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Blood Testing Following Criminal Incidents Where There is a Risk of Infection – Proposals for Legislation.

I am writing to you on behalf of the Scottish HIV/AIDS Group (SHIVAG), a multidisciplinary body with representation from doctors in Infectious Diseases, Genitourinary Medicine, and Laboratory Medicine; Nurses, Allied Health Professionals, Social Work, Voluntary Sector and Patients' groups. Virtually all HIV-positive patients in Scotland receive their care from members of SHIVAG. All the Consultants participate to a greater or lesser extent in the management of cases of potential exposure to the Blood-borne viruses (BBV) HIV, hepatitis B (HBV) and hepatitis C (HCV). We would like to base our reply to this proposed legislation upon our considerable personal experience.

Current arrangements for the management of police officers who have been subject to potential exposure to Blood-borne viruses (BBV) are haphazard. In the absence of the details of specific cases, a degree of conjecture is required; however, most incidents are almost certainly dealt with in Accident and Emergency Departments by staff with limited experience of HIV, HBV or HCV and the assessment of the need to prescribe post-exposure prophylaxis (PEP). This is likely to be particularly problematic in more rural areas where Health Care Workers are likely to have less experience of working with people at risk or living with BBV than those working in major cities.

The situation when a Health Care worker is potentially exposed to BBV is different to that for the subjects of these proposals. Such exposures unfortunately occur frequently, in a range of scenarios that will be recognisable as similar to incidents experienced through police duties.

- Sick patients cough blood/saliva into the faces of staff
- Blood spillage during restraint of violent (usually psychiatric) patients
- Neeedlestick injuries

Following any of the above incidents, health care workers immediately contact the duty Occupational Health staff, and if they have any concerns about potential BBV risk, they in turn immediately contact the oncall medical staff who are specialists in HIV and other BBV, and who will provide all subsequent advice. Prescription of PEP or testing of the source case is the exception, as in most settings reassurance can be given as follows:-

Coughing/spitting in the face, especially eyes or mouth, is extremely distressing but carries no risk of transmission of HIV or HCV if there is saliva alone. Blood-stained saliva carries so little risk that intervention is not routinely recommended. Potential transmission of HBV could be completely nullified by vaccination of all police officers.

Blood spillage onto unbroken skin carries no risk of transmission of HIV, HBV or HCV. The risk from contamination of broken skin is extremely low, as blood can easily be washed away from the site of contamination. As indicated above, potential transmission of HBV could be completely nullified by vaccination of all police officers.

Needlestick injuries in the police setting usually carry virtually no risk as any contaminated fluid should have long since dried out, resulting in the non-viability of HIV, HBV or HCV. (This contrasts with the Health care setting where there is often fresh material on the penetrating instrument, and yet we are still able to offer considerable reassurance in the vast majority of cases.)

Bites are relatively uncommon in health care, but have been mentioned as a source of anxiety for police officers. The penetrating fluid in this case is saliva (any blood comes from the victim), and this does not carry a risk of HIV or HCV transmission.
As indicated above, potential transmission of HBV could be completely nullified by vaccination of all police officers.

It is rare for an experienced assessor to ask for the source patient to be tested. We don't request HBV tests because all staff are vaccinated against this virus. We don't request HCV testing because there is no potential intervention in the light of a positive result. We will occasionally request an HIV test, and my experience is that every *request* that I have made has been agreed to by the patient, with no necessity to apply undue pressure.

SHIVAG acknowledges without reservation the considerable anxiety experienced by police officers as a result of these incidents, but the proposed legislation leaps many bounds beyond the steps that could meaningfully be taken to minimise that anxiety.

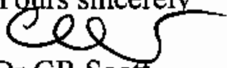
SHIVAG proposes that immediate specialist advice be available to police officers (and any other members of the public exposed to potential risk) on a 24-hour basis. This advice would be backed up by an agreed protocol encompassing risk assessment, circumstances when voluntary testing of the source would be sought, and grounds for prescribing PEP for HIV. We believe that access to specialist advice is the most appropriate route to alleviation of anxiety for Police Officers, and would be in keeping with the response to the management of incidents in Health care settings.

Coercive methods countermand current guidance such as that from the General Medical Council, and risk undermining the basis of trust and goodwill established between

professionals and patients/communities affected by HIV, with no evidence of compensatory gain at an individual or public health level.

This legislation will be perceived as potentially draconian with a fundamental breach of human rights at its core. We would strongly advise that the proposals be abandoned while alternative responses are put in place that address the concerns of the SPF yet protect the rights of suspects,

Yours sincerely



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