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

The following is a response to the above consultation paper. I apologise for it arriving after the official deadline of the 20th May: I understand that the Minister for Justice has indicated that responses will be accepted until the 6th June. I confirm that I am responding as an individual, and that I agree to my response being made available to the public along with my name and address.

I have answered the consultation questions in turn, but I have some rather extensive general comments to make at the outset. (I have also written an article on the subject which is to appear in the June issue of the Scottish Legal Action Group's journal, SCOLAG, and I have enclosed this for information.)

First, I am concerned that it is not clear what mandatory testing is intended to achieve. The consultation paper suggests that the process might be used to provide "appropriate medical help" to the injured party. However, post-exposure prophylaxis (PEP) treatment for exposure to hepatitis B or HIV must be commenced (as is acknowledged elsewhere in the paper) very soon after exposure. Mandatory testing could simply not be carried out quickly enough to inform the decision to administer PEP.

It is true that the results of a mandatory test might (although this is by no means certain given the timescales involved) be received quickly enough to inform a decision to *discontinue* PEP treatment for HIV (but not for hepatitis B). Even then, however, it is unlikely that results would be available until the exposed individual is nearing the end of the normal 4-week PEP regimen at the earliest, if they are available within that period at all.

I say this because any court process is likely to take some time to conclude. The consultation paper suggests that a court hearing should take place *no less* than 48 hours after an initial writ is drafted and intimated, but there is no guarantee that court time will be available immediately, particularly given that these proceedings are likely to be contentious and that it will probably be necessary for evidence to be led, which is necessarily time-consuming.

There would then be a right of appeal: here, the consultation paper proposes that there should be a "strict limit on the time allowed for an appeal, of perhaps 48 hours". I assume this means that an intention to appeal must be intimated within 48 hours, but again court timing is unlikely to be available for an appeal hearing immediately.

If this is intended to suggest that an appeal hearing should *take place* within 48 hours, I simply do not see how this is possible without creating some sort of unique civil proceeding which has no counterpart at present (bearing in mind that a mandatory test order is an order to *do* something, or at least consent to something being done, as opposed to an order such as an interim interdict which might be obtained without proceedings being intimated to the individual affected, and which simply *prevents* them from acting in a particular way pending a full hearing). An appeal from a decision of the sheriff would ordinarily be to the Sheriff Principal, but if the action is brought (for example) in Aberdeen Sheriff Court and the Sheriff Principal of Grampian, Highland and Islands is engaged in judicial business in Lerwick (or, indeed, on leave), it seems utterly inconceivable that an appeal court be heard in such a timescale. Even if the Sheriff Principal were in Aberdeen at the relevant time, he would be likely to have a considerable amount of judicial business to deal with and would be unlikely to be in a position to deal with an appeal (which might involve relatively complex and novel human rights arguments) immediately. Furthermore, the decision of the Sheriff Principal might itself be subject to appeal to the Inner House of the Court of Session (and thereafter to the Appellate Committee of the House of Lords), unless the Executive are proposing certain constraints on the right of appeal, none of which have been made the subject of consultation.

The procedure envisaged by the consultation paper would, to stand any chance of being effective, require the creation of a highly unusual bespoke form of civil process, after appropriate consultation with (at least) the Lord President and the Sheriff Court Rules Council. None of this appears to have been given consideration.

I appreciate that there is a benefit in relieving the anxiety of persons who are concerned that they may have been exposed to a risk of infection. This might apply even where information cannot be obtained sufficiently quickly to inform treatment decisions (although lengthy court proceedings are likely to heighten anxiety rather than relieve it).

However, anxiety is best relieved by providing accurate information on the risk of transmission of HIV or hepatitis in relevant situations. It is clear that misconceptions persist in this regard, and I am astonished that the Consultation Paper impliedly suggests – flying in the face of the available medical evidence – that spitting in someone's face might run the risk of HIV transmission (para 1.5). I am also concerned that there is no discussion of any of the medical or epidemiological evidence on transmission risks, which suggests that police officers are not, in fact, at increased risk of infection compared to the general population.

In any event, the Executive must be aware that compulsory blood testing is an interference with the right to respect for privacy guaranteed by article 8(1) of the European Convention on Human Rights. Interferences with this right can be justified where they are necessary in a democratic society for one of the reasons specified in article 8(2), including the protection of health or morals (article 8(2)). Relieving anxiety does not fall within any of the article 8(2) grounds for interfering with the Convention right.

The Executive will, of course, be acutely aware that mandatory testing legislation will be *ultra vires* and outwith the competence of the Scottish Parliament unless it is compatible with the Convention. Unless it can be shown that such legislation is necessary for the protection of health or morals – as opposed to simply relieving anxiety – I do not see how it could be considered within the Parliament's competence.

Even if the "protection of health or morals" ground is relied on, it is difficult at best to see any real benefit, in health terms, for mandatory HIV testing. It is near-impossible to see any such benefit for mandatory hepatitis testing given that PEP is not available for hepatitis C exposure, and that hepatitis B PEP treatment will have been completed before any mandatory test result becomes available.

Furthermore, interference with Convention rights should be a course of last, rather than first, resort. It is disappointing that the Executive has brought forward these proposals without first considering, for example:

1. Whether police officers should be routinely vaccinated for hepatitis B. (I understand that the SPF has indicated that it is confident that there is a very high uptake of hepatitis B vaccination already, whether through occupational health departments or through police officers' own GPs. Even if that is the case – and I find it surprising, because my understanding is that GPs do not normally make hepatitis B vaccination available free of charge, even for occupational health reasons – it does not mean that proper follow-up testing will take place to ensure that the vaccination has been effective. If the view is taken – as I understand it has been in the past – that police officers are not at a sufficiently high risk of hepatitis B exposure to justify routine vaccination, it is difficult to understand how mandatory testing for hepatitis B could be justified.)
2. Whether steps can be taken to increase the rate of voluntary consent to testing.
3. Whether better guidance on transmission risks can be provided to help reduce anxiety.
4. Updating relevant police guidance to help reduce the risk of exposures taking place.
5. Whether steps can be taken to avoid the unnecessary prescription of PEP, particularly PEP for HIV, and to ensure an appropriate risk assessment takes place after "starter" PEP is prescribed so that treatment can be discontinued if appropriate.

Such action would be far more likely to be of real benefit to police officers (and other persons) than mandatory testing.

I understand that parallels have been drawn (as is implicit in paragraph 2.8 of the consultation paper) with the position in the hospital setting, and that it has been suggested that the police are at a comparative disadvantage because it is considered to be much easier for healthcare workers to persuade source persons in hospitals to consent to HIV or hepatitis testing where there may have been an exposure. A number of points should be made in response to this:

1. Testing carried out in the healthcare setting will (with very rare exceptions) be voluntary rather than mandatory, and will therefore take place much more quickly. Voluntary testing is much more likely to be of use in informing treatment decisions. Mandatory testing could never put police officers "on a par" with healthcare workers – at the very best it would be a poor substitute, if not a worthless token.
2. The view that it is much more difficult for the police to obtain consent to HIV or hepatitis testing is not borne out by the available evidence. Research studies in Amsterdam and Denver have found very high rates of voluntary consent (84% and 94% respectively), which are comparable to – if not higher than – those achieved in the healthcare setting.
3. Voluntary testing will be of far more benefit than mandatory testing could ever be. Given this, if it is the case that rates of consent are lower in Scotland than elsewhere, it would be of far more use to police officers (and others exposed to a risk of infection) to consider how these rates could be increased rather than to resort to mandatory testing legislation.
4. Even if it were true that it is more difficult for the police to obtain consent to testing, the risk of occupational transmission of hepatitis or HIV in the healthcare setting is considerably higher than that faced by police officers. The available evidence does not demonstrate that police officers face a risk of infection which is greater than that faced by the general population.

Full references regarding points (2) and (4) above are contained in the enclosed article.

My answers to the specific questions are below. My views are, at all times, subject to the caveat that I do not believe there should be any legislation requiring mandatory testing. For that reason, some of my answers on points of detail are rather brief.

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?

I agree that it should apply universally.

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

Yes.

Question 3. Do you agree that mandatory blood testing should <u>not</u> 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?

I agree that any legislation should be restricted in this way.

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?

No. My reasons are set out in the earlier, general, part of this letter.

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?

It seems to me that the most sensible approach would be to limit the scope of any mandatory testing legislation to category (i) at para 4.3 (exposure as the result of being a victim of an alleged crime). I do not think it would be necessary or helpful to produce a list of offences which are or are not within the scope of the legislation: it would seem odd to include some crimes which create the risk and some which do not.

With regard to the example of the needlestick injury noted in paragraph 4.4, the Executive should be aware that the suspect would be guilty of a criminal offence if they had knowingly or recklessly denied that they were carrying a needle, but would not be guilty of an offence if they had simply failed to disclose the fact (see *Mallin v Clark* 2002 SLT 1202). I think that is sufficient to meet the point which is being made here.

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

The consultation paper does not appear to specify what is meant by "under age" and I am not sure what age is being referred to here. I doubt any pressing need to mandatorily administer HIV or hepatitis tests to persons who are too young to consent themselves can be demonstrated.

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?

I agree that the person's GP or other doctor should be able to seek this information on their behalf where they feel it to be medically necessary. I do not think that the person at risk should be able to seek the information directly and therefore have it provided without accompanying medical advice.

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

I am extremely concerned about the "reasonable suspicion" requirement (para 4.14.2). Given the limited information on risk which is likely to be available, I do not understand how (exceptional cases aside) this could be satisfied other than by reference to the suspect's ethnicity, sexuality or history of intravenous drug use (alongside information on the general prevalence of hepatitis or HIV in certain populations), and there would seem to be considerable potential for the legislation to be applied in a discriminatory and stigmatising fashion.

I am also unsure about what is meant by "risk" in para 4.14.3: on its face, any risk, however minor, would satisfy this requirement. The criteria should probably refer at least to a "more than negligible risk".

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

No.

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?

Yes.

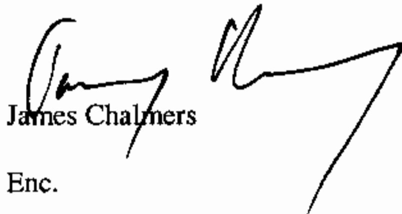
Question 11. Do you agree that the costs of the testing process should fall to the applicant?

Yes.

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

Yes, although I am not sure what organisations these would be and I note that the consultation paper does not identify any who have stated that they would be willing to accept such a role.

Yours sincerely,



James Chalmers

Enc.