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

Report on the Consultation Responses

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INTRODUCTION

Acknowledgements

1. The Scottish Executive would like to thank all those who responded to the proposals set out in the consultation paper *Blood testing following criminal incidents where there is a risk of infection.* The Executive will now consider the way forward in the light of all the responses and other relevant evidence and information.

The consultation process

2. The consultation document was published on 24 February 2005, both on the Internet (www.scotland.gov.uk/consultations/justice/btfci-00.asp) and by mail to some 350 organisations. During the consultation process Executive officials were grateful for the opportunity to attend a meeting of the Advisory Group on Hepatitis and meetings organised by HIV-Scotland and by Positive Voice, to discuss the proposals. It is also clear from the consultation responses that a number of organisations have held internal discussions about the proposals before forming a collective response.

3. Except where confidentiality has been requested, the individual responses are available to the public in the Scottish Executive Library, K-spur Saughton House, Broomhouse Drive, Edinburgh EH11 3XD, tel 0131-244-4556, or on the Scottish Executive website at: www.scotland.gov.uk/justice/btfci-responses

4. Health Protection Scotland has not made a formal response to the consultation but has, on request from the then Chief Medical Officer, given the Scottish Executive its own advice about some issues raised in the other consultation responses. This advice is available whithin www.scotland.gov.uk/justice/btfci-responses

The purpose of this report

5. This report provides a summary and analysis of the written responses received by the Scottish Executive on the proposals set out in the consultation paper. The aim of this report is to describe the range of views expresses by the respondents and to identify, without attributing them to individual respondents, the main issues raised.

Terminology

6. Some respondents criticised some of the terminology in the consultation document and in particular the use of the word “suspect” to imply someone who is both alleged to have committed a criminal offence and is the possible source of an infection. We apologise for any offence unintentionally caused by this or other wording in the consultation. This report therefore uses the term “suspected source” to denote the person about whom medical details are sought, and (as in the consultation document) “applicant” to denote the person at perceived risk of infection who applies for that information.

7. “Mandatory testing” in this report is used as shorthand for the full range of proposals which would give an applicant, under due process of law, the right to information about whether the suspected source was infected with Hepatitis B, Hepatitis C or HIV. It therefore covers mandatory access to medical records as well as mandatory blood testing.

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Version 1.2

8. Many of the responses concentrated on the issues as they affect police officers, given the prominence that was given to this group in the consultation document. As a result there are many references to "police officers" in the summary of responses below. It should be borne in mind, however, that the consultation document specifically proposed that any legislation should apply to anyone infected as a result of a crime committed by the suspected source.

9. A number of the responses commented on the incident drawn to our attention by the Scottish Police Federation in which the wife of a serving police officer under stress following such an incident "was so badly affected that she aborted their unborn child". Some respondents took this to mean an intentional abortion. We regret the ambiguity but can clarify that it was in fact a miscarriage.

The consultation proposals

10. The consultation document was in part a response to the Scottish Police Federation's 2002 petition to the Scottish Parliament, which asked for legislation to make it compulsory for assailants and others who have caused police officers to be exposed, or potentially exposed, to risk of blood-borne virus infection, to submit to a blood test, so that the officer concerned could be informed as soon as possible of the results of tests for Hepatitis B, Hepatitis C and HIV.

11. The Executive's consultation document proposed legislation to allow a police officer, or anyone else, to apply for mandatory blood testing of a suspected source for this purpose. However, it was proposed that such applications should only be upheld if there was:

a) evidence that the applicant had come into contact with a bodily substance of another individual as a result of that individual committing a crime; and
b) reasonable suspicion that the suspected source might be the carrier of Hepatitis B, Hepatitis C or HIV; and
c) medical advice that there was a risk of transfer of a blood-borne viral infection through the incident.

12. The document proposed that applications could be made either to a procurator fiscal (who would only be able to provide information if this had been sought in connection with the prosecution's investigation of the incident in question) or to a sheriff by way of a civil hearing.

13. Readers who are not familiar with the consultation document may wish to refer to it at www.scotland.gov.uk/consultations/justice/btfci-00.asp to see details of the proposals.

The consultation responses

Characteristics of respondents

14. 70 responses were received to the consultation. Responses were received from a wide range of organisations and individuals but the majority came from those in fields related to front line services (including policing), HIV or Hepatitis C, or healthcare more generally.

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Some organisations and individuals came from a background which covered both healthcare and policing, or both healthcare and HIV/Hepatitis.

15. A summary, to some extent simplified, is shown in the following table. Responses have been assigned to rows according to their background, where appropriate.

Field to which respondent is related	From Organisations and groups	From Individuals	Total number of responses
Police or Fire	13	2	15
Policing and healthcare	2	1	3
HIV/ Hepatitis	9	1	10
HIV/ Hepatitis and healthcare	6	-	6
Other medical and healthcare	16	2	18
Local Authorities	4	-	4
Other	9	5	14
Total responses	59	11	70

Overview of responses

16. There was a mixed response to the consultation, with several supportive responses and also several opposed. The balance of responses differed between the various groups, with support coming predominantly from those representing police or other front line workers and victims, and opposition coming predominantly from fields related to HIV or Hepatitis.

17. Respondents both supporting and opposing the proposals emphasised the importance of high quality care and counselling being provided to both applicant and suspected source following such an incident.

18. Overall, of the 70 responses received, 29 were opposed to the proposals and 29 were broadly supportive, although some of the supportive responses had reservations about particular aspects. 7 responses were supportive of a victim's right to obtain the relevant information from a procurator fiscal, while opposed to the proposals for civil applications to a sheriff. The remaining 5 responses were either neutral or reserved judgement on the proposals. The comments made by the respondents can most easily be summarised by considering each of these groups separately.

The 29 supportive responses

19. All these responses accepted the arguments put forward in the consultation document that provision for mandatory testing would be beneficial to the person at risk and was

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justified in cases where the suspected source had committed a serious assault (Question 4). The vast majority also accepted that the provisions should also apply where the incident was the result of any kind of crime (Question 5). None disagreed with the legal mechanisms proposed, ie the applications either to a procurator fiscal (Question 7) or to a sheriff.

20. None of these responses disagreed with the proposal (Question 2) that mandatory testing should only be authorised by a due legal process or that the provisions should apply irrespective of the age of the suspected source (Question 6) – though a few commented on the particular arrangements that would be necessary to ensure cases involving an under-age suspected source were handled appropriately and sensitively.

21. The majority of these respondents supported the proposal (Question 1) that applications could be made by anyone in the defined circumstances, rather than be limited to certain occupational groups, though a few of the responses indicated that they thought the legislation would be more important for (and would be more appropriately used by) police and other emergency workers than the general public.

22. A number of these responses disagreed with the suggestion that only those who had committed a crime could be subject to a mandatory testing order (Question 3). These respondents argued that the at-risk person's need for the information was just as great if the infection risk had arisen accidentally, and therefore proposed that the provisions should be widened to encompass accidental incidents. A few of these felt that the criterion limiting mandatory testing to those who had committed a crime was unacceptable because, on principle, such a criterion should only be applied following conviction of a crime in a criminal court. (The same point was made by a number of opposing responses as an argument against mandatory testing altogether – see paragraph 41 of this report.)

23. Dissent from the proposed criteria for mandatory testing orders in a sheriff court (questions 8 and 9) came from the above group of responses for the reasons described in the previous paragraph and also from a few others, who objected to the criterion that a sheriff should have to judge whether there was reasonable suspicion that the suspected source may be the carrier of HIV or Hepatitis B or C. These felt that there was a danger that such a criterion would lead to discrimination and stigmatisation of groups with a higher prevalence of these infections, such as gay men or those of African origin. It was also pointed out that this criterion was not necessary: the requirement for the sheriff to take on board medical advice on whether there was a genuine risk to the applicant was sufficient for the purpose on its own.

24. Furthermore, some respondents emphasised the need for the legal processes to work as quickly as possible in the interests of getting information for the person at risk, and a few expressed some doubt about whether the civil application process could deliver the necessary speed.

25. A number of responses disagreed with the proposal that the information obtained from mandatory testing should not be retained by the police (Question 10). These respondents felt that this information could be useful in order to lessen risks of infection in future incidents.

26. The only aspect of the proposals which did *not* get majority support from those in favour of mandatory testing was the suggestion that the costs of testing should fall to the applicant (Question 11). The majority of the supportive responses proposed instead that the

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costs should come from elsewhere, such as the NHS or from employers. There was unanimous support, however, for the suggestion (Question 12) that appropriate support organisations should be able to help applicants through the processes, with some specifically indicating that this should include financial support for those who needed it most.

27. Several of the 29 supportive respondents gave additional comments alongside their answers to the Executive's questions. These included the importance of other aspects of the care given to police officers at risk of infection; the difficulty of applying the mandatory testing provisions where the suspected source was an individual with a chaotic lifestyle; and the need to limit the transfer of personal health information to the minimum necessary.

The 29 opposing responses

28. The great majority of the opposing responses expressed sympathy for the position of police officers and others put at risk of infection with HIV or Hepatitis, and acknowledged that the consultation document had raised some important issues. But each of them set out, in their own way, their reasons why they did not believe the interests of the applicant justified recourse to mandatory testing on the suspected source.

29. Many of the opposing responses did not provide comments on the 12 specific questions set out in the consultation document. It is therefore more helpful to analyse the reasons they gave for opposing the main aspects of the proposals.

30. A number of the responses felt that the consultation document set out insufficient evidence to justify mandatory testing. They argued that before such legislation should be contemplated there should be systematic records assembled of incidents of this type, detailing the nature of the incident, the care provided and any cases when infection was transferred.

31. Besides the lack of evidence to justify the policy, the main reasons cited against the proposals can be grouped under 4 headings: (a) that the consultation document overstated the benefits to the victim which mandatory testing would bring; (b) that the proposals could be damaging in a number of ways; (c) that the ethical basis for the Executive's proposals was flawed; and (d) that there are other ways to improve care for police officers and others put at risk of HIV infection.

The benefits are not as great as the document had implied

32. The consultation document stated that the results of mandatory drug testing would be useful to inform treatment given to those at risk. However, opponents of the proposals argue that only in a small proportion of cases would information obtained from mandatory testing actually affect the treatment given to patients. This is partly because for all 3 viruses there is a real possibility of a negative test coming from a positive and infectious source – this will commonly occur when the source has only recently contracted the virus. This is compounded by the fact that mandatory testing will deliver information within days or up to 2 weeks, whereas the main decisions on treatment will need to be taken and acted on much faster than that.

33. For example, in the case of HIV, judgements would have been taken on day 1 about whether to embark on post exposure prophylaxis (PEP), which lasts 4 weeks. So although a few might be able to terminate the treatment on receipt of a negative result, in many cases

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doctors would recommend that the course of treatment be completed (especially in view of the risk of false negatives from the tests).

34. It was acknowledged by several opponents of the proposals that a mandatory test result might to some extent allay anxiety on the part of the victim, which was a key feature of the SPF petition. However, given the possibility of a false negative, it was felt that any reassurance it provided would be limited, and that all victims at risk would need to wait for testing on themselves at 3-6 months to be more certain of their position.

35. In addition, some respondents expressed doubt about whether a mandatory testing regime would actually be successful in getting more test results to victims, than improving procedures without such legislation. They pointed to two overseas studies which suggested that even criminal suspects were usually willing to provide samples voluntarily if asked in the right way, by a doctor or nurse, after the heat of the moment has passed. On the other hand, these respondents felt there could be some such suspects who would react in defiance to any mandatory testing regime, especially given the limited penalties which could be imposed.

The proposals could be damaging

36. Many respondents felt that the legislation could be open to malicious applications by people wanting to find out if someone in their neighbourhood (typically a gay man, or someone of African origin) was HIV positive. They felt this would be highly unwelcome, even if the procedures were cast in such a way as to make it unlikely that such applications would succeed.

37. Even where an application was made in good faith and upheld by a sheriff, many respondents were concerned that there was nothing to stop the successful applicant using the information that the suspected source was carrying a blood-borne virus maliciously against that individual as well as for their own healthcare.

38. Some respondents suggested that the introduction of this legislation would, of itself, heighten the unrealistic fears among some (including some police officers) about the dangers of HIV infection from this kind of incident.

39. Some also felt that these proposals could damage the trust that is being built up between the medical profession and the HIV–positive, Hepatitis-C positive and drug using communities. They advised that the maintenance of this trust is central to improving the uptake of voluntary testing and so supporting public health efforts to tackle these infections. More generally, some respondents felt that the concept of mandatory testing applied in such circumstances would damage the trust in the doctor-patient relationship amongst some individuals with blood borne viral infections.

The ethical basis for the proposals

40. Most respondents who opposed the proposals drew attention to the very small risk of actual infection (which was acknowledged by the Scottish Police Federation and in the consultation document), and argued that this meant the introduction of mandatory testing would be a disproportionate response to a small problem. Those that acknowledged the Federation's argument that the main threat to officers was from anxiety rather than actual

infection argued the proposals would give limited relief from anxiety and that this aim was not sufficient to justify the proposals either.

41. Many respondents, including some who were in favour of the basic proposals, were unconvinced by the proposal that mandatory testing should only be considered for 'those who had committed a crime'. They felt that to include this condition meant that mandatory testing would be seen, in effect, as in some sense a punishment for the commission of a crime. In that case, they felt that it was inappropriate to make such decisions in advance of the suspected source being convicted of the offence beyond reasonable doubt.

Other ways to improve care for police officers and others put at risk of HIV infection

42. A number of responses with professional knowledge of the treatment of blood-borne viruses suggested that more could be done to ensure that police officers (and others) at risk get access to the best quality care, including counselling and advice on treatment. It was suggested that current arrangements for the clinical management of police officers who have been subject to potential exposure to Blood borne viruses are haphazard, and may contrast unfavourably with the quality of care which is given to health care workers in the same position.

43. A number of responses expanded on this theme and suggested that, without mandatory testing, better care could be provided to police officers (and others) at risk, for example by:

- Giving better education about the risks;
- Ensuring guidance on preventative measures is up to date;
- Making use of tests for Hepatitis C RNA at two weeks after the incident, thereby giving an early (though not fully reliable) indicator of whether the person had contracted an infection, and allowing earlier commencement of treatment for Hepatitis C where appropriate;
- Improving procedures whereby suspected sources in custody are asked to give a blood sample voluntarily (see para 35 above).

44. In addition, a few responses drew attention to a 2004 GMC publication, *Confidentiality: Protecting and Providing Information,* which states that in certain specific circumstances personal information may be disclosed without a patient's consent where a failure to disclose that information may expose the patient or others to risk of death or serious harm. It was suggested that it may be possible to draw on this principle to entitle doctors caring for those put at risk of blood borne viruses to get access to information from medical records of the suspected source, without the need for mandatory testing legislation.

45. Two other points raised by opponents of the proposals included suggestions that if any such legislation went ahead, applications should be made by medical professionals rather than directly by the person at risk; and that the legislation would do little for those injured by contaminated needles as it was possible that the needle could have been contaminated by more than one source.

The 7 responses supportive of the procurator fiscal route only

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46. 6 of these responses concurred with many of the arguments put forward by those opposed to mandatory testing orders (see above), and in these respects these responses echoed many of the arguments set out in the previous section. The 7th was neutral on those aspects of the proposals.

47. Despite this, these 7 respondents expressed support, at least in principle, for those at risk of infection as a result of crimes to be able to benefit from any information about blood borne virus risks which was obtained by the procurator fiscal as part of his investigation into the alleged offence. One of these specified that the information should not be given directly to the applicant by the procurator fiscal but should be conveyed via a doctor able to give appropriate counselling and support in the event of a positive test for any of the viruses.

48. Few reasons were given to explain why these respondents supported the procurator fiscal route. However, one explained that this was because the information was likely to come out in open court anyway.

The 5 responses which were neutral or reserving judgement

49. These responses provided comments on medical, scientific or legal aspects of the proposals. One advised that although a case could be made for mandatory testing, this should not be pursued until all other ways to improve care for those at risk had been explored first. Others commented on the small risk of actual infection and on the timing issues, discussed above.

Conclusion

50. A wide range of responses was received to the consultation, which in numerical terms were roughly balanced between those in support of the proposals and those against. Those opposing the proposals set out a range of reasons for their view which suggested that mandatory testing would be an ineffective and inappropriate way to improve care for people at risk of blood-borne viral infections through criminal incidents, and sometimes making alternative suggestions for the way such care could be improved.

SE Approved
Version 1.2

List of Respondents

Organisations

Scottish Police Federation
St John Ambulance
Scottish Police College
Royal College of Physicians and Surgeons of Glasgow
Educational Institute of Scotland
Canadian Professional Police Association
Grampian Fire and Rescue Service
Highlands & Islands Fire Brigade
Aberdeenshire Council
Waverley Care
Association of Chief Police Officers in Scotland
C-Level
Expert Advisory Group on Aids
Strathclyde Police Forensic Dept
Strathclyde Joint Police Board
Tayside Fire Board
NHS National Services
Strathclyde Passenger Transport
Medical & Nursing Advisers to the Scottish Police Service
Association of Scottish Police Superintendents
Royal College of General Practitioners Scotland
British Association for Sexual Health & HIV
UNISON Scotland
Royal College of Physicians of Edinburgh
Scottish Police Authorities Conveners Forum
HIV Scotland
Fife Council
NHS Fife
Glasgow Addiction Services
Perth & Kinross Community Safety Partnership
NHS Grampian
Scottish Legal Aid Board
NHS Forth Valley
British Medical Association Scotland
Medical Foundation for AIDS & Sexual Health (MedFASH)
Society of General Microbiology
Church of Scotland HIV/AIDS Project
NHS Highland
South Lanarkshire Council, Social Work Resources
Advisory Group on Hepatitis
NHS Grampian Health Protection Team
Orkney Islands Council
NHS Argyll & Clyde
NHS Ayrshire & Arran, Public Health
Victim Support Scotland
Scottish HIV/AIDS Group (SHIVAG)
British HIV Association (BHIVA)
Scottish Drugs Forum
Terrence Higgins Trust
National AIDS Trust

SE Approved
Version 1.2

General Medical Council
Positive Voice
NHS Lothian, Public Health and Health Policy
Royal College of Nursing Scotland
Scottish Prison Service and Scottish Prison Service Trade Union Partners
Testing Barriers Project
North Edinburgh Social Inclusion Partnership Health & Social Care Group
The Association of Forensic Physicians
Mainliners

<u>Individuals</u>

Donald Mackay
Jennie Kermode
Dr Ray Brettle
Dr Charles Saunders
Marion Chatterley
James Chalmers
Prof Sheila Bird
and 4 others (3 of whom advised that their responses could be published anonymously)

response NOT to be made public

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