

BLOOD TESTING FOLLOWING CRIMINAL INCIDENTS WHERE THERE IS A RISK OF INFECTION

Summary

The National AIDS Trust opposes mandatory blood test orders following alleged criminal incidents where there is a risk of infection.

In relation to HIV, the orders would provide no treatment benefit and have only a marginal effect on anxiety. In the absence of any evidence that alternative and less coercive approaches have been fully explored and implemented, the introduction of mandatory blood test orders would be a disproportionate measure, infringing human rights and fuelling the HIV-related stigma and discrimination which drive the epidemic.

Introduction

The National AIDS Trust is the UK's leading independent policy and campaigning voice on HIV and AIDS. We develop policies and campaign to halt the spread of HIV and AIDS, and improve the quality of life of people affected by HIV, both in the UK and internationally. We aim to prevent the spread of HIV and AIDS, ensure people living with HIV have access to treatment and care, and eradicate HIV-related stigma and discrimination.

We are aware of the great risks run by police officers in the course of their duties protecting the public. We wish to support all reasonable and effective methods to keep police officers safe and confident in the performance of their duties. We must also emphasise that the mandatory order of a blood test is a serious infringement of the right to privacy as set out in article 8 of the European Convention on Human Rights.

The question to be answered is whether the risk is sufficient to warrant such an infringement of a basic human right, and whether in any event the infringement would achieve the objectives claimed for it.¹

¹ Our paper concentrates on HIV testing but where appropriate we do also refer to the question of tests for Hep B and Hep C.

There is a clear and evidence-based international consensus that HIV and AIDS are only effectively and successfully addressed where the human rights of those living with HIV are respected, where HIV-related stigma and discrimination are combated, and where HIV medicine is in accordance with ethical best practice. The proposal for mandatory blood test orders marks a worrying departure from the human-rights based approach to HIV in the United Kingdom, an approach which has meant we have had one of the lowest HIV incidence rates in the developed world.

The proposed mandatory blood test orders establish an unwarranted and stigmatising link between HIV and criminality, communicate an unfounded and excessive fear of HIV transmission, and fatally undermine the confidentiality of HIV diagnosis.

What are the risks of HIV transmission in such incidents?

'The risk of acquiring HIV infection following occupational exposure to HIV-infected blood is **low**' ('HIV Post-Exposure Prophylaxis – Guidance from the Chief Medical Officers' Expert Advisory Group on AIDS' DH revised Feb 2004)

We were concerned to see the consultation document imply that HIV could be transmitted by saliva. In fact, only in association with dentistry as a result of blood contamination is there a possible risk of HIV transmission from saliva. A full list of body fluids and materials from which exposure is possible is found as Annex A to the HIV PEP national guidance referred to above. In reality and in relation to the circumstances addressed in the petition and consultation document it is only blood which raises questions of risk.

But HIV transmission is only possible from HIV-infected blood through percutaneous exposure (contact of the infected fluid with tissue under the skin e.g through a cut or needle stick injury), or through mucocutaneous exposure (contact of the infected fluid with mucous membranes e.g through a splash to the eyes, nose or mouth). There is no risk of HIV transmission where intact skin is exposed to HIV-infected blood.

It is estimated that the risk of infection from a single percutaneous exposure to HIV-infected blood is 0.3% (1 in 300) and for mucocutaneous exposure it is 0.1% (1 in 1,000). It must be recalled that for blood where the HIV status is unknown the risks will be very considerably less than these low percentages, even for people from high-risk groups. For example, it has been estimated

in a Canadian study that whilst the risk of HIV infection after a single percutaneous needle exposure from a known HIV positive source person is 0.3%, where the source person is an injecting drug user but status is unknown, the risk reduces to 0.12% (1 in 800).² Where an HIV positive source person is on anti-retroviral treatment, again the risk is reduced below 0.3%.

We note that the petition states that there has not been over the period cited an incident of HIV infection of a police officer through occupational exposure (the one case of Hep B infection would have been avoided by routine immunisation). This underlines the most important point to bear in mind when considering this proposal - that the risk of HIV infection through occupational exposure is extremely low.

To whom would the orders apply?

Those who would be subject to these orders are individuals who are alleged to have committed a crime [para.4.3]. The title of the consultation paper is therefore misleading – what is proposed are mandatory blood tests following **alleged** criminal incidents. Given the need for an order within a matter of hours, it is highly likely that incidents will still be being investigated and that in many cases charges will never be brought, or be dropped, or not result in convictions. When considering the justification for such a significant infringement of personal liberty, it is worth remembering that those subject to orders will be at the time of the order innocent in the eyes of the law, and may well remain so.³

There is considerable potential for discrimination in these proposals. The petition speaks of 'the very large numbers of criminals and drug addicts in our communities who are infected with blood borne infectious diseases such as HIV and Hepatitis B and C'. No prevalence figures are provided and a claim of prevalence which bundles together HIV, Hep B and Hep C in this way is irresponsible. We note that the Health Protection Agency reports HIV prevalence amongst injecting drug users in Scotland at 0.4%, which is lower than the rest of the UK (0.5%) and much lower than London (2.9%).

² British Columbia Centre for Excellence in HIV/AIDS Therapeutic Guidelines Section 7

³ The consultation paper decides to term 'the person from whom the infection may have been transferred' as 'the suspect' which 'is used to denote the individual from whom it is *suspected* infection could have transferred, without prejudice to whether they are also suspected of having committed a crime' [para.1.8].

To use the term 'suspect' in this context is extremely stigmatising if it is referring simply to suspicion of having transferred the HIV virus. HIV positive people should not be described using terms ordinarily applied to those being investigated for criminal acts. It only adds to HIV-related stigma and discrimination.

It will be for the police officer or other applicant, and then ultimately for the Sheriff Court where the allegation is at issue, to decide, on the basis of 'reasonable suspicion', whether the person is likely to carry a blood-borne virus. In all likelihood not only drug addicts but gay men and Africans will be disproportionately affected by these proposals, with assessment of risk not being based on professional clinical advice but on personal and often unfounded beliefs relating to certain already marginalised groups.

The provision of treatment

There is no cure for HIV. It is, however, believed that a course of Post-Exposure Prophylaxis (or PEP), if commenced within 72 hours of possible HIV transmission and adhered to for about a month, can prevent HIV infection. The national guidance recommends that for optimal efficacy PEP should be commenced as soon as possible after the incident and ideally within the hour. Given the time needed to request a voluntary test, receive a response, apply for an order where a voluntary test is refused, hold a hearing and deal with any appeal, it will be impossible to wait for the results of a mandatory test before making the decision whether or not to commence a course of PEP. The decision will simply have to be made on the best advice given in accordance with national guidance. Mandatory orders will thus have no impact on treatment via PEP of possible HIV infection.

It can be argued that a test result received later, once the course of PEP had begun, would indicate to someone that they are unlikely to be infected and could discontinue the course before its completion. This would provide welcome relief both from the worry at possible infection and from the unpleasant side-effects of PEP.

Whilst a later negative result might provide relief and allow for PEP to be discontinued, if, as appears likely, the tested person is from an at risk group, any decision to discontinue PEP must take account of the possibility of a 'false negative' test during the three-month window period after infection when the positive status of the tested person might not be picked up.

Thus mandatory orders do not provide any advantage in terms of HIV treatment, nor do they eliminate judgements based on risk, and the potential for worry. Although there may be at later stage some lessening of worry as a result of a mandatorily acquired test result, the Scottish Executive and Parliament should consider whether such marginal advantage justifies such a serious change in

the law with all its implications for civil liberties, human rights and possible impact on HIV-related stigma and discrimination.

Relieving anxiety

The petition emphasises the stress and anxiety endured by police officers who feel they may have been exposed to HIV, Hep B or C. We submit that the proposal does not effectively dispose of this problem. As has been stated above, even when someone is known to be HIV positive, the likelihood of infection during occupational exposure is extremely small. A positive test result in a 'suspect' will certainly increase anxiety until the applicant is tested rather than diminish it, even though there is a very low probability of infection having occurred. A negative result may give an indication that infection is extremely unlikely but until the three-month window period is over the test could be a 'false negative' and infection still theoretically possible. If this difficulty of the 'false negative' test is understood, we believe in many cases police officers and their families will remain unduly anxious even with a negative test from the 'suspect'.

Fears and anxieties around HIV are most effectively addressed through a combination of clear information about HIV and risks of transmission, plus expert clinical advice for those worried about the possibility of occupational exposure. There is no information in the consultation document on the current state of HIV-knowledge within the Scottish Police forces nor on whether information on HIV is included in basic training.

Alternative measures

As the consultation paper makes clear, the principle of proportionality is central to any measure which overrides or derogates from a basic human right. One key test of proportionality must be whether alternative but less stringent and intrusive measures have been attempted to meet the same ends.

In relation to Hep B, is there a recommended process of Hep B immunisation routinely explained and offered to all police officers?

Are all possible measures being taken in occupational settings to minimise the possibility of transmission of blood-borne viruses?

In relation to fear and anxiety over possible HIV infection, as stated above, is there appropriate training, information and clinical advice to remove unfounded or excessive concern of risk of infection and unnecessary recourse to PEP?

In relation to the alternative course of a request for a blood test on a voluntary basis, there is evidence from overseas jurisdictions of considerable success in securing blood tests voluntarily. This contrasts with the petition's claim, apparently accepted uncritically, that those asked to submit voluntarily to a blood test rarely do so. In a study in Denver 94% of source persons consented to HIV testing and in an Amsterdam study 84% did so. The Amsterdam study gives as a possible explanation of the high proportion voluntarily tested that fact that 'In our experience, arrested people volunteer a sample more often when an independent person (forensic doctor or a public health nurse) rather than a police officer asks for permission'.

We do not believe enough has been done to maximise consent to voluntary blood tests and recommend this course of action, involving suitably trained health professionals, before any change in the law to provide for mandatory tests.

Until all such alternative measures have been fully explored we do not think the case for proportionality can be made.

RESPONSES TO QUESTIONS IN CONSULTATION DOCUMENT

As has been made clear in NAT's general comments, we are opposed on grounds both of principle and practicality to any use of mandatory blood test orders. All responses to specific questions must be read in this context, and for this reason some of the responses are 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?

Whilst being wholly opposed to such orders, should they be introduced we accept the argument that the right should be applied 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 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?

Yes.

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, for the reasons set out in NAT's general comments on the proposal.

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?

No.

Question 6

Do you think there should be any variation in these provisions for cases where the suspect is underage?

We do not think the provisions should apply to those under age (we note the definition of 'under age' is not specified). With regard to HIV, the number of HIV positive minors in the UK is small (the cumulative total of HIV-1 diagnoses amongst under 14s in Scotland to 30 June 2004 is just 82). We cannot see the justice in ordering a test of someone not in a position to consent voluntarily.

Question 7

Do you agree that the 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?

No.

Question 8

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

Our general comments opposing mandatory orders apply. We would stress again our concern at the potential for discrimination from the 'reasonable suspicion' criterion. It is also unclear whether in the third criterion 'a risk of transfer' means any risk of transfer, however low, or a risk which, according to agreed professional guidance, would justify PEP. As currently stated, the phrase 'risk of transfer' is too broad and would allow mandatory orders in wholly unnecessary and inappropriate circumstances.

Question 9

Do you have any comments on the proposed civil application procedure?

No, but see general comments on a more effective voluntary testing approach.

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. We believe, however, that in practice it is inevitable that the person's privacy will often be compromised and contacts of the applicant, both personal and professional, will become aware of the person's status.

Question 11

Do you agree that the cost 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?

We have no view here other than to emphasise the need for the applicant to be properly counselled on the risk of transfer of HIV or other blood borne viruses, on the advisability of PEP and on the need for such an order by an appropriate clinician.

National AIDS Trust 2 June 2005