

Investigation Guidance relating to the Criminal Transmission of HIV

for police forces in England, Wales and Northern Ireland.



Security Classification:		NOT PROTECTIVELY MARKED	
Disclosable under FOIA 2000:		Yes	
Author:	DCI Gerry Campbell	Force / Organisation:	ACPO – MPS
Date Created:	19 January 2010	Telephone:	0207 321 9127

Introduction

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 Police Online Knowledge Area (POLKA) hosted by the National Police Improvement Agency. We reproduce here the key guidance documents so that people with HIV, and organisations which support them, can know how the Guidance recommends police conduct these sensitive investigations.

Contents

[1. Police Investigation Flowchart](#): 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 documents providing more detail on important aspects of an investigation, namely -

[2. HIV - Key Facts for Police](#): This document gives information on HIV for police officers, including key biological and clinical facts, information on PEP, HIV testing, ARV medication and discrimination issues.

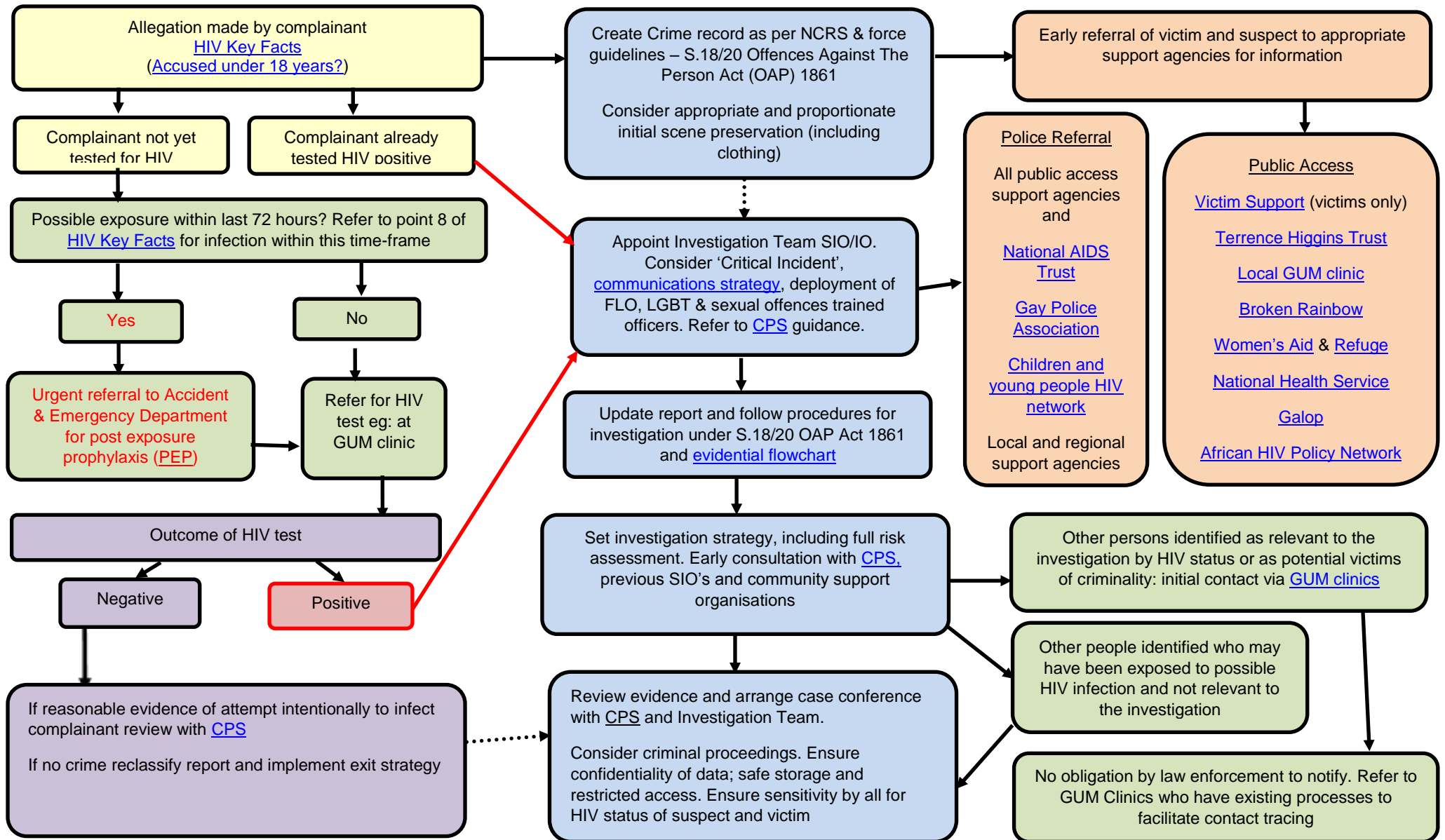
[3. Accused under 18?](#): This document alerts police officers of the requirement to have special consideration of their process where the accused is under 18.

[4. Communication Strategy](#): This document gives some guidance to police officers on communication around an ongoing and completed investigation, and deals with issues of confidentiality and media relations.

[5. Evidential Flowchart](#): This important document 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.

[6. Initial contact via GUM clinics](#): This document 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.

The Guidance was produced in response to concern over the handling of early police investigations. THT's report '[Policing Transmission](#)' reviewed some of the past cases and that report's recommendations informed the work of the ACPO working group which developed the Guidance



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 drugs for their HIV treatment, 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. Can you tell if someone has HIV?

You cannot tell from how someone looks that they have HIV. Only an HIV test can determine whether or not someone has HIV (see below). People can live for many years with HIV without any symptoms of infection.

3. 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.

4. How is HIV transmitted?

HIV is transmitted through blood, semen, vaginal or anal fluid secretions, and breast milk. HIV doesn't live for more than a few moments 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 with someone who has HIV.

- Sharing needles (for injecting drugs, tattooing or piercing).
- From a mother to her child during pregnancy, birth or breastfeeding. However, with treatment and care, this risk is reduced to less than one 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.

5. 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

There have been well over 60 million cases of HIV transmission across the globe but only two examples worldwide where a bite might have passed on HIV, neither of which occurred in the UK. In both cases the person had high levels of HIV in their blood because of advanced HIV-related disease, unusually there was blood in their saliva, and the bite broke the skin. This combination of very exceptional circumstances is not all likely during any police investigation.

6. 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 was used.

For example, without condoms or successful treatment, the risk of HIV transmission during vaginal sex for an uninfected woman is 1 in 1,250 (or 0.08%) and for an uninfected man it is 1 in 1,666 (or 0.06%).¹

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

7. 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).

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' it is extremely unlikely that the individual will transmit HIV. Although medical advice in the UK is still to use condoms even where treatment has reduced the virus to an undetectable level, it is important to be aware of the impact of treatment in reducing infectiousness.

8. 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 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

¹ The risk will be different if the HIV positive person has him/herself been infected very recently or if the HIV person has AIDS.

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

9. What tests are available for HIV infection?

There are a number of different tests for HIV. The most common tests do not test directly for the virus itself but for the antibody created in response to HIV infection. Such antibodies are usually detectable 2 to 8 weeks after infection. If someone believes they have possibly been infected recently, they will be advised to have a second confirmatory test three months after the possible exposure to HIV.

But there are now newer tests which in addition to testing for the antibody also test for a protein called 'p24 antigen' – this is produced by the body at an earlier stage of infection and so these tests (sometimes called 'fourth generation tests' or 'combined p24 antigen/antibody tests') can reliably test for HIV one month after exposure.

HIV tests are available at all sexual health clinics and this is usually the best place to refer someone for an HIV test. Most tests are of a blood sample, which is then sent to a laboratory for analysis, and a result is provided in a few days.

Rapid tests

There are now rapid tests which can test anywhere for HIV through either a finger-prick blood sample or a saliva sample.² The result is available in less than 30 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.

10. 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 live into their 70s.

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).

Someone infected with HIV only needs to begin treatment once their immune system has deteriorated to a certain level as a result of HIV infection. Some people will be able to continue for a number of years without treatment whilst others start almost immediately after diagnosis. About 3 out of 4 people diagnosed with HIV are now on HIV treatment. Currently HIV treatment continues for life.

² 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.

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.

11. 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%.

12. 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'.

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

Under the Disability Discrimination Act 2005 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. The law is currently being changed so that it will also outlaw harassment which is defined as 'violating a person's dignity' or 'creating an intimidating, hostile, degrading, humiliating or offensive environment' for that person.

14. 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, for example, for employment or for children in school.

Investigators must take great care must therefore be taken 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.

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 strategy³

1. Communication is a fundamental thread, which runs through every facet of all police investigations or allegations relating to the criminal transmission of **Human Immunodeficiency Virus (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 biological 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
 - Media activity relating to Investigation / Prosecution
 - Police Service employee Safety and Occupational Health.
4. Other important areas associated with such investigations are covered elsewhere in the criminal transmission of HIV package produced for investigating officers.

Disclosure of HIV status

5. It is likely that a person's HIV status may be disclosed either directly by her/him as she/he reports an allegation of suspected / crime or by someone acting on their behalf.
6. However, it should be considered that the person disclosing this information may do so not knowing how this information maybe stored, who has got access to it and how it maybe used in the future. Suffice to say it is essential that timely, accurate and reliable information is given at the earliest possible time to allay any fears or concerns that this person may harbour.
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. Disclosure may come from other sources e.g. prison records, medical records (which is confidential material / information) or from a healthcare professional. If you need to access a complainant's medical records this should be achieved with their informed written consent. An alleged suspect's medical records should be accessed using a Court Order as he/she can withdraw their consent at any time.

³ The contents of this document are equally applicable to other suspected biological conditions.

9. The occasions on which police will disclose a person's HIV status to others will be rare. The Senior Investigating Officer (SIO) should take legal and independent legal 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's further recommended that independent advice is obtained from a suitably qualified Police Independent Advisory Group (IAG) member and / or specialist NGO such as Terrence Higgins Trust, NAT (National AIDS Trust) etc to complement the legal advice given and provide specialist guidance and advice.
10. There must be a specific reason why disclosure 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.⁴
11. There are grounds for disclosure of a person's status in relation to the prevention and investigation of crime or if the disclosure is for the purpose of instituting, or otherwise for the purposes of, proceedings before a court or tribunal. To this end analogy could be drawn from section 22 Gender Recognition Act 2004.
12. Any decisions regarding disclosure and the decision-maker's rationale should be accurately recorded in a Decision Log or Policy File in an accountable, transparent and retrievable way.
13. 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

14. 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.
15. 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.
16. Each Force as a Public Authority has a lawful responsibility and duty to provide a safe and non-discriminatory working environment for its employees and to eliminate unlawful discrimination.

⁴ See document 'Initial contact via GU clinics' in the 'criminal transmission of HIV package'

Important Reminder: Section 49A Disability Discrimination Act 1995, as amended, establishes a duty that has become known as the Disability Equality Duty (DED). This duty requires that every public authority in carrying out its functions shall have due regard to-

- the need to eliminate unlawful discrimination;
- the need to eliminate harassment of disabled persons that is related to their disabilities;
- the need to promote equality of opportunity between disabled persons and other persons;

17. Anyone with HIV is considered in law to be disabled for the purposes of the Disability Discrimination Act 1995.
18. 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/NUJ 'Guidelines for Reporting HIV' www.nat.org.uk⁵).
19. 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.
20. During and after a trial any reporting restrictions must be carefully adhered to.
21. An updated set of guidelines on open justice and reporting restrictions in the criminal courts has been published by the Judicial Studies Board (JSB), Newspaper Society, Society of Editors and Times Newspapers Ltd⁶. Associated press teams and legal service departments will be able to advise SIOs of their context and where potential breach could occur.
22. 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).
23. There should be no **unfounded speculation** as to 'motive' in relation to a charge of reckless transmission.
24. 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

⁵ <http://www.nat.org.uk/sites/default/files/publications/June-2010-Guidelines-for-reporting-HIV.pdf>

⁶ <http://www.jsboard.co.uk/publications.htm>; <http://www.societyofeditors.co.uk/>;
<http://www.newspapersoc.org.uk/>.

irresponsible or sensationalised reporting can also fuel other people's prejudices potentially resulting in the perpetration of (hate) crimes against other community members and community groups.

25. 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.

Police Service employee safety and occupational health

26. Officers are trained to take precautions against the suspected transmission of diseases from body fluids, namely blood and saliva. In cases where officers or other staff members have been deliberately, accidentally or recklessly exposed they should be offered timely and accurate information, counselling and other support, which meets their needs.
27. The National Aids Trust (NAT) **HIV document**⁷ is informative and will serve the purpose of ensuring that exposed and other staff members can access reliable information to inform their actions.
28. It is essential that a balance is drawn between over-reaction and under-reaction in circumstances when staff believe that they may have been exposed. Access to timely and accurate information will allow those concerned to then make informed decisions about the course of further action needed e.g. referral to further medical support as per their In Force Standard Operating Procedures.
29. Refer to [HIV – SIX IMMEDIATE THINGS YOU NEED TO KNOW](#).
30. It is possible for other serious sexually transmitted infections e.g. Hepatitis B and Hepatitis C to be the subject of investigation for reckless or intentional transmission. The same advice in relation to confidentiality, care around disclosure, media relations and use of language all apply. For Hepatitis B and Hepatitis C, NAT documents are available setting out some 'Key Facts for Police', similar to that for HIV.

⁷ See <http://www.nat.org.uk/sites/default/files/publications/May-2011-Police-Investigation-of-HIV-Transmission.pdf>

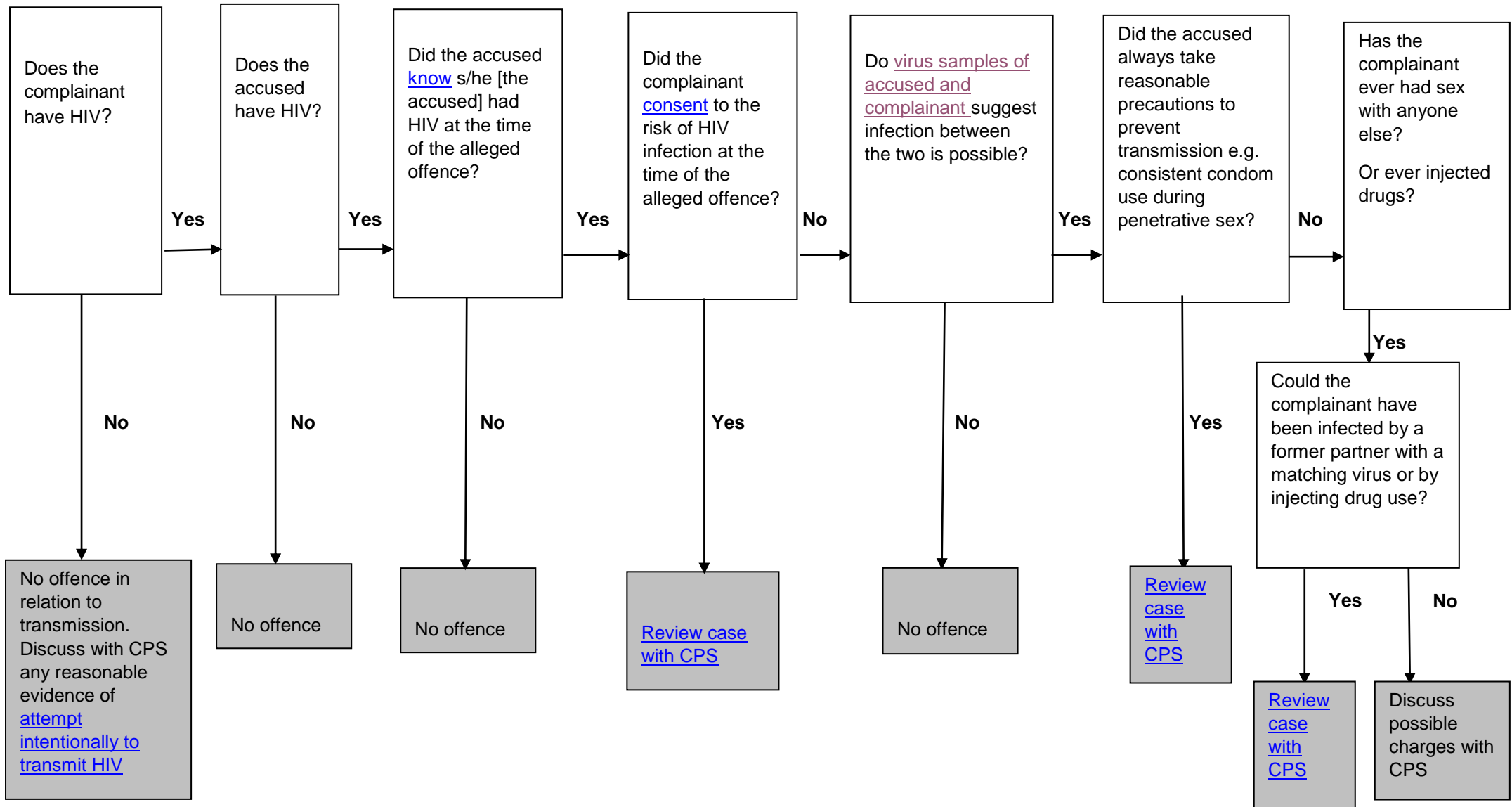
EVIDENTIAL FLOWCHART INTRODUCTION - HIV

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 aims 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.

EVIDENTIAL FLOWCHART - HIV



EXPLANATORY TO EVIDENTIAL FLOWCHART

‘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 very rare but any possible evidence of such intention should be discussed with the CPS.

‘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.

‘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 very rare but any possible evidence of such intention should be discussed with the CPS.

‘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 section 12’ and CPS Legal Guidance paras.6.1-6.

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.