ID48

24 MAY 2005

**SOCIAL WORK RESOURCES**

EXECUTIVE DIRECTOR **SANDY CAMERON CBE**

**CRIMINAL JUSTICE SERVICES**

**Our Ref:** **MB/AMS**
**Your ref:**
**If calling ask for:** **Mairi Brackenridge, Justice Services Manager (01698 453715)**
**Date:** **19th May 2005**

Mr Bill Barron
Police Bill Team
Police Division 1
St Andrews House
Regent Road
EDINBURGH EH1 3DG

Dear Mr Barron

**Blood Testing following Criminal Incidents where there is a risk of infection: Proposals for legislation**

Please find attached response from South Lanarkshire Social Work Resources.

Yours sincerely

Mairi C. Brackenridge

**Mairi E Brackenridge**
**Justice Services Manager**

**Enc:**

**Floor 8, Council Offices, Almada Street, Hamilton ML3 0AA**
**Telephone: 01698 453715 Fax: 01698 453784**
**E-mail: mairi.brackenridge@southlanarkshire.gov.uk**
I:\Headquarters\HQSecretariat\SecCriminalJustice\Letters\L037.doc

Comments on

# Blood Testing following criminal incidents where there is a risk of infection: Proposals for legislation.

**Points in General:**

Concern about employment and criminal exposure to blood borne viruses has been the subject of some concern in various parts of the around the world. With regard to the employment aspect of the current proposal it would appear that responses post exposure have reduced significance in comparison to protective measures.

In this regard the guidance offered by U.K. Chief Medical Officers (CMO), recent report on HIV Post-Exposure Prophylaxis (Feb 2004) has some resonance in this subject. In particular to confidentiality; those to target for testing; and measures to protect the public from exposure from an infected worker. The later point is absent from the Scottish Executive proposals as they currently stand.

With regard to the degree of risk from HIV, the above report noted "the risk of infection following occupational exposure to HIV infected blood is low. Epidemiological studies have indicated that the average risk for HIV transmission after percutaneous exposure to HIV-infected blood in health care settings is about 3 per 1,000 injuries. After a mucocutaneous exposure the average risk is estimated at less than 1 in 1,000. It has been considered that there is no risk of HIV transmission where intact skin is exposed to HIV-infected blood"

With regard to the risk of contracting Hepatitis B, It would appear that Hep B vaccination affords considerable pre exposure protection.

In relation to targeting those to seek mandatory testing, annex A of the proposals states, "Our members are at special and increasing risk when dealing with the very large number of criminals and drug addicts in our communities who are infected with blood-borne infectious diseases such as HIV and hepatitis B and C.

With the above statement in mind it is worth considering the following,

Before 1992, tests to detect antibodies to the hepatitis C virus in the nation's blood supply were unreliable or nonexistent. As a result, many patients who received blood then may have contracted the virus unknowingly. Recipients of organ and tissue transplants in the UK before 1992 or abroad in countries where HCV is common and donors may not have been screened. The introduction of organ and tissue donor screening in the UK, in November 1991, has largely eliminated these routes of transmission. However, people who have had transplants pre-1992 or abroad in countries where HCV is common and donors may not have been screened for HCV, may have been exposed to HCV. Some people who received blood or blood products before 1991 may be infected, e.g. haemophiliacs (and pregnant women who received anti D as a treatment for rhesus incompatibility in the Republic of Ireland). For example, there is a high prevalence of HCV in people with haemophilia who received clotting factors before 1986. ( British liver trust)

Reference is made to legislative developments in both Australia and Canada over the past 5 or so years, but this includes no consideration of the effectiveness (Or unintended consequences) of the measures is included.

Specific response to the questions posed by the current proposals.

**Question 1. Do you agree that any legislation giving rights to individuals to apply for information about blood-borne viral infections with which they may have been infected, should apply universally? Or should the protection be restricted to particular groups of people? If the latter, what groups should it be restricted to and what would be the justification for this?**
Although we have concerns about the justification, if it is introduced it should be applied universally but there has to be a reasonable supposition of risk. Could the request be mutual?

In this regard, testing following alleged acts of criminal activity or acts of a "Good Samaritan" coming to the aid of a road traffic victim or the victim of assault would be significant implications. It could well follow that the persons alleged to been involved in criminal activity could enquire as to the Blood Bourne Virus (BBV) status of the police who may have had blood contact with the alleged suspect. Similarly the victim of a Road traffic or similar incident could enquire as to the status of their "good Samaritan". Both of these are particularly worrying in relation to confidentiality.
The proposals 4.20 state "The results of the analysis would be available to the successful applicant and their nominated doctor, and the suspect and their nominated doctor. There would be provisions to limit its transfer to other parties, and in particular it would not be admissible as evidence in any subsequent criminal prosecution (although it may be referred to in any statements made to the Court by the victim about the impact a crime has had on their lives). In essence the only people entitled to the information will be the applicant, the suspect, their doctors, and those in the health, police, Crown and courts services who require to see the information to fulfill their functions and due process of law. *The applicant and the suspect would in general be at liberty to pass this information to others".* (Our italics)
The last sentence is of particular concern as there would appear to be no restrictions as to the wide sharing of the information on another person BBV status with all the implications that could well follow.
The guidance offered by the CMO (Feb 2004) offered the following sections of particular significance to this question:
89. Those responsible for occupational health provision to people in professions who may be at some risk of exposure to HIV-infected material outside health care settings (e.g. police, fire service, voluntary aid agencies and the armed forces) may wish to use these guidelines as a basis for developing guidance appropriate to the particular occupational setting.
This would appear to be relevant with the particular sensitivity surrounding confidentiality
44. It is important that all information about the health care worker and the source patient is kept confidential. Arrangements will need to be in place to ensure this, including the use of codes as identifiers where appropriate.

**Question 2. Do you agree that mandatory blood testing should only be ordered by a sheriff?**

We agree that this should be the case. However, Sheriffs would need advice to assess degree of risk to those exposed. There is no allowance for those who are unable to voluntary agree to test by reason mental illness, disability or consciousness. On the general principle of mandatory versus voluntary consent, research cited by a Canadian group in their opposition to the similar legalisation suggested that "One study of police officers in the United States found that one-third of exposures reported by police officers were "significant." These exposures were rarely percutaneous or mucotaneous exposures to blood (most exposures were to non-intact skin), but when they were, they occurred in circumstances where precautions were not an option or would not have been effective. Of the identified source persons, 94% consented to HIV testing. None of the police officers in the study were infected. [2]"

**Question 3. Do you agree that mandatory blood testing should not be applied to anyone who has committed no crime but may *accidentally* have exposed another person to a prescribed blood-borne viral infection, so that such people should be free to decline to give a blood sample?**

Given that the health risks are identical, the key test should be reasonableness or supposition of risk. However we have similar concerns to Q1 in relation to confidentiality. It also has implications for post exposure for HIV, the best response to treatment by drugs is within the hour of exposure. If time is of the essence, gaining Sheriffs approval for mandatory testing would need to be addressed.

**Question 4. Do you agree with the principle of mandatory blood testing for those who commit serious physical or sexual assaults and thereby put the victim of the crime at risk of infection with a prescribed blood-borne virus?**

As above in relation to response times in starting post exposure treatment.

**Question 5. Do you agree that the provisions for mandatory testing should extend to any type of case where the applicant may have been exposed to a prescribed blood-borne viral infection as a result of a crime being committed by the other party?**

As the proposals themselves note, "For obvious reasons, the provisions can only be of value where there is little doubt as to the identity of the suspect." Also the alleged index offence is not critical to consideration of health care risks.

**Question 6. Do you think there should be any variation in these provisions for cases where the suspect is under age?**

Age is not a factor in risk, however, issues of informed consent are relevant where the suspect is underage. There may well be issues re prevalence of infection, and particular concern and sensitivity re informing the underage of their BBV status.

**Question 7. Do you agree that persons at risk of infection from a criminal incident should be entitled to seek information from the Procurator Fiscal about the prescribed blood-borne viral infection risks they may face?**

Yes, in principle should have the right to enquire. However we would suggest that medical opinion should be sought in the first instance with particular regard to infectious diseases from a BBV specialist. The timescales should fit with advice on the need for early medication post exposure.

**Question 8. Do you agree with the proposed criteria for mandatory testing orders?**

Once again suggest reference is made to the CMO report (Feb 2004) in particular to section 4.14.2 which states "there is reasonable suspicion that the suspect may be the carrier of a prescribed blood-borne viral infection; and" CMO suggests
"A universal approach to asking source patients to agree to have an HIV test avoids the need to make difficult judgements, simplifies and normalises the process and avoids the appearance of discrimination against people perceived as belonging to groups associated with higher than average HIV prevalence. However, there may be occasions when a preliminary risk assessment may be helpful in avoiding inappropriate HIV testing."

**Question 9. Do you have any comments on the proposed civil application process?**

There are issues as noted in the proposals re "window period" and note the above comments re starting post exposure prophylaxis. The proposal does not make mention of test sensitivity and the possibility of false positive results which could well have a significant bearing on reaction to results by the applicants. We also have concerns about confidentiality.

**Question 10. Do you agree that information provided from mandatory testing orders should be for the sole purpose of benefiting the applicant, and should not be retained by the police?**

Absolutely. There is no locus for the police as they have not commissioned the testing?

**Question 11. Do you agree that the costs of the testing process should fall to the applicant?**

Yes.

**Question 12. Should some support organisations be empowered to act on an applicant's behalf and to provide support and advice as appropriate?**

Organisational support should be available for both the applicant and the defender, this may then decrease the need for mandatory testing.
Could also fulfill the role of educator which may in light of media and other sources of misinformation, prevent unintended consequences of positive and negative results from such tests. Or indeed concern over the implications of possible secondary infection.
The last comment is in reference to the scenario set out in ANNEX A of the proposals

"We have evidence from our members of a case where the wife of such an officer was so badly affected that she aborted their unborn child."

It is interesting to note that the introduction to the proposals which intended to give an idea of the magnitude of the problems faced, stated that " 24 of these was the risk considered serious enough for the officer to embark on post-exposure prophylaxis against HIV, but in only one incident is an officer thought to have been actually infected, with hepatitis B."

We would respectfully suggested that the proposals are disproportionate to the risk and that by targeting "high risk groups" could well be further alienate and stigmatize those groups i.e Gay men, and I.V drug users. It is also worthy of note that getting blood from long term I./V drug users is a protracted and difficult affair due to having few sites available for the extraction of blood.