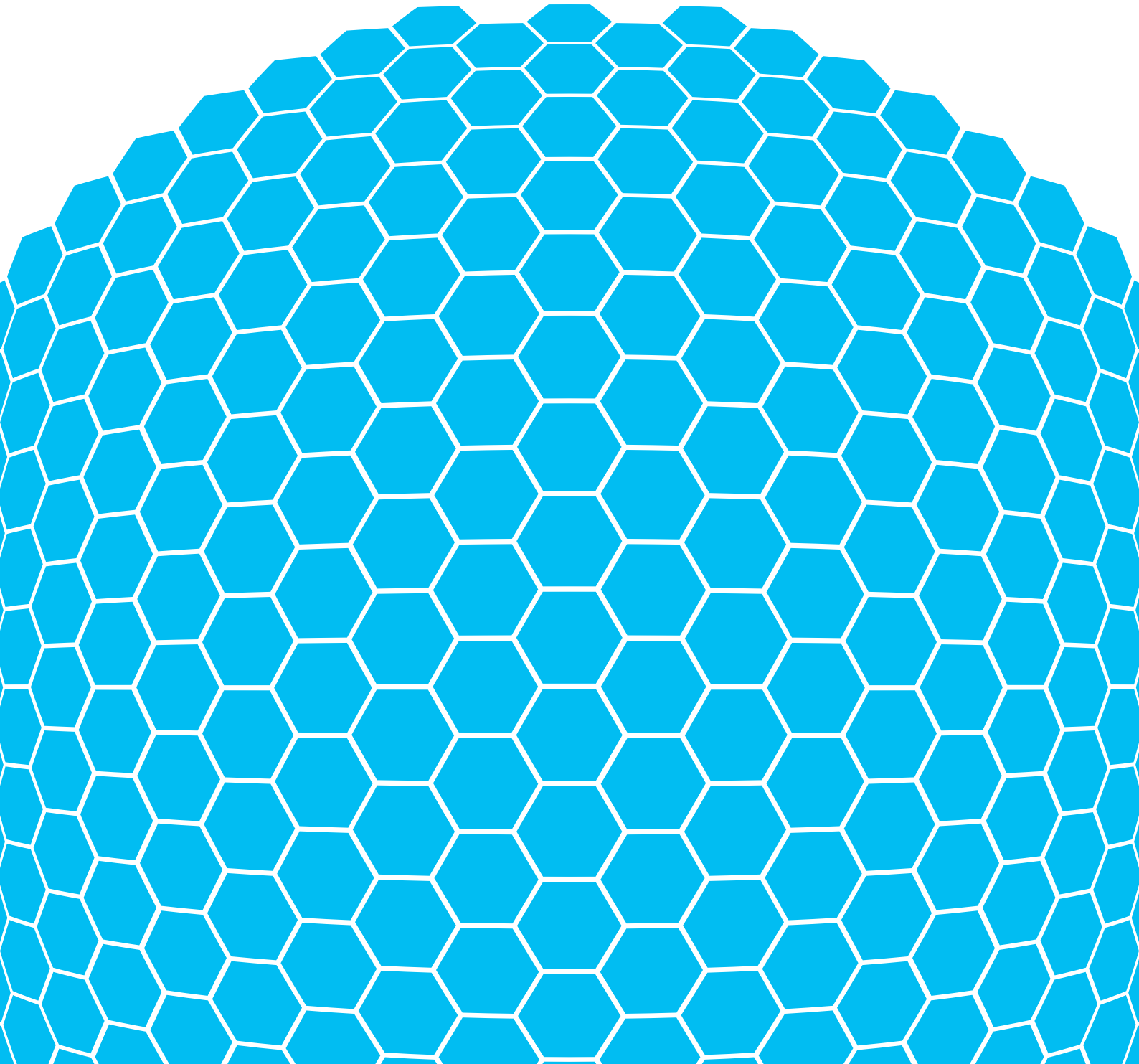
Understanding Criminal Prosecutions for Sexual Transmission of Infection

A report on charges of grievous bodily harm via sexual transmission of infection handled by the Crown Prosecution Service in England and Wales between 2008-2012, their management and outcomes.



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Introduction

This paper is based on research undertaken in 2013–14 on a series of criminal prosecutions and cases brought by, or referred to, the Crown Prosecution Service (CPS) between 2008 and 2012 for grievous bodily harm (GBH) by sexual transmission of infection. A relatively small number of charges of GBH have been brought in England and Wales (and under a different law in Scotland) for transmission of sexually transmitted infections (STIs), almost but not entirely for transmission of HIV. Other prosecutions have been brought for transmission of herpes, gonorrhoea and hepatitis B and C. Further information on specific cases can be found at www.nat.org.uk

The aim of this research was to determine, by examining available and anonymised cases, whether there were any lessons to be learnt or further understanding of process to be gained from such cases which were, or were not, successfully prosecuted after being passed to the CPS.

All the cases examined for this paper were charges relating to the transmission of HIV.

Although prosecutions for STI transmission are rare in comparison to actual incidence of transmission, they have attracted considerable attention both within the UK and globally among public health and HIV experts. This is primarily because of public health concerns that such prosecutions may affect the willingness of people with HIV specifically, to test for the condition and to subsequently disclose or not to their sexual partners. Research has shown that there is confusion among people with HIV, and the communities most at risk of HIV, as to what the law is and inappropriate expectations about how people are likely to behave as a result of it[1].

Such debates have taken place in a number of countries, often with the hope of informing direct law reform. Within the UK sexual health advocacy groups, notably Terrence Higgins Trust and the National AIDS Trust (NAT), initially took the different approach of monitoring the ways in which allegations and cases were managed. They approached the CPS, the Association of Chief Police Officers (ACPO) and the Metropolitan Police to work together to establish best practice under existing law.

As a result of both case monitoring and advocacy, a number of useful publications and guidelines have subsequently been produced, mainly for England and Wales. These are listed in Appendix A.

Following discussions about possible patterns in cases which were, or were not, successfully prosecuted, Terrence Higgins Trust was funded by the Monument Trust to undertake an analysis of how recent cases had been conducted. This was in order to understand what lessons could be learned from them in order to further improve practice and conduct and to feed into any further amendment of CPS and ACPO guidance that might take place. Terrence Higgins Trust then approached the CPS to provide anonymised case data and recruited an independent advisory group, comprised of legal and community advocates, to comment on process and data. The CPS kindly agreed to participate by providing case notes and commenting.

Details of the cases examined were provided by the CPS in an anonymised data collection template designed specifically for this project. This template was based on questions agreed by the independent advisory group. In total 13 cases were examined. Case selection was purely on the basis of those cases which had been closed recently enough to have full data available to the CPS staff who interrogated their database. No ongoing cases were examined. The most lengthy case was the result of a complaint made almost five years previously. Thus, these cases were those most recently resolved and not necessarily those most recently brought.

The questionnaire used covered the following areas:

- CPS area
- police force involved
- outcome of case
- age, sex, sexual orientation, ethnicity and country of origin of both complainants and defendants, where known
- number and type of charges suggested by police
- number and type of charges brought by the local CPS
- number and type of charges brought following Principal Legal Advisor (PLA) review
- substance of complaint (précis)
- key dates in the investigation for blood samples and sexual history taking

[1] Phillips, M. D. & Schembri, G. (2015). Narratives of HIV: measuring understanding of HIV and the law in HIV-positive patients. *Journal of Family Planning and Reproductive Health Care*, published online ahead of print. doi:10.1136/jfprhc-2013-100789

- date of key stages from initial complaint to case finalisation, including any known explanation for any major time lags in this
- defence details including type of plea, details of solicitors and any changes made
- disclosures: to the media, of the defendant's HIV status and of medical records to police
- expert advice sought and given
- any explicit mention of CPS policy or failure to consider it.

After the data was provided to the researcher, CPS staff made themselves available for any queries or clarifications needed. Of necessity these were confined to the data available within the records kept. Some of the cases examined were also known to individual members of the advisory panel through professional involvement and a small number of additional clarifications on specific cases were provided by them. This has been noted where used.

Case outcomes

Of the 13 cases available for examination seven were discontinued post-charge, at a wide variety of points in the process. Three cases resulted in convictions, while one other defendant was acquitted at the direction of the judge. One of those marked as 'discontinued post-charge' actually went to trial but was dismissed without being heard due to repeated problems with obtaining and disclosing evidence and resulting delays. In two cases the CPS advised, after examining the initial case, that no charge could be brought since there was none to answer under the guidelines.

The acquittal was an unusual outcome, not only within the cases examined but also in general. Cases involving sexual transmission of infection are usually subject to very close CPS scrutiny and clear guidelines and only two cases are known which have resulted in acquittals. In both these cases, the judge stopped the trial. In the case examined they did so at the end of the prosecution case, formally directing the jury as to the result. In the other case, not examined here, the jury had already retired to consider their verdict when the judge called them back and instructed them as to the result, presumably because they were concerned about an understanding of the highly complex medical evidence. Thus, there is no known case in which a jury has made a decision to acquit a defendant for this particular offence.

Less than a third of cases went to full Crown Court trial after being referred to the CPS. Given that many initial complaints reported to advocates (by complainants, accused and clinic staff) and subject to initial investigation by police do not result in referral to the CPS, it is clear that most complaints do not carry through to convictions. This may be for a variety of reasons, some of which became clear during the case examinations and will be discussed below. Anecdotally, a number of cases do not progress because police are aware that they do not meet the basic threshold of transmission (ie, the complainant does not actually have HIV and thus there is no basis for a charge of GBH).

It would be useful to know whether this low proportion that progress to trial is comparable with other more general charges of GBH or for other allegations of criminal violence. Although GBH is not a sex crime, HIV transmission is often compared to sexual assault – and from time to time police officers have tried to bring charges of sexual assault even where transmission did not occur – so this could also be a useful comparison.

Geography of cases

HIV spreads in clusters and is concentrated within particular population groups, most often in key cities. However, the geographical origins of the cases examined did not correspond to the varying levels of HIV across England and there was a notably disproportionate number of cases in one region.

Almost half of all people with HIV in the UK are in London, which also continues to see a disproportionate amount of new diagnoses (42% in 2013)[2]. Many others are in particular cities and towns where there are concentrations of gay men and/or African migrants, the two groups most often affected by HIV. These are concentrated in the south east but also in areas in the Midlands and north west.

This was not reflected in the cases examined. Of these 13, four were from London. Three were from the north east and a further two from the adjoining Yorkshire and Humberside. The other four were from individual CPS areas: West Midlands, Kent, Wessex and Northamptonshire.

[2] Yin, Z., Brown, A. E., Hughes, G., Nardone, A., Gill, O.N., Delpech, V. C. & contributors (2014). *HIV in the United Kingdom 2014 Report: data to end 2013. November 2014.* Public Health England, London

While almost a third of the cases were charged in London, this was still an under-representation given that 42% of all people in England with HIV are seen for care in the capital[3]. More notably, the north east of England is overall one of the lowest prevalence areas in England with only 8.5% of all people who are being seen for HIV care within the two health authorities[4]. Yet the two police forces covering this area provided five of the 13 cases examined. Of the five cases from South Yorkshire and Humberside and the north east, three came from a single police force (Cleveland).

Of the Cleveland cases, two were discontinued post-charge. One was a case where no transmission took place and the charge was subsequently amended to one of rape (outcome not known) and which took one month. In the other, involving two complainants, sexual history taking suggested complex possibilities and medical evidence (window periods, specifically) was disputed. This case took 21 months before being dismissed at Crown Court with no evidence offered. The third case resulted in a conviction.

Because of the low frequency and overall geographical diversity of these cases, which often involve highly complex medical evidence, sensitive disclosure of sexual histories and sometimes domestic or personal disputes, it is unlikely that most police and CPS officers involved in a case will have previous experience of them. This makes an understanding of the relevant guidance and knowledge of its existence even more important.

Gender and sexuality issues

HIV in England disproportionately affects gay men and overall there are twice as many men with HIV as women. Again, this was not reflected in the cases examined and here the difference was stark.

In all there were 14 complainants (two in one case, one in all others). Of these 14 complainants only three were men and two of these were in a single case. This is grossly disproportionate to transmission rates in the UK, where the majority of new HIV diagnoses are due to sex between men (54% in 2013)[5].

Only a third of the overall population living with HIV in England are women[6], whereas almost four-fifths of the complainants in the cases examined were women. In two of the cases where heterosexual transmission was alleged, the male defendants were categorised as bisexual. None of the cases examined had been brought against women and, in general, such cases reaching court has been extremely rare in England and Wales.

Equally disproportionately, only two of the 13 cases examined were for transmission between men, which in no way reflects the realities of current onward transmission. Of the 6,000 new cases of HIV in 2013, 54% were through men having sex with men (MSM). Additionally, MSM make up around 45% of all people currently in HIV care[7]. Both of these cases resulted in acquittals, one when the case was abandoned after complex issues about both medical data and sexual histories arose and the other being the sole acquittal after full trial. Thus, in the timespan and cases examined, there were no successful prosecutions of complaints of same-sex (MSM) transmission.

It was notable that in both the MSM cases examined as part of this exercise, the defendant actively sought support and used an experienced solicitor who consulted expert medical and other advice and was able to (apparently successfully) deploy highly complex scientific arguments in these areas.

[3] Yin, Z., Brown, A. E., Hughes, G., Nardone, A., Gill, O.N., Delpech, V. C. & contributors (2014). *HIV in the United Kingdom 2014 Report: data to end 2013. November 2014.* Public Health England, London
[4] ibid
[5] ibid
[6] ibid
[7] ibid

Ethnicity issues

HIV in England disproportionately affects migrant populations, some more than others, among both gay and heterosexual people with HIV. Although many of these people may have contracted HIV in another country, there are also a growing number of cases where transmission has taken place within England or the UK. In 2013, 25% of all new diagnoses were within people born in Africa but 16% were from other European countries and around 6% each from Asia and the Americas[8]. Some 46% of new diagnoses were in people born in the UK. However, once again, this is not reflected in those involved in criminal charges.

While ethnicity data of some sort was available for all defendants, it was very poorly recorded for complainants. Nevertheless, the data collected from defendants gives an interesting picture. Of the 13 defendants, seven were logged as White British (W1) and three as African (B2). Of the remaining three, one was officially not logged but described as Zimbabwean, one was described in the records as both Portuguese and African and one was Caribbean (B1). Thus there was an almost even split between black and minority ethnic (BME) defendants, most of whom were migrants, and white British defendants.

Although many heterosexual people with HIV in the UK do originate from Africa, as shown above, the majority diagnosed in that group are women[9] and thus, again, the cases give a disproportionate picture. Men of African origin seemed more likely to be prosecuted than is statistically proportionate to their representation in the population of men with diagnosed HIV and of HIV overall.

Of the seven white British-born defendants, five were heterosexual men. While this is in line with the relatively high level of cases involving heterosexual transmission, it should be noted that white British-born heterosexual men constitute one of the less common groups of men with HIV in the UK. Again, this is anomalous and disproportionate.

In only one case was the ethnicity of the complainant formally recorded – they were White British (W1). From examination of the cases, another eight were identifiable as 'British' and one as Swedish. Three were not identifiable in any way, which makes it difficult to draw clear conclusions. However, it is clear that the great majority (at least nine out of 13) were not migrants.

Charges brought

There are two categories of GBH under which the offence of transmission can be brought under the Offences Against the Person Act 1861: Section 18 (S.18), which is for intentional transmission of infection and Section 20 (S.20) which is for the lesser charge of reckless transmission. Conviction for S.18 carries up to a life imprisonment, but has a very high threshold of proof, whereas S.20 carries up to five years per charge and proof can consist of any transmission without prior disclosure of risk. It is possible to charge someone with attempted intentional transmission (S.18) but not with attempted reckless transmission (S.20) since attempting to do anything requires an intention to do it.

Police can charge a suspect initially, or more commonly will remand them on police bail while making recommendations to the CPS about the charge to be formally brought. The CPS can accept this initial suggestion or can amend or even reject the charge if they think it inappropriate. At the time of the cases examined, local CPS officers were required to forward their initial decisions on these cases for scrutiny and final decision by the Principal Legal Advisor (PLA) in the Policy team, given the complexity and sensitivity of the cases. This ensured not only expert scrutiny but also consistency of decision in an area of law with which most local officers were (and many continue to be) unfamiliar.

In four cases (all of which were dropped post-charge) the original charge was a S.18 offence. In three of these cases this was reduced to S.20 before being dropped and in the other case was dropped without being changed. In two of these cases, the S.18 charge was accompanied by other charges suggested by the police involved. In one case by two suggested charges of rape and in another case by attempted intentional transmission. After CPS consideration, all these were dropped, the latter one being made impossible when the charge itself was amended to S.20. The four initial attempts to charge a S.18 offence each emanated from different police forces – London, Cleveland, Dorset and Northampton.

[8] Yin, Z., Brown, A. E., Hughes, G., Nardone, A., Gill, O.N., Delpech, V. C. & contributors. (2014). *HIV in the United Kingdom 2014 Report: data to end 2013. November 2014.* Public Health England, London

[9] ibid

In three cases the suggested charge was S.20 from the outset and in a further five cases it was unclear what the original charge proposed by the police was. Three of these unknown cases were eventually charged after CPS involvement as S.20 – one of these also being charged with rape separately from the transmission charge. Two were dropped without a specific charge ever being recorded, although they were clearly referred on suspicion of a sexual transmission charge of some kind.

In four cases (two London, one each in Cleveland and Northamptonshire) the local CPS had either brought, or considered bringing, S.18 charges which were subsequently either amended or dismissed outright following PLA scrutiny.

These findings suggest that in some cases, expert CPS advice based on their own guidelines has mitigated unreasonably high initial charges, mostly from police but also sometimes from local CPS offices. They also suggest that the involvement of the PLA improved practice and consistency in charging in a complex and new area of law.

In one case, it appeared from the notes and from personal knowledge within the advisory group that a decision to charge – despite the particular case not fully meeting evidential requirements – might have been influenced by the persistence of the complainant. Given that many of these cases include an element of ongoing interpersonal disputes or 'revenge' behaviours, it is particularly important that decisions to prosecute are made solely on the basis of the evidence available.

Length of case from complaint to resolution

In terms of absolute length of time for a case to be resolved, there were huge variations. The shortest case, which was dropped post-charge, took only nine days to resolve whereas the longest, which resulted in acquittal at trial, took 53 months. These were both outliers, however. Four cases took less than six months, followed by a leap to the next case of 21 months. In all, only five, or less than half the cases, took less than two years to bring to conclusion. Another six took between two and three years, with one taking well over three years. The three convictions (C8–10) all took around two years including full court proceedings, but several other cases which did not reach Crown Court or which resulted (as mentioned above) in acquittal took as long or longer.

Case number	Length of time for case resolution	Length of time to reach CPS
C1	21 months	5 weeks
C2	9 days	1 day
C3	5 months	Same day
C4	27 months	5 months 2 weeks
C5	29 months	7 months
C6	24 days	Same day
C7	43 months	21 months
C8	26 months	23 months
C9	27 months	15 days
C10	22 months	4 months
C11	18 weeks	8 weeks
C12	at least 27 months	no date recorded until consideration by CPS
C13	53 months	8 months

A number of reasons have been advanced for the lengthier cases by advisers. These varied from case to case and included inadequate initial evidence gathering by police; lack of understanding of required proofs; length of time to collect or analyse blood samples; difficulties in pursuing and clarifying sexual histories; tracing and eliminating other potential sources of transmission and delays in accessing and disclosing medical records by either side of a case.

The time from the initial logging of a complaint by police to its referral to the local CPS team varied from the same day to almost two years. Around half (six) of the cases were referred within two months from the initial complaint, with another three taking between four and seven months to reach the CPS. Two cases took respectively 21 months and 23 months to be referred to the local CPS and in one case the timeline was unclear. Another case was initially referred to and dropped by the CPS but was revisited after the complainant objected and this case was then sent for trial but resulted in acquittal.

While it is natural that some cases may require investigation before matters are clear enough to refer to the CPS, it was notable that two of the cases took almost two years before they were initially referred locally. The first was the case finally dismissed by a Crown Court judge because of repeated delays due to evidential difficulties. It had taken more than a year to obtain medical records from the defendant and authorities had refused to disclose records without a court order – this was the second longest case, taking 43 months overall without a trial. This case also included a change of defence solicitor and a subsequent dispute over the admissibility of phylogenetic evidence (blood samples). The CPS themselves, in a note appended to this case, accepted that neither proper protocols nor guidance had been followed in the early stages.

The second case which took a long time to local referral was one of the three convictions, and although the police made an initial charge following a complaint, they were unable to obtain a blood sample from the defendant for almost two years. Once this was obtained and the case formally referred to the CPS, it proceeded swiftly.

Time from CPS referral to resolution

This also varied considerably, from a few days to 45 months. The longest was a case which was initially dropped (a decision agreed by the CPS) but then revisited following an objection by the original complainant and this was the case that resulted in an acquittal at trial. The other lengthy anomaly was a case dropped without charge after 27 months with the CPS. The limited data available on this case notes that it was eventually decided that there was no realistic prospect of conviction due to medical records not showing whether the defendant knew his HIV status at the time of the alleged offence. Four other cases which were dropped after charge took from 17–22 months to resolve. The reason usually given for this was the gathering of further evidence – the CPS often advises police to obtain further evidence before a decision can be made on whether a case is deemed strong enough to have a realistic prospect of conviction.

Time within CPS, locally and centrally

There were also wide differences in the time taken by local CPS officers to refer a case onwards to the PLA, from the same day to 21 months. Four cases were referred onwards in under a week, with five cases taking more than six months to be referred. The two cases dropped without charge were the shortest (one day to PLA and one day to decision to drop) and the second longest overall (21 months to refer and 4 months to decide to drop). It is possible to speculate that some of these may have been due to local requests for further evidence gathering, but there is no clear explanation of the variety of times to internal referral to the PLA.

Once a case reached CPS headquarters and the PLA, things generally moved a lot faster. Four cases were decided on the same day and another within 24 hours of referral. Only one case, which resulted in a conviction, took as long as seven months. Another, the case for which little data was available, took four months before a decision to drop it was reached due to lack of an essential legal element. The case which had been dropped locally and then revived due to a complaint also took three months for a decision at PLA level but all other cases were decided in three weeks or less once they reached this stage.

Case number	Length of time to PLA	Length of time to decision
C1	5 months	2 weeks
C2	5 days	Same day
C3	19 weeks	Same day
C4	Just under 12 months	18 days
C5	6 months	21 days
C6	3 days	13 days
C7	11.5 months	Same day
C8	Same day	Same day
C9	8 months	8 days
C10	11 months	7 months
C11	1 day	1 day
C12	21 months	4 months
C13	13 months	3 months*

*C13 is anomalous because the case was originally dropped by the local CPS, but revisited following a complaint from the original complainant and then passed up to the PLA, who took a substantial time to review the evidence before deciding to charge. This is the case where the trial was stopped at the close of the prosecution case and the defendant acquitted on the direction of the judge.

In some of these cases, delays are explained by the CPS referring the case back for more investigations – however, some offices did take longer than others to refer onwards. In only one case was the delay known to be due to failure to refer the case according to procedure. However, given the far swifter decision-making process at PLA level (due to expertise and experience of a growing number of cases) it could be argued that an earlier referral to the PLA might have reduced the length of more cases overall.

Policy and legal guidance to prosecutors is clear that details of all cases in which charges of intentional or reckless sexual transmission of infection are being considered should be referred to the Director's Legal Advisor (DLA) – the current title of what was the Principal Legal Advisor – to ensure consistency of approach.

Plea entered

Seven of those accused entered and maintained pleas of not guilty throughout. In two other cases no formal charge was ever made. In one case, while it was not clear what if any charge was made, there was extensive involvement of the CPS over time and this was included by the CPS in the list of cases dropped after charging. In the three convictions (C8–10) one person pleaded guilty from the outset, the other two altered their pleas from not guilty to guilty during the course of the investigation. In the cases under review, no person who maintained a plea of not guilty throughout was convicted.

In one case resulting in a conviction, the notes state that the complainant refused to provide details which would enable other sexual partners to be traced and cleared from the enquiry. Phylogenetic evidence was never presented in this case because the defendant pleaded guilty despite claiming he had disclosed his status, because 'he accepted that he foresaw a risk of the complainant contracting the disease' (CPS note). It was the view of independent experts who reviewed the case notes that this prosecution did not fit the guidelines on necessary evidence and that the defence was potentially negligent in failing to explore these anomalies and failing to advise the client not to plead guilty until it had been established that the accused was the source of transmission.

Defence solicitors

Nine different firms of solicitors were identified in the case notes, with two cases having no named solicitor involved and one defendant changing solicitor part way through. The change was from one not known to have any experience in such cases to a solicitor frequently recommended by HIV support organisations. This solicitor appeared in four of the cases and another from a second recommended firm appeared in one other case. All five of these cases were either discontinued post-charge (including the case dismissed after reaching the lower courts) or (in one case) resulted in a directed verdict of not guilty.

The other seven solicitors, who each handled one case, were not known to Terrence Higgins Trust or the members of the independent advisory group. The outcomes from this group included all three convictions and a further four cases which were discontinued post-charge. There is some suggestion here that outcomes may be impacted by the expertise and experience of a defence solicitor who fully understands the complexities of phylogenetic evidence[10] – as well as the police and CPS Guidelines – and who can identify and commission appropriate expert witnesses.

[10] More information about phylogenetic evidence can be found at: www.nat.org.uk/HIV-in-the-UK/Key-Issues/Law-stigma-and-discrimination/Criminal-prosecutions.aspx

Media statements

Information on media relations was only available for 11 of the 13 cases and in none of these was it recorded that any statement had been made to the press by the CPS prosecutor. This included all three convictions. However, it is known from press cuttings and personal experience of the researcher and expert advisers that statements were made in some of these cases – notably two of the convictions where statements were made after the case was concluded. Information on reporting restrictions was only available for 10 of the cases. Four cases, including two of the convictions, were known to have had reporting restrictions in place while three cases, including one conviction, explicitly did not. In the other cases it was not known.

In at least two cases which collapsed or were dropped at a relatively late stage there were no reporting restrictions in place. Given levels of HIV prejudice are still common in society and the ease of access and longevity of internet-based data, this could have had serious consequences for someone who was not subsequently convicted of any offence.

It should be noted that the question and the data supplied in response do not distinguish between types of restrictions, which can vary.

External medical experts used by police

Again, data was only available for 11 of the cases. Of these, police were noted as having sought external expertise in at least eight cases and definitely not in two. It was not entirely clear in some cases whether the experts had been called in by the police or the CPS. Those reported as being consulted at police stage were given a variety of titles including Professor of Virology (x4), Forensic Scientist (x2), Medical Practitioner (x2), Microbiologist/ Virologist, Honorary Consultant ID Physician and HIV/GU Consultant.

In two cases which were dropped, it was noted that the police had contacted local clinicians treating one or more of the parties to the complaint, but only for the purpose of obtaining medical records.

External medical experts used by CPS

This information was difficult to interpret as the titles given in case notes varied considerably. Of the 11 cases where information was available, the CPS was recorded as having sought separate external medical expertise in eight. All three of the convictions involved such expertise at both police and CPS stages of the prosecution. Of the people contacted (sometimes more than one in a case) five cases specified a Professor of Virology and six other titles were each used once: GU Consultant, Phylogenetic Expert Virologist, 'expert in date of infection', Scientist, Forensic Scientist and just plain 'expert'.

It is likely that in all CPS decisions to prosecute, barring possibly the case already noted where a defendant pleaded guilty without recourse to any confirmatory evidence, that one expert contacted would be the Professor of Virology at Edinburgh University who regularly provides phylogenetic reports for the CPS in such cases.

CPS policy statement

In eight of the 13 cases, specific reference was made to the relevant CPS Guidelines within the charging advice report. Of the five that did not, one contained other remarks which showed that the policy had been taken into consideration. Four of the 12, three of them cases discontinued post-charge, therefore made no reference to the policy at all. Two of these cases were dropped on referral to the PLA due to actual transmission not having occurred (and thus no charge being possible under S.20). A third was the very lengthy case already identified as problematic by the CPS themselves – and in which the defence solicitor stated that the judge himself gave his view when dismissing the case that guidance had not been followed. The fourth was the case dismissed part way through trial, partly (again, according to the defence solicitor) because the phylogenetic evidence did not match. It seems likely that explicit use of the Guidelines was helpful in establishing the appropriate course of action for cases and that in at least some of the cases, where they do not appear to have been consulted, this caused difficulties in proceeding.

Why and how were some cases discontinued?

In two cases, the local CPS officers gave faulty charging advice which was corrected on referral to the PLA. In five other cases significant doubt arose post-charge, most of which related to closer scrutiny of, or greater information about, the sexual history of the complainant. In two of these cases no evidence was offered at court following further CPS scrutiny, while in one case the process appears to have been stopped after further evidence was produced by the defence and the complainant was deemed to be an unreliable witness. One case was discharged by the judge due to an apparent lack of clarity around the sexual histories and a failure to produce related medical evidence in a timely manner.

Case Number	Outcome
C1	No evidence offered by prosecution due to scrutiny of sexual history and unreliability of witness/es.
C2	Dropped after preliminary hearing at Magistrates' Court by PLA decision due to faulty charging (no transmission).
C3	No evidence offered due to PLA decision that evidence not strong enough.
C4	Case stopped in Crown Court due to documents produced in court shedding doubt on sexual history issues and veracity of complainant.
C5	Dismissed by judge due to sexual history issues and lack of medical evidence (blood sample refused by accused).
C6	Discontinued after PLA decision due to faulty initial charging (no transmission).
C7	Unclear, but appears that judge stopped case due to policy not being followed/late disclosure of evidence/repeated delays.
C8	Convicted at trial.
C9	Convicted at trial.
C10	Convicted at trial.
C11	Retracted by complainant before charge, but also transmission not shown.
C12	Dropped by CPS as no realistic prospect of conviction due to lack of clarity re knowledge of status (dates of the case also suggest a lack of clarity about the origin of transmission).
C13	Judge either dismissed the case or gave a directed verdict of not guilty due to insufficient evidence according to the defence solicitor. This was because the phylogenetic tests showed differing strains of the virus, which strongly implies a separate source of infection. It is unclear why this did not cause the case to be stopped at an earlier stage.

The final case in this category is very unclear, but according to statements from the defence solicitor was dismissed by the judge on several grounds. As noted previously, there was an early attempt by the local CPS to discontinue this case due to lack of evidence but this was overturned after a complaint by the original complainant. It was eventually, after considerable delay, subject to a directed verdict of not guilty due to insufficient evidence.

Scrutiny of the case papers suggests a repeated issue of sexual history either being incompletely followed up – allowing room for defence submissions – or of further discoveries subsequent to charging which imply lack of complete disclosure earlier.

It should also be noted that the papers show that in one of the convictions, the complainant refused to divulge previous partners or to allow a full sexual history to be taken. Consideration could have been given to adjourning the case until such time as full disclosure had been made or else challenged in court by the defence. It does not appear that either of these happened, possibly due to an early guilty plea by the accused.

Recommendations for future action:

1 Use of the CPS Guidelines on prosecutions of sexual transmission has helped to inform and improve charging decisions. The Guidelines should be maintained and promoted to regional staff through appropriate channels such as in-service training, internal publications, designating a trained key officer in each region etc. There is already a high quality e-learning module available.

2 The level of complexity of investigating these charges appears to be variably understood by local police and CPS staff despite the existence of high quality guidance. This suggests that further efforts should be made to disseminate this information to all relevant personnel, including the police. The latter might be done through incorporation into existing training, through coverage in relevant publications or through targeted training of appropriate individuals within each region.

3 The online training tool used by the CPS to instruct its officers in managing these cases should be reviewed in the light of the findings of this paper and if necessary revised.

4 Obtaining expert legal advice appeared to favourably impact the outcome of some cases for the defendant and, in at least one case examined, failure to do so negatively impacted the outcome for them. Support and advocacy groups for people with diagnosed HIV or STIs should renew efforts to ensure that people understand the importance of getting such advice if faced with accusations of transmission of any STI.

5 People with HIV in certain social and demographic groups are disproportionately subject to these charges. Further advocacy efforts to improve understanding of the law and how it operates in this area should be targeted at all people with diagnosed HIV, and in particular these groups.

6 Central scrutiny by the Director's Legal Advisor (the current title of what was the Principal Legal Advisor) clearly improved the quality of charging and increased the swiftness of accurate charging decisions during the period examined. The DLA should continue to play a vital role in ensuring quality and consistency in charging.

7 The length of investigations in some cases could also have been reduced by better use and/or understanding of the ACPO guidance relating to the criminal transmission of HIV by police and further efforts should be made to improve knowledge of it by forces.

8 Pre-verdict reporting restrictions should be put in place for both complainants and defendants to protect their identities, because of the damaging nature of the stigma that can still be attached to having HIV (or, indeed, other non-curable STIs such as herpes). Failure to do so could result in someone being acquitted but still facing a future of severe discrimination due to ongoing access to media coverage via the internet. Because of the nature of the offence, such stigma can also attach to third parties such as children or other sexual partners not directly involved in the complaint.

9 The sexual history of the complainant was a key issue in the likelihood of a successful prosecution or otherwise. However, it appears often to have not been fully examined or resolved before charging, leading to a high level of discontinuation at a later stage. Much greater emphasis on doing so in a timely fashion should be placed on this within both CPS and ACPO guidance.

Appendix A: Useful links:

National AIDS Trust and Terrence Higgins Trust (2010). *Prosecutions for HIV Transmission. A guide for people living with HIV in England and Wales* (2nd Edition).
- **www.tht.org.uk/our-charity/Resources/Publications/Policy/Prosecutions-for-HIV-transmissions**

For general information about criminalisation of HIV:
- **www.tht.org.uk/myhiv/Telling-people/Law**
- **www.nat.org.uk/HIV-in-the-UK/Key-Issues/Law-stigma-and-discrimination/Criminal-prosecutions.aspx**

For information about police investigations including key Association of Chief Police Officers (ACPO) guidelines and documentation:
- **www.nat.org.uk/HIV-in-the-UK/Key-Issues/Law-stigma-and-discrimination/Police-investigations.aspx**

For full Crown Prosecution Service (CPS) guidance on prosecutions:
- **www.cps.gov.uk/legal/h_to_k/intentional_or_reckless_sexual_transmission_of_infection_guidance/**

For information on phylogenetic analysis:
- **www.nat.org.uk/HIV-in-the-UK/Key-Issues/Law-stigma-and-discrimination/Criminal-prosecutions.aspx**

For information on Recent Infection Testing Algorithm (RITA) testing:
- **www.nat.org.uk/media/Files/Policy/2011/RITA%20Testing%20Report.pdf**

For international criminalisation and advocacy information:
- **www.hivjustice.net/site/about/**