policing website](#). It is also available on the [NAT website](#) so that people with HIV, and organisations which support them, can know how the Guidance recommends police conduct these sensitive investigations.

Guidance sections:

Police Investigation flowchart (p.3): This flowchart sets out the overall investigative process for police once an allegation is made. Linked to the Police Investigation Flowchart are a number of other sections providing more detail on important aspects of an investigation, namely -

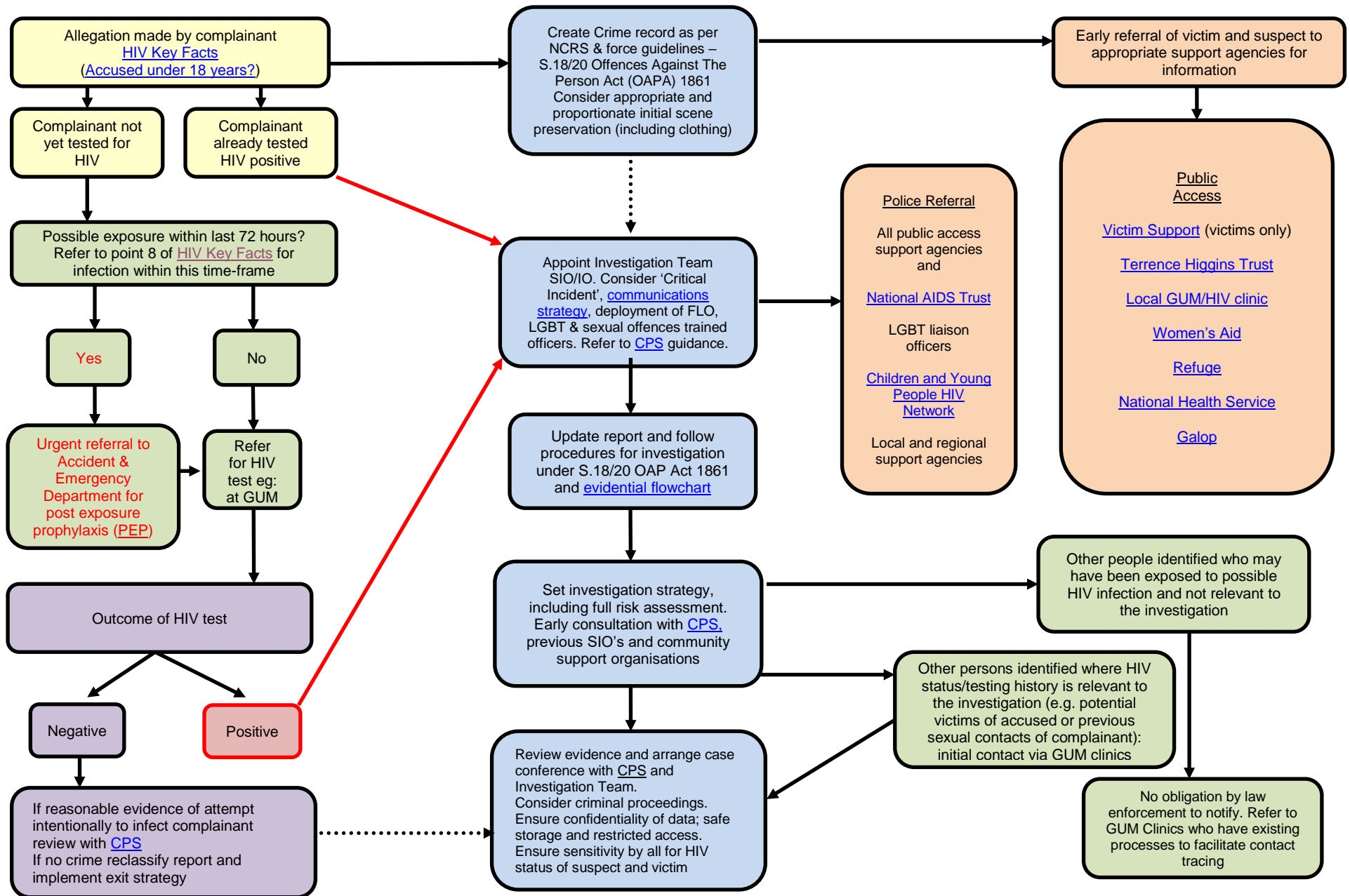
HIV Key facts (p.4): This section gives information on HIV for police officers, including key biological and clinical facts, information on PEP, PrEP, HIV testing, ARV medication and discrimination issues.

Accused under 18? (p.12): This section alerts police officers of the requirement to have special consideration of their process where the accused is under 18.

Communication Strategy (p.13): This section gives some guidance to police officers on communication around an ongoing and completed investigation and deals with issues of confidentiality and media relations.

Evidential Flowchart (p.17): This section sets out the evidential steps in any investigation which will limit unnecessary intrusion and ensure appropriate collection of evidence. Police are recommended ordinarily only proceed to the next stage of evidence gathering as set out in the arrows and boxes of the flowchart after they have established the relevant set of facts appropriate to the previous stage.

Initial contact via GUM clinics (p.20): This section recommends that where third parties emerge during a police investigation whose HIV status is of interest to the police, initial contact with the individuals should be made by a GUM clinic rather than by the police themselves.



HIV – KEY FACTS FOR POLICE

HIV – SIX IMMEDIATE THINGS YOU NEED TO KNOW

- 1. You cannot get HIV from someone through everyday contact. There is absolutely no need for gloves, masks or any form of additional protection or precaution for normal interaction. For spillages of body fluid or handling of sharps, universal precautions apply as usual.**
- 2. It is unlawful to discriminate against someone with HIV. This can include abusive or judgemental comments whether around HIV, sexual behaviours, sexual orientation or race. All communication should be respectful and supportive.**
- 3. Use the word ‘HIV’ – avoid using the term ‘AIDS’**
- 4. If someone tells you they are worried they may have been infected in the previous 72 hours, you must advise them to go immediately to either an open sexual health clinic or the nearest hospital Accident and Emergency Department to ask for PEP, which can prevent HIV infection.**
- 5. If someone tells you that they or someone else has HIV, take care to protect the confidentiality of the HIV positive person.**
- 6. If someone is in custody with HIV it is essential to find out whether they are taking treatment for their HIV, and, if they are, ensure that they have continuing and uninterrupted access to their medication.**

1. What is HIV?

HIV stands for Human Immunodeficiency Virus. HIV attacks the body's immune system – the body's defence against disease – so that it can no longer fight off certain infections and diseases. When someone is diagnosed as having HIV in their body they are described as being HIV positive, or living with HIV.

You should not say that someone with HIV has ‘AIDS’.

Whilst the virus can be treated, there is still no cure or vaccine for HIV.

2. What is the difference between HIV and AIDS?

The terms 'HIV' and 'AIDS' do not mean the same thing. 'AIDS' should not be used to refer to HIV.

AIDS is a medical term, often misused, for advanced HIV disease and has a very exact meaning.

When the immune system becomes weak following HIV infection, it gradually becomes unable to fight off certain infections and diseases (for example, TB, Non-Hodgkin's lymphoma, one type of pneumonia). Some infections or diseases are on an official medical list of 'AIDS-defining illnesses'. Most people with HIV do not have an AIDS-defining illness and will never get one - and most people who get AIDS-defining illnesses fully recover from them.

3. How is HIV transmitted?

HIV is transmitted through blood, semen, vaginal or anal fluid secretions, and breast milk. HIV only lives for a very short time outside the body and to be transmitted must find a way quickly into another person's bloodstream. There is no risk of HIV transmission from ordinary social contact.

The main routes of HIV transmission are:

- Unprotected anal or vaginal sex.
- Sharing needles (e.g for injecting drugs).
- From a mother to her child during pregnancy, birth or breastfeeding. However, with treatment and care, this risk is reduced to less than 0.5 per cent.
- In some countries HIV may be transmitted through infected blood products. In the UK all blood is screened to ensure this does not happen.
- Oral sex poses a much smaller but still identifiable risk that is increased if ejaculation in the mouth takes place and/or there are open sores in the mouth.

4. and how is it not transmitted .. ?

HIV is NOT transmitted by –

Kissing or touching
Sitting on toilet seats
Sharing cutlery, mugs, razors or toothbrushes
Picking up discarded needles and syringes
Using swimming pools

Spitting or sneezing
Insect or animal bites
Sharing eating utensils

Injuries from needles

There has never been an attested case of someone being infected with HIV by an attack with a needle or through being injured by a discarded needle outside a healthcare setting. There is a risk of other infections in these circumstances.

No gloves or masks

Universal precautions in first aid or for dealing with spillages are sufficient to deal with any minimal risk of HIV transmission in these circumstances. It is unnecessary and unacceptable for a police officer to use gloves, masks or any other additional form of protection when dealing with someone with HIV which would not otherwise be required in relation to an uninfected or undiagnosed person.

Biting and Spitting

There have been over 78 million cases of HIV transmission across the globe since the beginning of the HIV epidemic but only four examples worldwide where a bite might have passed on HIV, none of which occurred in the UK. In those four cases the person had high levels of HIV in their blood because of advanced HIV-related disease, they were not taking HIV treatment, unusually there was blood in their mouth, and the bite caused a deep wound. This combination of very exceptional circumstances is not at all likely during any police investigation. There has never been a known case of an emergency worker or police officer getting HIV as a result of a bite. The risk of HIV from being bitten by an HIV positive person is negligible.

The same survey of the scientific literature which presented these findings on biting also found that there was no case anywhere in the world of someone getting HIV from being spat at. The authors concluded that being spat on by an HIV-positive individual carries no possibility of transmitting HIV.¹

5. How likely is HIV transmission during sex?

Unprotected sex with someone with HIV does carry a risk of HIV transmission, but HIV is much less infectious than most people think. HIV infection is not inevitable from any act of sex and depends on a number of factors including the kind of sex, the stage of infection of the HIV positive person, whether the HIV positive person is on successful treatment, and of course whether a condom or PrEP was used (see below).

¹ Cresswell FV et al. *A systematic review of risk of HIV transmission through biting or spitting: implications for policy*. HIV Med, online edition. DOI: 10.1111/hiv.12625 (2018).

For example, without condoms or PrEP or successful treatment, the risk of HIV transmission during vaginal sex for an uninfected woman is 1 in 1,000 (or 0.1%) and for an uninfected man it is 1 in 1,219 (or 0.08%).²

The proper use of condoms or use of PrEP or being on effective treatment all reduce the transmission risk during sex to extremely low levels.

6. How can HIV transmission be prevented?

Where condoms are used properly and without breaking or slipping, they are very effective at preventing HIV transmission, with rates of well over 90% usually quoted for preventing transmission. When condoms do slip or break, and a person's sexual partner has or may have HIV, immediate treatment with PEP is advisable (see below).

PrEP (pre-exposure prophylaxis) is medication taken by an HIV negative person in order not to get HIV. It is almost 100% effective in preventing HIV transmission when taken as prescribed. It is taken daily (one pill a day) during a period of risk. Alternatively men who have sex with men can take it around the time of the act of sex (two pills taken between 2 and 24 hours before sex, one pill then taken within 24 hours after that first double dose and a second pill taken within 48 hours).

Effective HIV treatment reduces the amount of virus in an individual's blood to very low levels – so low they are termed 'undetectable'. When HIV is 'undetectable' as a result of HIV treatment the individual cannot transmit HIV – it is even more effective than condom use in preventing HIV transmission.³ Undetectable equals untransmittable, U=U.

97 per cent of people with HIV on treatment have an undetectable viral load and so are non-infectious.

7. Emergency HIV Prevention - PEP (Post Exposure Prophylaxis)

If someone was exposed to the risk of HIV infection within the last 72 hours, PEP (Post Exposure Prophylaxis) must be considered. This reduces the chance of any HIV exposure becoming an HIV infection.

Refer the person immediately either to the nearest open sexual health clinic or, if the clinic is closed, to the nearest hospital Accident and Emergency Department, with

² The risk will be different if the HIV positive person has him/herself been infected very recently or if the HIV positive person has AIDS.

³ Rodger AJ, Cambiano V, Bruun T, Vernazza P, Collins S, van Lunzen J, et al. *Sexual Activity Without Condoms and Risk of HIV Transmission in Serodifferent Couples When the HIV-Positive Partner Is Using Suppressive Antiretroviral Therapy*. JAMA. American Medical Association; 2016 Jul 12;316(2):171.

advice to ask for PEP. The person will be advised by the clinic/A&E whether PEP is necessary.

PEP has to be taken daily for a month and can cause unpleasant side effects.

For those who are complaining of an incident in the last 72 hours provision of PEP is always preceded by an initial HIV test to ensure the individual has not previously been infected with HIV. If this test is positive there can be no charge of criminal HIV transmission re any incident in the last 72 hours

8. What tests are available for HIV infection?

There are a number of different tests for HIV. HIV tests are available at sexual health clinics and this is usually the best place to refer someone for an HIV test. Most HIV clinic tests are of a blood sample which is sent to a laboratory for analysis, and a result is provided within a few days. With any HIV test there is a period immediately after infection where the test will not pick HIV up – this is known as ‘the window period’. These HIV clinic tests (often known as ‘fourth generation tests’) can pick up HIV reliably from four weeks after infection.

Rapid tests

There are also now rapid tests which can test anywhere for HIV through either a finger-prick blood sample or a saliva sample.⁴ The result is available in a few minutes. If someone tests positive in a rapid test it will still be necessary to have a confirmatory laboratory test because these tests can sometimes produce false positive results. Rapid tests should not be used for people who believe they may have recently been infected since the window period, during which HIV may not be picked up, is three months from possible infection.

In addition to rapid tests available in clinics and community settings, a rapid HIV self-test can now be bought online and used in the privacy of one’s own home. Another option is the HIV home-sampling test (also known as ‘HIV postal tests’) where the individual takes the blood or saliva sample themselves and then posts it for analysis. They then receive their confidential test result from the healthcare provider.

9. Modern HIV treatment really works

Treatments for HIV have now transformed the lives of people with HIV in the UK. With modern treatments HIV is NOT a death sentence but a long-term manageable condition. The drugs do not cure HIV, but people can now expect to have a normal lifespan.

⁴ Whilst HIV is present in saliva and detectable by tests, it is not present in sufficient quantities to make it possible to infect someone through saliva.

The treatment is known as Anti-Retroviral Therapy, or ART (more rarely now it can be referred to as HAART, or Highly Active Anti-Retroviral Therapy).

96 per cent of people in the UK diagnosed with HIV are now on HIV treatment and it is expected that people with HIV will start treatment very soon after their diagnosis. Currently HIV treatment continues for life.

HIV treatment can cause side-effects, for example diarrhoea, tiredness, nausea and vivid dreams, though there has been significant progress recently in reducing and managing such impacts of treatment.

10. People with HIV must take their treatment

It is extremely important that people with HIV who have started treatment can continue to take it every day, on time, without fail. HIV treatment must be taken at least once a day, sometimes twice or three times a day, depending on the drugs. If someone misses a dose of their treatment there is a possibility that HIV in that person's body will become drug-resistant and the treatment will no longer work. The fewer treatment options open to someone with HIV the more at risk they are of no longer having drugs available which will work for them. Failing to take HIV treatment properly leads to avoidable early deaths.

With HIV treatment people must take almost all their pills as prescribed. This means missing no more than one dose a month if someone is taking once-daily therapy, or two doses a month if someone is taking twice-daily therapy. With HIV treatment doctors insist on 'treatment adherence' of 95% (i.e at most only one dose in 20 missed). For some drugs it is also necessary for them to be taken with food, or for certain foods not to be taken with the drug.

11. Can scientific evidence tell us who infected someone with HIV?

It can be very difficult to know who infected someone with HIV. That is why the Crown Prosecution Service demands strong scientific evidence to support an allegation that someone is responsible for another person's infection. It is NOT enough for a person to 'admit guilt' – they cannot know for sure they gave the infection to another.

Most HIV infections come from people who didn't know they had HIV when they passed it on. Just because someone has been diagnosed does not mean they are necessarily the source of infection – the source could be someone who has not yet tested.

There is a form of scientific test known as 'phylogenetic analysis' which can assess how closely related is the HIV in two particular individuals. If the two virus samples are not closely related this proves that HIV transmission did **not** take place between the two individuals.

If the two virus samples are closely related this shows that transmission **could have** taken place between the two individuals. It does not provide any information on which of the two infected the other. Nor does it prove that HIV transmission occurred between the two individuals – there are other possibilities, for example that both individuals were infected by the same third person. Additional evidence will be necessary to establish for the purposes of a prosecution for HIV transmission that an individual was responsible for someone else's HIV infection 'beyond reasonable doubt'.

12. What does the law say on discrimination against people with HIV?

Under the Equality Act 2010 it is unlawful to discriminate against someone with HIV in employment, housing, education and training, provision of goods and services, and trade union membership.

Discrimination against someone with HIV includes treating someone less favourably than others without HIV. It is also unlawful to harass someone living with HIV. Harassment is defined as 'violating a person's dignity' or 'creating an intimidating, hostile, degrading, humiliating or offensive environment' for that person. Both police service employees and members of the public who have dealings with the police are protected by these legal provisions.

13. Why is it important to take great care to respect confidentiality with respect to someone's HIV positive status?

Unfortunately stigma and discrimination continue to exist in relation to HIV, although attitudes are changing. As a result some people with HIV do not feel able even to tell people close to them that they are HIV positive. This means that some people with HIV are understandably concerned about breaches of confidentiality and privacy, which could possibly have very harmful consequences. People can be shunned, evicted, insulted and harassed, assaulted, denied access to family or children. Even though discrimination is unlawful, there can be serious consequences from inappropriate disclosure of HIV status, for example, for employment or for children in school.

Investigators must take great care not to disclose an individual's HIV status to third parties except in those limited and permitted circumstances where it is absolutely necessary for the purposes of the investigation.

14. Police safety and occupational health

The risk of HIV transmission to police in the course of their duties is extremely low and in almost all instances universal precautions will be sufficient protection. It is important police are aware that behaviours such as spitting or routine social contact carry no risk of transmission. In instances of biting which pierce the skin, puncture wounds from a needle, or blood in the eye, risk of transmission is extremely low or

merely theoretical and PEP would not usually be thought necessary, but any concerns should be raised with a healthcare professional.

It should be borne in mind at all times that there are people living with HIV working for the police service, whose HIV status may or may not be known to colleagues, and who have a right to a well-informed and supportive working environment free from HIV stigma and prejudice.

More information for police officers about HIV can be found in 'HIV: A Guide for Police Forces' Revised Edition June 2014.

<http://www.nat.org.uk/Publications>

If the accused is under 18

If the accused is under 18, particular care must be taken in the handling of the allegation. Any criminal investigation or proceedings involving a person under the age of 18 must have regard to the welfare of the person concerned. Young people with HIV are especially vulnerable individuals. Great care must be taken to keep their HIV positive status confidential, shared only with those necessary to take forward the investigation of the complaint and ensure the welfare of the accused. An appropriate adult should be available to support all accused persons under the age of 17. It is highly likely that the accused young person may have special educational needs, mental health issues or poor understanding of his/her HIV status and infectiousness, so even in the case of 17 year-olds there should be consideration of the involvement of an appropriate adult. The paediatric HIV consultant responsible for the young person's HIV care should be contacted as soon as possible. Early consultation is encouraged with the CPS.

The criminal transmission of HIV: Communication strategy

1. Communication is a fundamental thread, which runs through every facet of all police investigations of allegations relating to the criminal transmission of **HIV**.
2. The police service, its employees and others acting on its behalf must recognise the importance and the effect(s) of our actions, words and conduct on the complainant, witnesses and people living with HIV – their partners, family (in the widest sense), friends and community when investigating such allegation. There is still stigma attached to HIV and other medical conditions e.g. Hepatitis B and C, which means that cases must be handled sensitively and confidentially.
3. This short paper relates to:
 - Disclosure of HIV status and Confidentiality
 - Media activity relating to Investigation/Prosecution
4. Other important areas associated with such investigations are covered elsewhere in this best practice advice for police officers on investigating allegations of criminal transmission of HIV.

Disclosure of HIV status

5. It is likely that a person's HIV status may be disclosed either directly by a complainant when they report an allegation of (a possible) crime, or by someone acting on their behalf. The HIV status of accused, complainant and possibly others may well be disclosed to the police.
6. The person disclosing this information may do so not knowing how this information may be stored, who has got access to it and how it may be used in the future. It is essential that timely, accurate and reliable information is given to anyone with HIV involved in a police investigation, at the earliest possible opportunity, to allay any fears or concerns over their confidentiality that they may have.
7. It is extremely important to maintain the highest standards of confidentiality during the investigation of criminal transmission allegations, protecting the identities of the accused, complainant and others drawn into enquiries who may be HIV positive.
8. If you need to access a complainant's medical records this should be achieved with their informed written consent. A suspect's medical records can also be accessed with their consent but use of a Court Order is recommended as they can withdraw their consent at any time.
9. The occasions on which police will disclose a person's HIV status to others will be rare. No disclosure should take place without the approval of a Senior Investigating Officer (SIO) of inspector rank or above. The SIO should take legal advice as well as further independent advice prior to doing so. It is

recommended that such legal advice will be sought from the SIO's Force Legal Service's Department (or similar). It is further recommended that independent advice is obtained from a suitably qualified Police Independent Advisory Group (IAG) member and / or specialist NGOs such as Terrence Higgins Trust, NAT (National AIDS Trust) etc, to complement the legal advice given and provide specialist guidance.

10. There must be a specific reason why disclosure by the police of a person's HIV status to another individual possibly at risk of infection was considered necessary, rather than simply allowing specialist sexual health services to provide appropriate sexual health advice to any traced contact. ⁵
11. Any decisions regarding disclosure and the specific reason for the disclosure should be accurately recorded in a Decision Log or Policy File in an accountable, transparent and retrievable way.
12. When such sensitive information is disclosed it must be accompanied by handling instructions, including advice relating to retention, storage and further disclosure.

Media Communication Activity relating to Investigation/Prosecution

13. The first police employee that has contact with the complainant should start the police investigation; therefore how this staff member conducts himself or herself, including their use of language, will determine whether or not the complainant has trust and confidence in the police service.
14. In addition, the Senior Investigating Officer (SIO) must clearly and unequivocally set out their standards at the outset of the secondary investigation in order to retain and maintain the complainant's trust and confidence. Any inappropriate language or conduct will have a notable impact on the complainant and this will be magnified across the external community and the relevant Force's internal community. We must not lose sight of the fact some police employees may be HIV positive.
15. Each Force as a Public Authority has a responsibility in law to provide a safe and non-discriminatory working environment for its employees, and not to discriminate in the way it treats both its employees and any member of the public it deals with.

Important Reminder: Section 149 of the Equality Act 2010 establishes the Public Sector Equality Duty. This Duty requires that every public authority in carrying out its functions shall have due regard to -

- a) eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act;

⁵ See section 'Initial contact via GU clinics' in this Guidance

- b) advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;
 - c) foster good relations between persons who share a relevant protected characteristic and persons who do not share it.
16. Anyone with HIV is considered in law to be disabled for the purposes of the Equality Act 2010. Discrimination law and the Public Sector Equality Duty therefore also apply to how police officers treat people with HIV during these investigations and prosecutions.
17. Any public and/or internal statements in relation to a case involving HIV must ensure the information and language are accurate, non-stigmatising and conform to agreed best practice on the media reporting of HIV (NAT 'Guidelines for Reporting HIV'⁶ and 'NAT/BHIVA 'HIV: A Guide for Police Forces'⁷).
18. Consideration should be given to applying for reporting restrictions in appropriate cases. Even in relation to an HIV positive person whose identity is in the public domain, care must be taken not to disseminate additional information (e.g. street address), which can assist in the identification of close relatives (e.g. spouse, civil partners, partners or children) who may as a result of publicity face harassment or discrimination.
19. During and after a trial any reporting restrictions must be carefully adhered to.
20. An updated set of guidelines (June 2014) on open justice and reporting restrictions in the criminal courts has been published by the Judicial College, Newspaper Society, Society of Editors and Media Lawyers Association⁸. Press teams and legal service departments will be able to advise SIOs of their context and where potential breach could occur.
21. Care should be taken to describe any charge accurately – for example, a charge of reckless transmission (section 20 Offences Against the Person Act 1861) should be described as such rather than 'deliberate' or 'knowing' transmission of HIV (intentional transmission is a separate offence under s18 of the OAPA 1861).
22. There should be no unfounded speculation as to 'motive' in relation to a charge of reckless transmission.
23. Consideration should always be given when considering media work to the significant impact that the media's actions and statements can have on people living with HIV and on those groups most affected by HIV. In addition, irresponsible or sensationalised reporting can also fuel other people's

⁶ <http://www.nat.org.uk/Publications>

⁷ <http://www.nat.org.uk/Publications>

⁸ <https://www.judiciary.gov.uk/wp-content/uploads/2014/06/Reporting-Restrictions-Guide-2014-FINAL.pdf>

prejudices potentially resulting in the perpetration of (hate) crimes against other community members and community groups.

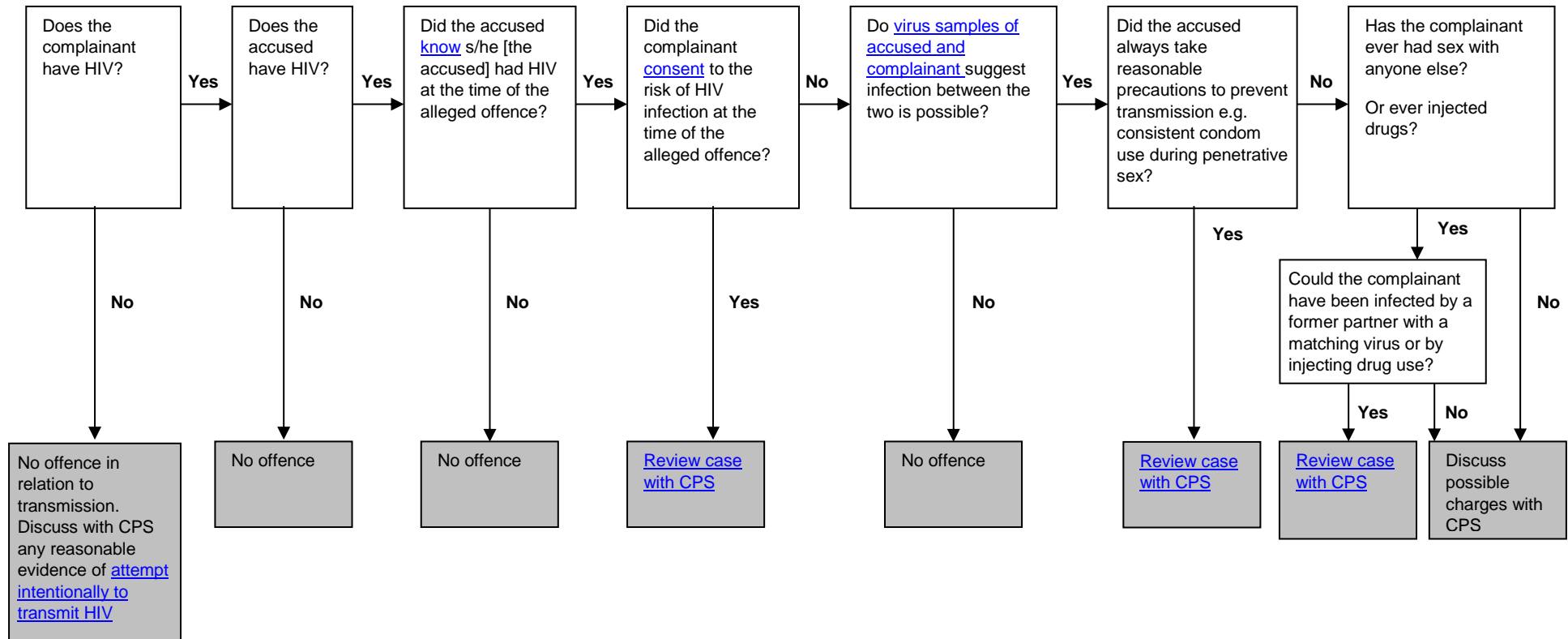
24. Any decisions regarding the SIO's Media Strategy and the decision-maker's rationale should be accurately recorded in a Decision Log or Policy File in an accountable, transparent and retrievable way.

EVIDENTIAL FLOWCHART INTRODUCTION - HIV

The 'evidential flowchart' sets out key evidential steps in investigation of allegations of criminal transmission of HIV.

Investigation of such allegations is a very sensitive matter. The flowchart, and the following notes to the flowchart, aim to set out stages in investigation which will limit unnecessary intrusion and ensure appropriate collection of evidence.

It is recommended that ordinarily investigators only proceed to the next stage of evidence gathering as set out in the arrows and boxes of the flowchart after they have established the relevant set of facts appropriate to the previous stage.



‘Attempt intentionally to transmit HIV’

There is no crime of ‘attempting recklessly’ to infect someone with HIV. There is a possible crime of ‘attempting intentionally’ to transmit HIV.

Where the complainant is not infected him/herself there is therefore usually no crime and so no further action for police. But there should before closing the case be a check that there is no evidence the accused was deliberately trying to infect the complainant. Such cases will in all probability be extremely rare but any possible evidence of such intention should be discussed with the CPS as soon as possible to determine if there are any grounds for the investigation to continue. Investigations should not be unnecessarily protracted through inappropriate consideration of an attempted intentional transmission charge

‘Did the accused know’

For recklessness to be proved it will be necessary to show the accused knew s/he had HIV at the time of the alleged offence. The CPS state that ‘the best and usual evidence’ will be that the accused had previously received an HIV positive medical diagnosis.

The CPS does consider that ‘on rare occasions’ someone might know they are infected even without such a diagnosis, though these cases will be ‘exceptional’ [see CPS Legal Guidance paras.6.10-6.11].

In the absence of a diagnosis no further investigation of the allegation should occur without first discussing with the CPS what other evidence might exist to demonstrate the accused knew s/he was infected at the time of the alleged offence.

‘Did the complainant consent .’

There is no crime if the accused reasonably believed that the complainant had consented to the risk of HIV infection at the time of the alleged offence.

Such informed consent exists when **the complainant knows that the accused has HIV at the time of the alleged offence.**

This will usually be the case when the complainant has been informed by the accused of his/her HIV positive status. But the CPS states this is not the only way that a complainant might be considered to be ‘informed’ for the purposes of consent. Other possibilities include the complainant being informed of the HIV status of the accused by a third party, or learning of the HIV status of the accused through other circumstances [see CPS Legal Guidance para.5.4].

The defence of consent may be undermined if the accused and complainant had agreed always to use condoms to avoid HIV transmission, but the accused has then deliberately abandoned condom use without the complainant’s knowledge during one or more acts of sex, and transmission has occurred as a result.

'Review case with CPS'

For all boxes which advise 'Review case with the CPS', the probability is that there is no offence or no likelihood of a successful prosecution but given the complexity of some of these cases it is worth the CPS reviewing the case before any decision to end the investigation. **It is extremely important this review process takes place in a timely way** so that any investigation of innocent individuals is not prolonged beyond what is absolutely necessary.

'Virus samples of accused and complainant'

See 'HIV: Key facts for police para.11' and CPS Legal Guidance

Initial contact via GUM clinics

On occasion other persons may be identified whose HIV testing history and/or HIV status are relevant to an investigation.

These persons will usually be:

- either other possible victims of the accused
- or previous sexual contacts of the complainant whose HIV status and/or testing history may be relevant to ascertaining whether the complainant was in fact infected by the accused.

In such cases, it is recommended that the initial approach to the individual requesting information should be made by the relevant local sexual health clinic (often known as 'GU clinic') who have expertise in HIV, in such contact tracing, and in HIV counselling and confidentiality issues.

Police officers should:

- identify the individual to the GU clinic,
- explain that they are interested in information relevant to an investigation into possibly criminal HIV transmission,
- request information as appropriate on the person's HIV status and HIV testing history for the relevant period of interest
- provide contact information should the person wish to contact the police directly.

The GU clinic will:

- inform the person of the police request
- provide direct contact information should the person wish to communicate with the police directly
- as appropriate ask whether they are willing to have an HIV test
- as appropriate ask for/confirm information on the person's HIV testing history
- ask whether they would consent for relevant information to be passed on to the police by the GU clinic.

If the person consents to relevant information being passed on to the police, officers can then determine on the basis of the information received whether there is a need for further discussion with that person and contact them directly as appropriate.

If the person does not consent to information being passed on to the police, the GU clinic will only pass on relevant confidential information if a court order is produced.

It should be noted that enquiries of past sexual contacts of the complainant will only be useful if all relevant contacts can be traced. If there are untraced sexual contacts who could possibly have infected the complainant with HIV, it will be difficult to prove it was the accused who was responsible for the complainant's infection.