In Line or Out of Sync? Science, Criminal Law, and HIV: An In-Depth Assessment

Kimberly Shindel, JD, LLM

Submitted in fulfilment of the requirements of the Degree of Doctor of Philosophy

School of Law
College of Social Sciences

November 2024

Abstract

Laws criminalising HIV transmission and/or exposure are controversial measures and the subject of frequent debate. Beyond the philosophical arguments for or against their utility, another controversy remains: are these laws leading to unjust outcomes by relying on outdated science? This is the primary question addressed by this thesis. In pursuing this question, the subsequent chapters break down the history of criminalised HIV exposure and transmission in England and Scotland as well as the elements of the relevant offences. Medical and scientific evidence is most pertinent in these cases when assessing causation, recklessness, and harm. This thesis argues that, particularly where recklessness and harm are concerned, there is a gap between the law and science. The reason for this gap, it is submitted, owes largely to a narrative that exists in much of the case law which emphasises the underlying betrayal of trust. This narrative can serve as both a distracting element and as a factor which can exacerbate cognitive biases people are prone to. These biases can impact how risk and harm are perceived. In support of this assertion, recklessness and harm will be discussed both generally and in connection to criminalised HIV transmission specifically. Other areas will likewise be drawn upon as a basis of comparison, including English civil cases involving HIV and the laws of other common law jurisdictions. It is argued that recklessness should be assessed in a two-pronged approach which considers both the objective risk and the defendant's subjective stance, and that the harm of HIV should remain a live issue assessed on a case-by-case basis. This thesis aims to highlight the importance of the law adjusting to changing medical advancements in order to protect the rights of a group of people that are already highly marginalised.

Table of Contents

Chapter 1. Introduction ……1

Chapter 2. Legal Landscape…….….13

Chapter 3. Transcript Review: Looking Beyond the Reported Judgements …….. 53

Chapter 4. Recklessness, Knowledge, and Consent: An Interplay…….86

Chapter 5. Harm and HIV: Why is HIV a Grievous Bodily Harm?.....130

Chapter 6. Civil Law and HIV Transmission ……159

Chapter 7. HIV and the Criminal Law Outside the UK ……195

Chapter 8. Conclusion…….….222

Bibliography …….227

Acknowledgements

I would like to express my sincere gratitude to my supervising professors, James Chalmers and Fiona Leverick, for their consistently invaluable support, guidance, feedback, and advice. I consider myself extremely lucky to have been able to work with you both.

I would additionally like to thank my mom and stepdad, Beverly and Stuart Feldheim, for always being there for support.

Finally, I would like to thank my husband, Jamie Harvie. Your unending patience in dealing with me through all this was remarkable. I could not have done this without you.

Author's Declaration

I declare that, except where explicit reference is made to the contribution of others, that this dissertation is the result of my own work and has not been submitted for any other degree at the University of Glasgow or any other institution.

Printed Name_Kimberley Shindel

Table of Abbreviations

ABH	Actual Bodily Harm
AIDS	Acquired Immunodeficiency Syndrome
ART	Anti-Retroviral Therapy
COPFS	The Crown Office and Procurator Fiscal Service
CPS	The Crown Prosecution Service
GBH	Grievous Bodily Harm
HAART	Highly Active Antiretroviral Therapy
HSV	Herpes Simplex Virus
HIV	Human Immunodeficiency Virus
MSM	Men who have Sex with Men
NHS	National Health Service
OAPA	Offences Against the Persons Act 1861
PEP	Post-Exposure Prophylaxis
PLWHA	People Living with HIV/AIDS
PrEP	Pre-Exposure Prophylaxis
SHPO	Sexual Harm Prevention Order
SOPO	Sexual Offences Prevention Orders
STI	Sexually Transmitted Infection. Often used interchangeably with STD (Sexually Transmitted Disease).
U=U	A shorthand for undetectable equals untransmittable. The Prevention Access Campaign popularised the U=U Campaign

Chapter 1. Introduction

What is HIV, and what does it mean for the people who live with it? For most people, HIV is not something at the forefront of their mind—instead, many people consider it a topic more associated with the 1980s or 1990s.[1] That era saw major campaigns to spread information about HIV and AIDS, and several notable movies and TV shows likewise featured stories which focused on characters with the virus.[2] Many of these efforts successfully spread awareness of HIV/AIDS and humanised the people living with it.[3] However, few forms of media drew a meaningful distinction between HIV and AIDS, and many featured one notable theme: death. The 'Don't Die of Ignorance' campaign organised by the Department of Health and Social Security in 1986 was also known as the 'Tombstone' campaign.[4] Both *EastEnders* and *Grange Hill* featured storylines involving HIV-positive characters in the 1990s, and both affected characters ultimately died. Major films from that era, including *Philadelphia* and *Trainspotting,* likewise featured HIV-positive characters, many of whom died of AIDS-related complications within the course of the story. If someone grew up in the 1980s, 1990s, or early 2000s, chances are they were exposed to a lot of information which heavily linked HIV and death.

While there were certainly positive aspects to those media representations, over the last 40 years the medical and scientific community made significant strides that did not receive the same level of coverage. A recent study found that the majority of London-based respondents reported little to no recent exposure to any media which talked about HIV or AIDS.[5] Since the British government aired the 'Don't Die of Ignorance' campaign almost 40 years ago, there were no major television campaigns concerning HIV until Scotland aired a new advert in October 2023.[6] In consequence of this, there are a good deal of misconceptions

---

[1] Fast-Track Cities London and National AIDS Trust, 'HIV: Public Knowledge and Attitudes' (*NAT,* July 2021) <www.nat.org.uk/sites/default/files/publications/HIV%20Public%20Knowledge%20and%20Attitudes.pdf> accessed 10 May 2024.

[2] See Hannah Kershaw, 'Remembering the "Don't Die of Ignorance" Campaign' *(London School of Hygiene & Tropical Medicine: Placing the Public in Public Health: Public Health in Britain, 1948-2010*, 20 May 2018) <https://placingthepublic.lshtm.ac.uk/2018/05/20/remembering-the-dont-die-of-ignorance-campaign/> accessed 13 May 2024.

[3] See Megan McCrea, 'How the Media Shapes Perception of HIV and AIDS' (Frank Crooks ed, *Healthline*, 25 April 2020) <www.healthline.com/health/media-and-perception-of-hiv-aids#celebrities> accessed 18 March 2025.

[4] ibid.

[5] Fast Track Cities London and National AIDS Trust (n 1).

[6] Terrence Higgins Trust, 'First TV Ad on HIV since "Tombstones" 40 Years Ago Set to Tackle Attitudes Stuck in the 1980s' (*Terrence Higgins Trust*, 2023). <www.tht.org.uk/news/first-tv-ad-hiv-tombstones-40-years-ago-set-tackle-attitudes-stuck-1980s> accessed 13 May 2024.

about HIV that exist in the general public. A Scottish study found that 35% of respondents would not feel comfortable kissing a person with HIV in spite of the fact HIV is not transmitted through saliva.[7] A third of the respondents in the same study were unaware that people with an undetectable viral load could not transmit HIV.[8] The London study found that only 8% of the respondents could correctly identify the primary modes by which HIV can be transmitted without identifying an incorrect mode.[9] In practice, this means that a significant section of the public misunderstands what HIV is, how it is transmitted, and what life is like for those living with HIV/AIDS. These sorts of misunderstandings may not be based on malice, but neither are they harmless. A third of the HIV-positive respondents in a 2022 study reported having low self-esteem due to their HIV-status, while almost half indicated that they were ashamed of their diagnosis.[10] Approximately one in five respondents reported symptoms of anxiety and depression, with half of those receiving an official diagnosis of clinical anxiety or depression.[11]

The above-referenced studies demonstrate that there is an information gap between what much of the public knows about HIV and the actual state of modern medical science. But what of the law? Countries around the world enacted laws criminalising the reckless transmission of HIV or interpreted existing laws to cover such acts, and the UK is no exception. Both Scottish and English courts convicted people for reckless HIV transmission. Do the laws in Scotland and England demonstrate a modern understanding of HIV? Has it adapted quicky, or is there a lag between scientific or medical advancements and the law's recognition of such advancements? Is it likely there will be lags going forward? Have courts addressed the advent of U=U, an international effort initiated by the Prevention Access Campaign that aimed to spread awareness regarding the scientific fact that a person living with an undetectable viral load cannot transmit HIV sexually?[12] What about pre-exposure prophylaxis—i.e. medicine that can be taken prior to a sexual encounter that significantly reduces the likelihood of transmission—or the improved life quality and expectancy of

[7] ibid.
[8] ibid.
[9] Fast Track Cities London and National AIDS Trust (n 1) 21.
[10] Gov.UK, 'UK's Largest Survey of People Living with HIV Published' (*Gov.UK*, 12 January 2024) <www.gov.uk/government/news/uks-largest-survey-of-people-living-with-hiv-published#:~:text=In%202022%2C%20the%20survey%20found> accessed 13 May 2024.
[11] ibid.
[12] Prevention Access Campaign, 'Who We Are and What We Do' (*Prevention Access Campaign*) <https://preventionaccess.com> accessed 30 May 2024.

people living with HIV/AIDS?[13] If not, how are courts likely to address related issues? All of this is encompassed by the main question set out by this thesis: does Scottish and English law reflect the modern state of medical science where acts alleging criminal HIV transmission are concerned? This thesis seeks to address these questions by examining in-depth Scottish and English law as it relates to HIV and other communicable diseases. In pursuit of this answer, this thesis will break down the elements of the relevant offences and address whether the law is currently up-to-date with the science, whether that has always been the case, and why disconnects between legal and medical advancements might occur in connection to HIV transmission. It will also strive to answer the implicit question as to *why* it is important for the law to accurately reflect modern science in this area.

The first step in this analysis involves explaining the basics of HIV and how it intersects with the law. HIV is something most people are aware of but, as the above-mentioned surveys indicate, do not always fully understand. Chapter 2 will begin by addressing what HIV is, what AIDS is, and the basic science behind seroconversion (the process of a person becoming HIV-positive). From there, the chapter will discuss some of the relevant available treatments, including the importance of viral loads and the U=U campaign. Viral loads are critical when discussing the laws surrounding criminalised HIV transmission because while a high viral load can increase the risk of transmission, a person with a viral load which is low enough for medical practitioners to deem it 'undetectable' cannot transmit HIV via sexual means.[14] This means that where a person is accused of transmitting HIV in circumstances amounting to a criminal offence,[15] their viral load may be relevant to questions regarding both causation and the defendant's *mens rea*. The chapter will then discuss pre and post-exposure prophylaxes—drugs which may be taken before or after a sexual encounter which significantly reduce the risk of seroconversion. While both PrEP and PEP can be used by any sex, PrEP is particularly popular among men who have sex with men and is becoming increasingly used in those communities.[16] PrEP (and potentially PEP to a lesser extent) may,

---

[13] The term 'people living with HIV/AIDS' or PLWHA is used because other terms, such as 'AIDS patient,' are outdated, inaccurate, and emphasise the infection before the person.

[14] Robert Eisinger, Carl Dieffenbach and Anthony Fauci, 'HIV Viral Load and Transmissibility of HIV Infection Undetectable Equals Untransmittable' (2019) 321 JAMA 451, 452.

[15] While there are several ways HIV can be transmitted, this thesis will predominately focus on sexual transmission.

[16] Gov.UK, 'HIV Testing, PrEP, New HIV Diagnoses and Care Outcomes for People Accessing HIV Services: 2023 Report' (*GOV.UK*, 6 October 2023) <www.gov.uk/government/statistics/hiv-annual-data-tables/hiv-testing-prep-new-hiv-diagnoses-and-care-outcomes-for-people-accessing-hiv-services-2023-report#pre-exposure-prophylaxis-prep> accessed 14 May 2024.

like viral loads, affect questions of causation and recklessness; however, it may also raise new questions as to the role that consent can play in cases involving allegations of reckless HIV transmission. In addition to these preventative and treatment regimens, the chapter will discuss phylogenetic analysis. Phylogenetic analysis is a forensic tool that can compare different HIV strains and draw epidemiological links;[17] in practice, it is used as evidence to support or refute claims that the defendant transmitted HIV to the complainant. Phylogenetic analysis has several significant limitations, however, and some consider its use controversial.[18] While there is certainly more that could be addressed regarding the medical science of HIV, for the purposes of this thesis this section will discuss the relevant points.

Next, Chapter 2 will begin to discuss the laws concerning criminal HIV transmission in England and Scotland. In both countries there is no specific statute criminalising HIV transmission or exposure, however both countries' courts previously held it to be covered under existing laws. While there are no reported cases on point in Scotland that concern relevant substantive issues, there are several in England. The basis for criminalising contagions started in *R v Clarence*.[19] The majority in that case ultimately did not find that the reckless transmission of a sexually transmitted infection amounted to an offence under the Offences against the Persons Act 1861, however the dissenting opinions in *Clarence* became influential in *R v Dica*[20]–the first case that did. *Dica* not only overruled *Clarence*, it established that reckless HIV transmission could be a criminal offence under English law and allowed for consent to act as a possible defence.[21] The court in *R v Konzani*[22] reported its decision not long after *Dica* and came to a similar conclusion. After *Dica* and *Konzani* established that reckless HIV transmission could amount to a criminal offence, English prosecutors brought several cases alleging such. In more recent years the Crown Prosecution Service published a set of guidelines which specifically covered the intentional or reckless transmission of STIs.[23] Scotland, through unreported cases, established that reckless transmission as well as exposure could fall under the laws against culpable and reckless

[17] AB Abecasis, M Pingarilho and A Vandamme, 'Phylogenetic Analysis as a Forensic Tool in HIV Transmission Investigations' (2018) 32 AIDS 543, 544.
[18] ibid.
[19] (1888) 22 QBD 23.
[20] EWCA Crim 1103; [2004] QB 1257 (CA (Crim Div)).
[21] ibid [59].
[22] [2005] EWCA Crim 706; [2005] 2 Cr App R 14 (CA (Crim Div)).
[23] Crown Prosecution Service, 'Intentional or Reckless Sexual Transmission of Infection' (*Cps.gov.uk,* 13 December 2019) <www.cps.gov.uk/legal-guidance/intentional-or-reckless-sexual-transmission-infection> accessed 6 May 2025.

conduct.[24] Both countries, to date, have not enacted specific legislation criminalising reckless transmission or exposure.

With the legal foundation laid in place, this thesis will then discuss other more recent cases. Since there are only a limited number of cases addressing HIV transmission specifically, this thesis will look at similar cases involving other communicable diseases. The first case to be discussed will be *R v Marangwanda*.[25] *Marangwanda* was a somewhat strange case which focused on gonorrhoea rather than HIV. Unlike all of the other cases mentioned herein, the victims were young children rather than adults who engaged in consensual sex acts.[26] *Marangwanda* potentially established a far-reaching affirmative duty regarding preventing STI transmission that goes beyond the holdings in *Dica* and *Konzani*[27] as well as worrying implications for the scientific plausibility of proof of transmission. It remains to be seen whether courts will clearly distinguish *Marangwanda* owing to the unique circumstances underlying the case. *Golding*[28] likewise involved a non-HIV STI—herpes. *Golding* addressed questions regarding the evidence needed to prove transmission and—to a degree—addressed the topic of harm. *R v Rowe*[29] remains the most recent reported case to concern disease transmission. While *Rowe* did concern HIV, the allegations were not reckless transmission in violation of section 20 of the OAPA, but intentional transmission in violation of section 18 of the Act. Courts in both England and Scotland ultimately convicted Rowe, and the case drew international attention due to the severity of the allegations and number of complainants and complainers. Although the primary focus of this thesis is on reckless and not intentional transmission, the case addressed several relevant issues.

The next chapter will examine transcripts from a selection of cases. These transcripts include hearings from reported cases as well as unreported cases. While none of the transcripts referenced in Chapter 4 are binding precedent, they are illustrative for several reasons. The first is that they include hearings which were part of some of the above-listed reported cases which address aspects of the case that did not make it into the law reports.

---

[24] 'Exposure' in this case refers to acts where HIV transmission could have occurred (such as through a sex act) but did not. Where reckless HIV exposure is criminalised, it means that a person may be culpable for an act that did not result in HIV transmission.
[25] [2009] EWCA Crim 60.
[26] ibid [3].
[27] Matthew Weait, 'UK: Gonorrhoea Prosecution "a Dangerous Development"' (*Criminal HIV Transmission* 23, April 2009) <http://criminalhivtransmission.blogspot.com/2009/04/uk-gonorrhoea-prosecution-dangerous.html> accessed 2 August 2022.
[28] [2014] EWCA Crim 889.
[29] [2018] EWCA Crim 2688; [2019] 1 Cr App R (S) 38.

Several of these hearings specifically involved questions regarding the scientific evidence establishing that a defendant had HIV and transmitted it to the complainant or complainer. These hearings often show how courts assessed the medical evidence provided by the parties. Secondly, the transcripts provide insight into some of the unreported cases. There are no reported Scottish cases directly addressing criminal liability for HIV transmission, so this analysis helps better frame the position of Scots law as it relates to medical evidence. Additionally, several of the unreported cases address scenarios not encompassed by the reported cases, such as situations where a potential third party that could have been the source of the complainant's infection and where the defendant did not specifically know of their HIV status. Finally, the transcripts add to the story of cases involving HIV transmission and establish that there is a narrative that is common in most to all of the relevant cases. This narrative is one that focuses on a breach of trust and establishes that there is something unique about the way the criminal law in England and Scotland approaches HIV and other harms that occur through consensual sex. The 'betrayal of trust narrative,' as this thesis refers to it, is not harmless. This thesis argues that it affects cases in terms of how the judges, juries, and lawyers perceive scientific evidence. The emotions such a narrative evokes can exacerbate existing biases that people are prone to, such as anecdotal and hindsight biases.

Additionally, the combination of the transcripts with the reported decisions demonstrates that while the medical evidence has generally kept pace regarding a defendant's knowledge of their HIV-status and whether they were the source of the complainant's infection, there are disparities in other areas. Specifically, there is mixed evidence on how consistently and in-line with scientific evidence courts analysed recklessness, and little evidence that courts ensured that their assessment of the harm of HIV was in line with scientific advancements. This chapter builds on the background set up in Chapter 2, while additionally identifying the inconsistent approaches taken by courts towards recklessness as well as the fixation many courts seem to have with the narrative of the case. This notion, that courts are distracted by the betrayal of trust narrative to the detriment of objective analysis, is a theme that will appear in other chapters.

With the basics of the science and law surrounding HIV laid out, Chapter 4 will address several of the elements of reckless HIV transmission—including the defendant's knowledge of their status, the role of consent, and the *mens rea* of recklessness. This section will delve further into what prior chapters addressed: namely, have courts assessed questions regarding knowledge, recklessness, and consent in line with the scientific evidence available

at the time, and how are courts likely to deal with scientific advancements not available during *Dica* and *Konzani*? Additionally, when addressing questions of recklessness and consent, in what areas are medical and scientific evidence relevant, and how have prior court cases dealt with such questions? To answer these inquiries, the chapter begins by discussing the notion of recklessness broadly. Although 'recklessness' is a well-known *mens rea* in the common law, there is no single definition of it in English or Scottish law.[30] Following an inquest into the broader law regarding recklessness generally, the chapter will address the approaches taken in HIV-specific cases. When analysing recklessness, there are several different areas where the courts consider the knowledge of the defendant particularly relevant: regarding their HIV status, regarding the transmissibility of HIV, and regarding the harm of HIV.

The major relevant question that has not been adequately assessed by English or Scottish courts—and the question which is reflective of more recent scientific advancements than were available during *Dica* and *Konzani*—concerns whether a specific risk is justified.[31] While there is case law allowing for justified risk-taking to be an exception to cases involving recklessness, there is little guidance elucidating what factors are relevant for a court to deem a risk justified.[32] This is relevant to the questions explored by this thesis, because how objectively risky a specific act is may be dependent on scientific evidence that has grown or changed over time; this is particularly true in regards to the nature of the sex act in question, the viral load of the complaint, the presence of other health conditions, and whether the HIV-negative partner is on PrEP. Finally, the chapter will address the defence of consent. Consent plays a unique role in matters involving reckless HIV transmission since one is not consenting to the harm itself—an issue which has a whole separate governing case law[33]—but rather to the *risk* of harm. While *Konzani* did not require a defendant to directly disclose[34] their HIV-positive status in order to rely on the defence of consent,[35] in practice the case law leaves little room to establish the complainant's informed consent if the defendant did not do

---

[30] Findlay Stark, *Culpable Carelessness: Recklessness and Negligence in the Criminal Law* (Cambridge University Press 2016), 11.
[31] See Samantha Ryan, 'Risk-Taking, Recklessness and HIV Transmission: Accommodating the Reality of Sexual Transmission of HIV within a Justifiable Approach to Criminal Liability' (2007) 28 Liverpool Law Review 215.
[32] ibid 224.
[33] See, eg, *R v BM* [2018] EWCA Crim 560.
[34] 'Direct disclosure' as used here, refers to a person specifically informing another individual of their HIV status. 'Indirect disclosure' refers to a person disclosing their status through indirect means, such as discussing HIV-specific medication.
[35] *Konzani* (n 22) [44].

so. Even so, as PrEP becomes increasingly well-known and well-used—particularly in the MSM community—there is potentially a new avenue to argue for consent in the absence of direct disclosure. The gap between the science and the law regarding recklessness potentially leads to numerous issues. To address this, Chapter 4 argues that courts should approach the question of recklessness in transmission and exposure cases with a two-pronged analysis that accounts for both the objective risks as well as the subjective knowledge of the defendant. This analysis would assist in responding to issues that may arise in the future and ensure that all factors are considered when assessing whether the defendant's actions sufficiently met the threshold of criminal recklessness. The case law in its current form renders it possible for courts to convict people for acts which include negligible risks—something this thesis asserts is inherently unjust.

Although the thesis up until this point will have addressed many of the significant issues present in cases involving criminalised HIV transmission, there is one issue that the relevant caselaw has devoted little to no attention towards: the question of the level of harm of HIV. Chapter 5 of this thesis addresses this fundamental question. This is a key inquiry underlying this thesis because medical science is currently at a point where a PLWHA—assuming they are on proper treatment regimen under the supervision of a qualified medical professional—will have a lifespan approximately as long as a person without.[36] A court's perception of the level of harm posed by HIV is a key factor in determining the nature of the charge levied. Properly treated, HIV is now a very different infection than it was during the time of *Dica*. Are court's acknowledging the difference modern science has afforded PLWHA in terms of their health and lifespan, or are the court's relying on an antiquated view? Based on harm theories, what level of harm should HIV be considered in light of modern science? Why is this question important at all?

To answer these questions, first the chapter will look at the legal philosophies behind harm. Feinberg's legal harm theory[37] provides a solid starting point for assessing the harm of HIV, but leaves several possible avenues for ascertaining what the setback of interests[38] is as

[36] Adam Trickey and others, 'Life Expectancy after 2015 of Adults with HIV on Long-Term Antiretroviral Therapy in Europe and North America: A Collaborative Analysis of Cohort Studies' [2023] 10 The Lancet HIV 295 <www.thelancet.com/journals/lanhiv/article/PIIS2352-3018(23)00028-0/fulltext#:~:text=We%20estimated%20that%20women%20with> accessed 18 May 2024.
[37] Joel Feinberg, *The Moral Limits of the Criminal Law, vol 1: Harm to Others* (Oxford University Press 1984).
[38] ibid 46.

it relates to HIV infections. Alternate legal theories, such as those discussed by Gibson[39] provide a different perspective for assessing harm which may be more helpful in cases involving communicable diseases. After discussing the legal philosophies addressing what harm is and how it is assessed, the chapter will go on to examine the relevant case law. *Dica* and *Konzani* did not fully address the question of *why* HIV was a grievous bodily harm, and yet *Rowe* relied on those cases regarding the harm of HIV[40] in spite of the fact that they were heard almost 15 years prior. Even before to *Dica*, *Clarence* likewise provided very little analysis of the level of harm posed by gonorrhoea. When considered in light of the all of the relevant cases, including the unreported transcripts analysed in Chapter 3, there are two major inferences that one can draw: the first is that the harm posed by HIV has not been fully assessed in light of modern medical advancements, and the second is that there is a unique narrative that attaches itself to cases involving communicable disease—one which is more concerned with the underlying betrayal of trust and the stigma of STIs. Where the harm is associated with sex, and particularly where marginalised communities and taboo acts are involved, this thesis argues that English criminal courts may take a harsher stance which is less likely to allow consent as a viable defence. Consequently, the law's lack of engagement with modern science may lead to already marginalised communities being exposed to more serious charges with attendant heavier penalties than is just. This chapter further contends that previous courts treated the harm of HIV as a settled issue when it should be approached as a live one. While there are fact-specific circumstances which may mean HIV reaches the threshold of grievous bodily harm, in many cases this may not always apply, and a case-by-case approach is necessary.

Unfortunately, reported criminal cases involving HIV or communicable disease are few in number. To fully assess whether or not the sexual aspect of HIV affects how courts engage with it additional examples are helpful. In furtherance of this, Chapter 6 looks to several civil cases as a basis of comparison. While civil and criminal cases obviously have different stakes and burdens of proof, civil cases can highlight situations where HIV is not framed in terms of a perpetrator and a victim. Additionally, there are civil cases which do not focus on sexual transmission at all. If the taboo of sex and the betrayal of trust narrative are not at issue, do courts approach HIV and medical evidence in the same manner as criminal

[39] Richard B Gibson, 'No Harm, No Foul? Body Integrity Identity Disorder and the Metaphysics of Grievous Bodily Harm' (2020) 20 Medical Law International 73, 83.
[40] *Rowe* (n 29) [67].

ones? This is the primary question assessed in Chapter 6. The answer, after assessing several civil cases, is rather illuminating. Without sex or trust at issue, the focus is instead on the question of risk which courts are more likely to assess objectively based on statistics.[41] In several of the cases discussed, these objectively assessed risks were generally not deemed to be significant enough to outweigh a competing right. Additionally, this sort of objective assessment of risk from a statistical perspective has thus far not been a major factor in most of the cases involving reckless STI transmission even though the risk can vary significantly depending on numerous factors, including the type of sex act and the health of the individuals. This chapter argues that this civil versus criminal comparison highlights the existence of both an anecdotal bias and a hindsight bias. The anecdotal bias, which is exacerbated where emotions are high, is reinforced through the betrayal of trust narrative and can cause courts, prosecutors, and juries to favour the allure of a compelling narrative over the cold information of statistics.[42] This bias almost certainly compounds when combined with the hindsight bias. The hindsight bias posits that knowing that an 'outcome has occurred increases its perceived likelihood.'[43] Most of the civil cases involve assessing risk proactively while the criminal cases assess risk retroactively. Because the risk already actuated in the criminal cases, the hindsight bias can cause people to overestimate the likelihood of transmission—a factor not at play in many of the civil cases. The end result is a minimisation of statistical evidence of risk in criminal cases when compared to the civil ones.

To gain further insight into why the caselaw is what it is in England and Scotland, this thesis next compares the law to other common law jurisdictions, including the United States, Canada, and Australia. The main arguments of this section are two-fold: first, many HIV-specific laws came about as a reaction to highly publicised cases. This fear-based reactionary response exemplifies why so many statutes (as well as jurisprudence) may fall prey to the anecdotal bias. Secondly, this chapter highlights the benefits, risks, and drawbacks to taking a legislative response towards HIV criminalisation.

Overall, this thesis aims to review the law in England and Scotland as it relates to HIV transmission, assess how the law has kept pace with modern medical advancements such

---

[41] See *London Borough of Brent v Mr & Mrs N, The Minor's Foster Carers, P, a minor (appearing by her Guardian)* [2005] EWHC 1676 (Fam) [30].
[42] See Traci H Freling and others, 'When Poignant Stories Outweigh Cold Hard Facts: A Meta-Analysis of the Anecdotal Bias' (2020) 160 Organizational Behavior and Human Decision Processes 51.
[43] Baruch Fischhoff, 'Hindsight Is Not Equal to Foresight: The Effect of Outcome Knowledge on Judgment under Uncertainty.' (1975) 1 Journal of Experimental Psychology: Human Perception and Performance 288, 297.

as PrEP, statistical risk, and understandings regarding U=U and—in light of that review—suggest how courts should ideally address transmission cases going forward. In furtherance of this, this thesis looks back at the reported and unreported case law surrounding relevant cases and draws several conclusions. The first is that there is a general willingness to engage with medical science where there is a question regarding the defendant's HIV status and whether they transmitted HIV to a complainant. The second is that there is conflicting evidence as to the degree by which courts engage with up-to-date scientific evidence when assessing the presence of a risk. The third is that there is little to no evidence that any criminal court has fully reassessed the level of harm it attributes to HIV in light of medical advancements. The final conclusion is that while it is not explicitly stated, there is a narrative surrounding criminal cases that is likely rooted in the stigma surrounding STIs more broadly; because of this stigma, courts often focus on the betrayal of trust underlying the actions at the expense of objectively assessing the risk of transmission and the harm of HIV. HIV is not only an STI, but also associated with other taboo acts such as same-sex relationships and injecting drug use, and it is difficult to imagine that the biases associated with that do not impact a court's assessment. Many people still have an antiquated view of HIV in terms of both transmissibility and lethality, and this is likely to influence the minds of judges and juries. Additionally, regardless of any internally socialised stigma, this thesis argues that criminal courts in cases involving HIV may be uniquely prone to the sway of cognitive biases. Two biases in particular—the anecdotal and hindsight bias—can interact in such a way where the relevant actors may unknowingly de-prioritise scientific data.

Going forward, an examination of other jurisdictions shows that while there are ways to enact laws and render judgments that keep in line with scientific advancements, it is important to avoid pitfalls which may actually increase stigma and unjust convictions. PrEP in particular may have a major impact on questions of consent and risk, but it remains to be seen how courts will address such concerns. This thesis contends that in order for the law and science of HIV to be on the same page, change is needed. To initiate that change, defence lawyers need to take steps to ensure that questions regarding recklessness and harm are addressed at the appellate level. Beyond that, however, courts need to adjust their approach to how they analyse HIV transmission cases, particularly regarding risk, recklessness, and harm. This thesis argues that a more holistic approach to recklessness which considers both objective and subjective factors would protect the rights of people living with HIV while still leaving room for legal recourse where a particularly egregious course of action is taken. This

thesis further maintains that harm must be approached as a live issue, and assessments of harm should not simply rely on *Dica*. Instead, there should be a fact-specific analysis that considers HIV in light of current medical advancements. This may mean that most cases are no longer at the level of harm which a court may deem 'grievous,' however there would remain room for cases where there are exceptional circumstances. Finally, this thesis argues that the fascination with the betrayal of trust leads to a narrative which heightens emotions and causes courts to downplay statistical information in favour of emotional anecdotes. This narrative is thus not without harm, and places people in situations where science is ignored in favour of feelings. Overall, this thesis argues for the importance of appreciating how far science has progressed in its understanding and treatment of HIV. Adhering to outdated views regarding the harms, risks, and realities of living with HIV exposes already marginalised communities to a greater possibility of unjust treatment by the justice system.

Chapter 2. Legal Landscape

I. Introduction

Whether or not infecting another individual with a sexually transmitted infection should be capable of rising to the level of a criminal offence is a hotly debated issue. Legal academics, health care workers, politicians, social activists, and law enforcement workers have discussed the value of laws which target the transmission of communicable diseases, with many arguing that criminalisation leads to more harm than good.[1] Ethical and philosophical concerns remain in the background of any law concerning disease transmission. The tension between respecting the rights of PLWHA, personal autonomy, privacy (concerns addressed in the original cases regarding HIV transmission),[2] and the application of the law has only been further complicated over time by medical and scientific innovations. This thesis aims to determine whether there is a gap between the law and science of HIV.[3] Underlying this aim are two broad questions: what are we talking about when we talk about the law of HIV exposure and transmission, and what is the relevant science? To that end, this chapter sets the scene by introducing the relevant laws, cases, and scientific innovations that will be addressed in greater detail in later chapters.

First, this chapter will address the basic underlying question: what is HIV, and what are the relevant innovations regarding treatment that may affect cases involving transmission? Since this thesis aims to determine whether the law has kept pace with the science, a general account of the science of HIV is required. In furtherance of this, this chapter will give an overview of the history of HIV in the UK and the milestone advancements in medicine that occurred along the way. While the early treatment options for HIV were limited and often accompanied by severe side effects,[4] modern antiretroviral treatments have a low risk of serious side effects and may be as minimal as a single pill each day.[5] Since 2008, numerous studies confirmed that when HIV is being effectively treated, it

---

[1] See, eg, Matthew Weait, *Intimacy and Responsibility: The Criminalization of HIV Transmission* (Routledge-Cavendish, 2007); John G. Francis & Leslie P. Francis, 'HIV Treatment as Prevention: Not an Argument for Continuing Criminalisation of HIV Transmission' (2013) 9 Int'l J L Context 520; Amelia Evans, 'Critique of the Criminalisation of Sexual HIV Transmission' (2007) 38 Victoria U Wellington L Rev 517.
[2] *R v Dica (Mohammed)* [2004] EWCA Crim 1103; [2004] QB 1257 (CA (Crim Div)).
[3] Please note that while HIV transmission will be the predominant focus of this thesis, the laws regarding the transmission of diseases more generally will be discussed as a point of comparison.
[4] NIH, 'Antiretroviral Drug Discovery and Development' (*Nih.gov*, 2018) <www.niaid.nih.gov/diseases-conditions/antiretroviral-drug-development> accessed 25 March 2023.
[5] I-base, 'Introduction to ART' (*i-base.info*) <https://i-base.info/guides/starting> accessed 31 May 2024.

cannot be transmitted sexually.[6] This culminated in the U=U movement created by Prevention Access Campaign in 2016 which aimed to spread awareness on a global scale that an undetectable viral load means that HIV cannot be sexually transmitted.[7] PrEP likewise significantly changed the narrative surrounding HIV prevention by offering new, increasingly easy ways for HIV-negative people to protect themselves against seroconversion. PrEP increasingly common in MSM communities in particular.[8] Finally, this chapter will introduce phylogenetic analysis. Phylogenetic analysis is an epidemiological tool often used in cases involving HIV transmission. In short, phylogenetic analysis compares different viral strains to determine if there is an epidemiological link.[9] While it is a valuable tool in mapping how diseases spread and evolve from a research standpoint, its use as a forensic tool in criminal trials is not without criticism.[10]

With the basics of the science of HIV set out, this chapter will then introduce the relevant law. This chapter will discuss the law in terms of the material statutes, prosecutorial guidelines, and cases. The first part of this chapter looks at the early cases – *R v Clarence,*[11] *R v Dica, R v Konzani (Feston)*[12] – while also addressing the position of the government towards criminalising reckless or intentional HIV transmission at that time. After the stage is set with a discussion on those three cases, this chapter examines other post-2005 legal changes. The most notable addition is the creation of guidelines in both Scotland[13] and

[6] Pietro Vernazza and others, 'HIV-Infizierte Menschen Ohne Andere STD Sind Unter Wirksamer Antiretroviraler Therapie Sexuell Nicht Infektiös [HIV-Infected People Free of Other STDs Are Sexually Not Infectious on Effective Antiretroviral Therapy]' (2008) 89 Schweizerische Ärztezeitung 165.
[7] Prevention Access Campaign, 'Who We Are and What We Do' (*Prevention Access Campaign*) <https://preventionaccess.com> accessed 30 May 2024.
[8] Gov.UK, 'HIV Testing, PrEP, New HIV Diagnoses and Care Outcomes for People Accessing HIV Services: 2023 Report' (*GOV.UK*, 6 October 2023) <www.gov.uk/government/statistics/hiv-annual-data-tables/hiv-testing-prep-new-hiv-diagnoses-and-care-outcomes-for-people-accessing-hiv-services-2023-report#pre-exposure-prophylaxis-prep> accessed 14 May 2024.
[9] AB Abecasis, M Pingarilho and A Vandamme, 'Phylogenetic Analysis as a Forensic Tool in HIV Transmission Investigations' (2018) 32 AIDS 543.
[10] ibid.
[11] (1888) 22 QBD 23.
[12] [2005] EWCA Crim 706; [2005] 2 Cr App R 14 (CA (Crim Div)); [2005] EWHC 1676 (Fam)
[13] Crown Office and Procurator Fiscal Service, 'Prosecution Policy on the Sexual Transmission of Infection' (*Copfs.gov.uk*, 1 July 2014) <www.copfs.gov.uk/publications/prosecution-policy-on-the-sexual-transmission-of-infection/html/> accessed 6 May 2025 ['COPFS Guidance'].

England[14] which specifically address the circumstances where the Crown will prosecute cases of sexual disease transmission or exposure.[15]

Next, this chapter examines two cases: *R v Marangwanda*[16] and *R v Golding.*[17] While neither case concerns HIV specifically, both cases involve disease transmission and demonstrate some of the ways courts are stretching the rulings in *Konzani* and *Dica* to encompass different circumstances and infections. *Marangwanda* and *Golding* likewise each highlight the need for further clarification on two important questions: (1) What is needed for a harm to be considered 'grievous', and (2) What relevant factors impact an assessment of recklessness? Although questions regarding harm and recklessness will be discussed further in later chapters, this chapter will introduce the judgments in *Marangwanda* and *Golding* generally.

After discussing *Marangwanda* and *Golding*, this chapter will analyse the most recent reported case involving disease transmission: *R v Rowe*. *Rowe* is a significant case for multiple reasons: it was the first case involving intentional transmission, it was highly publicized, it interacted significantly with modern medical advances such as phylogenetic analysis,[18] and it addressed questions regarding the criminalisation of HIV transmission more broadly.[19] Prosecutors in both England and Scotland levied charges against Rowe.[20] As the most recent reported case, *Rowe* provides a more modern perspective on how the courts may approach cases involving HIV transmission.

The laws, policies, and history addressed in this chapter will serve as a jumping off point for later chapters, when the elements of criminal HIV exposure or transmission will be analysed in detail in light of the rapid medical and scientific advancements which occurred over the course of the HIV epidemic. In order to determine whether the law regarding HIV

---

[14] Crown Prosecution Service, 'Intentional or Reckless Sexual Transmission of Infection' (*Cps.gov.uk*, 13 December 2019) <www.cps.gov.uk/legal-guidance/intentional-or-reckless-sexual-transmission-infection> accessed 6 May 2025 ['CPS Guidance'].

[15] While the reckless exposure to a sexually transmitted infection may rise to the level of a criminal offence in Scotland, English criminal law requires actual transmission or an intention to transmit a disease.

[16] [2009] EWCA Crim 60.

[17] [2014] EWCA Crim 889.

[18] [2018] EWCA Crim 2688; [2019] 1 Cr App R (S) 38, [27].

[19] ibid [50].

[20] BBC, 'Daryll Rowe Admitted Infecting Men with HIV in Edinburgh' (*BBC News*, 4 May 2018) <www.bbc.co.uk/news/uk-scotland-edinburgh-east-fife-44003613#:~:text=An%20Edinburgh%20hairdresser%20has%20been> accessed 31 May 2024.

transmission is relying on modern science, one must first start out by identifying the science and laws in question. This chapter aims to do just that.

II. The Science of HIV

Since HIV entered the world stage approximately 40 years ago,[21] private and public bodies around the world have made massive strides in understanding, treating, and preventing the infection. Scientists and medical professionals initially knew next to nothing about the disease beyond the fact that it produced visible markings on the skin and predominantly affected MSM.[22] Although many referred to it as the 'gay cancer' at first, evidence of transmissions to other groups highlighted it as a more broad, transmittable disease which attacked the immune system.[23] These days, HIV (short for 'human immunodeficiency virus') is widely understood as a virus which attacks CD4 cells (a type of white blood cell and a subset of immune-related cells called 'T-Cells'[24]), leading to a weakened immune system that can eventually lead to opportunistic infections and signal that the individual has AIDS.[25] AIDS, which stands for acquired immunodeficiency syndrome, is not a virus distinct from HIV. Instead, AIDS is the advanced stage of HIV.[26] Consequently, while HIV can be transmitted, AIDS cannot. AIDS is diagnosed either when a person has a sufficiently low CD4 count (usually under 200 cells/mm^3) or an AIDS-defining condition.[27] Some individuals and institutions now use the term 'advanced HIV infection' instead of AIDS.[28] The official

---

[21] Intimacy and Responsibility (n 1) at 4.
[22] Joe Wright, 'Remembering the Early Days of "Gay Cancer"' (*NPR.org,* 8 May 2006) <www.npr.org/2006/05/08/5391495/remembering-the-early-days-of-gay-cancer?t=1583448714976> accessed 31 May 2024.
[23] ibid.
[24] Aaron Moncivaiz, 'CD4 vs. Viral Load: What's in a Number?' (*Healthline*, 18 July 2013) <www.healthline.com/health/hiv-aids/cd4-viral-count#cd-count> accessed 7 May 2025.
[25] U.S. Centers for Disease Control and Prevention, 'About HIV' (*CDC.gov*, June 2022) <www.cdc.gov/hiv/basics/whatishiv.html> accessed 31 May 2024. A healthy immune system should have a CD4 count of 500-1600; a CD4 count of less than 200 will generally receive an AIDS diagnosis. Moncivaize (n 24).
[26] Clinicalinfo.HIV.gov, 'Acquired Immunodeficiency Syndrome (AIDS)' (*clinicalinfo.hiv.gov*) <https://clinicalinfo.hiv.gov/en/glossary/acquired-immunodeficiency-syndrome-aids> accessed 12 November 2024.
[27] ibid.
[28] NICE, 'HIV Infection and AIDS' (*NICE*, May 2021) <https://cks.nice.org.uk/topics/hiv-infection-aids/> accessed 12 November 2024. Also note that the term 'full-blown AIDS,' which used to be a common term, is now out-of-date. It implies the existence of lower forms of AIDS when AIDS itself is the umbrella term for the late-stage condition. HIV Ireland, 'HIV Terminology and Appropriate Language Use Guidelines' (*HIV Ireland*, 2020) <www.hivireland.ie/wp-content/uploads/HIV-Terminology-Appropriate-Language-Guidelines-V1.3-09-2020.pdf> accessed 12 November 2024. Of similar note, no one technically 'dies of AIDS'; AIDS in itself does not kill, however it can weaken the immune system and lead to other lethal infections. The proper term in a situation where AIDS leads to death is 'death from an AIDS-related illness.' ibid.

term for a person becoming HIV-positive is 'seroconversion.' The terms 'seropositive' and 'seronegative' are synonymous with HIV-positive and HIV-negative in the context of this thesis. Seroconversion usually presents with flu-like symptoms, though some people may be asymptomatic.[29] After the initial seroconversion, HIV may not cause symptoms for years.[30]

HIV can be transmitted in several ways: sharing blood (whether through transfusion or shared needles), sexually, and from mother to child (via pregnancy, labour, or breastmilk). This thesis focuses predominately on sexual transmission. Not all sexual contacts are equal in reference to the risk of HIV transmission. Factors such as circumcision, the presence of other STIs, and the viral load[31] of the person with HIV can impact the likelihood of transmission as can the nature of the sexual contact itself. The per act risk of transmission is greatest for receptive anal intercourse, which carries an estimated risk of 138 transmissions per 10,000 acts, or 0.0138% risk of transmission per act.[32] Insertive anal intercourse carries an estimated per contact risk of 0.0011%, and there is a 0.008% estimated risk for receptive vaginal intercourse with a 0.0004% estimated risk for insertive vaginal intercourse.[33] While it is theoretically possible in certain circumstances for HIV to transmit via oral sex if the receiver has sores in their mouth or throat, the risk is statistically negligible as both saliva and stomach acid (if semen is swallowed) can inhibit the virus.[34]

The first drug used to treat HIV, azidothymidine ['AZT'], gained approval for use in the USA in 1987 and marked the beginning of the use of anti-retroviral treatments ['ART'] as a means of treatment.[35] AZT operated by slowing the virus's replication, allowing for an increase in CD4 counts and an overall healthier immune system; unfortunately, severe side effects could attend AZT usage.[36]

---

[29] NHS, 'Symptoms - HIV and AIDS' (*nhs.uk*, 22 April 2021) <www.nhs.uk/conditions/hiv-and-aids/symptoms/> accessed 19 November 2024.
[30] ibid.
[31] The term 'viral load' will be defined in the subsequent section.
[32] Pragna Patel and others, 'Estimating Per-Act HIV Transmission Risk' (2014) 28 AIDS 1509 <www.ncbi.nlm.nih.gov/pmc/articles/PMC6195215/> accessed 31 May 2024, table 1.
[33] ibid.
[34] Keith Alcorn, 'Oral Sex and the Risk of HIV Transmission' (*aidsmap.com*, 2 January 2021) <www.aidsmap.com/about-hiv/oral-sex-and-risk-hiv-transmission> accessed 31 May 2024. There are no known cases of someone contracting HIV through penetrative oral sex, but it remains theoretically possible in the right circumstances.
[35] NIH, 'Antiretroviral Drug Discovery' (n 4).
[36] ibid. An array of side effects could accompany AZT, including: 'severe intestinal problems, damage to the immune system, nausea, vomiting and headaches.' Park A, 'The Story behind the First AIDS Drug' (*Time*, 2017) <https://time.com/4705809/first-aids-drug-azt/> accessed 4 March 2025.

Even with improvements in AZT and ART, however, the virus often quickly mutated and developed resistances to treatment.[37] By the early 1990s, scientists began pursuing combination therapies—treatments that would use a mixture of more than two types of ART—and successfully developed more effective treatments that would be less prone to resistance.[38] Scientists compounded on this in 1996 with tests that used a triple-drug therapy, also referred to as highly active antiretroviral therapy ['HAART'].[39] HAART proved revolutionary not only because it could significantly suppress HIV, but also because it could create a 'genetic barrier against [the] development of drug resistance.'[40] Modern HIV treatments may involve as little as one daily pill and have minimal side effects.[41]

For all these advancements in treatments, however, HIV remains incurable. Consequently, medical professionals focus heavily on measures to prevent infection. For cases of sexual transmission, they advocated for consistent and correct condom use as one of the earliest tools for preventing transmission.[42] Condoms (when properly used) provide an impermeable barrier which prevents bodily fluids from contacting an HIV-negative person, thus cutting off the main way for HIV to enter the body during sex acts.[43] In 2000, a study on the efficacy of condoms found that their use decreased 'the risk of HIV transmission by approximately 85 percent.'[44] Unfortunately, condoms can fail in rare cases, can be improperly used, or can be forgotten. Some individuals, for a variety of reasons, may fail to use condoms regularly and engage in high-risk practices. Consequently, recent advancements focus on alternative ways to prevent HIV transmission in addition to condom use.

A. Viral Loads and HIV Prevention

Scientists eventually realised that HAART could not only serve as a treatment for PLWHA, it could function as a form of prevention for those without. Early observational

---

[37] ibid.
[38] ibid.
[39] ibid.
[40] ibid.
[41] While lethargy, malaise, headaches, and diarrhoea are common side effects, for most people the adverse effects are connected to initiating the treatment regimen and will lessen or abate completely over time. Amelia Jones, 'Side-Effects of HIV Treatment' (*aidsmap.com*, February 2018) <www.aidsmap.com/about-hiv/side-effects-hiv-treatment> accessed 16 March 2025.
[42] NIH, 'Condom Use for Preventing HIV Infection,' (*Nih.gov*, 29 November 2018) <www.niaid.nih.gov/diseases-conditions/condom-use> accessed 6 May 2025.
[43] ibid.
[44] ibid.

studies at the turn of the millennium 'suggested that viral loads lowered by ART were associated with reduced risk of HIV transmission.'[45]

The term 'viral load' refers to the amount of HIV per millilitre of blood;[46] viral loads, along with CD4 counts, are commonly measured ways to determine the prevalence of HIV in a person's system.[47] HIV attacks CD4 cells and uses them to make more copies of itself, essentially turning them into factories which increases the viral load over time. ART stops this replication process, allowing the body to recover and lower the viral load with consistent use over time.[48] When the amount of HIV copies per millilitre of blood falls sufficiently low (generally around 20-50 copies per millilitre), the infection may be considered 'undetectable.'[49] An 'undetectable' or 'nondetectable' viral load does not mean that the person is cured or that the HIV in their system is gone; it just means that treatment has successfully stopped the virus from replicating.[50] The virus will remain dormant in a certain number of cells, and will begin to copy itself once again if treatment is halted.[51]

In 2008, a study from Switzerland found that individuals living with HIV with non-detectable viral loads and no other sexually transmitted infection could not transmit HIV via sexual means.[52] A 2011 study came to similar conclusions, drawing increased attention to the notion of treatment being a form of prevention.[53] In 2016 the Prevention Access Campaign announced the U=U initiative which aimed to spread awareness on a global scale that undetectable=untransmittable, i.e. that a person with an undetectable viral load cannot sexually transmit HIV.[54]

---

[45] NIH, 'HIV Undetectable=Untransmittable (U=U), or Treatment as Prevention' (*Nih.gov*, 21 May 2019) <www.niaid.nih.gov/diseases-conditions/treatment-prevention> accessed 31 May 2024.
[46] Moncivaiz (n 24).
[47] Medical News Today, 'HIV Viral Load: What It Means, Detection, and CD4 Levels' (*www.medicalnewstoday.com*, 30 November 2018) <www.medicalnewstoday.com/articles/323851#cd-4-count> accessed 6 May 2025.
[48] NIH, 'HIV Treatment, the Viral Reservoir, and HIV DNA,' (*Nih.gov*, 27 November 2018) <www.niaid.nih.gov/diseases-conditions/hiv-treatment-viral-reservoir-hiv-dna> accessed 6 May 2025.
[49] U.S. Centers for Disease Control and Prevention, 'HIV Treatment as Prevention' (*CDC.gov*, 2019) <www.cdc.gov/hiv/risk/art/index.html> accessed 31 May 2024.
[50] Medical News Today, 'HIV Viral Load' (n 47).
[51] ibid.
[52] Vernazza and other (n 6).
[53] J Cohen, 'HIV Treatment as Prevention' (2011) 334 Science 1628 <https://science.sciencemag.org/content/sci/334/6063/1628.full.pdf> accessed 6 May 2025.
[54] Prevention Access Campaign (n 7).

B. Pre and Post-Exposure Prophylaxis

Countries began the use of ART in HIV negative individuals in the early 1990s, initially using it to reduce the risk of seroconversion following an occupational exposure to HIV.[55] This sort of treatment, referred to as post-exposure prophylaxis treatment [‘PEP'], became increasingly used in non-occupational settings. By 2005 both the World Health Organization[56] and the United States’s Centers for Disease Control and Prevention [57] issued guidelines which analysed the effectiveness of PEP and offered recommendations for its use. In order to be effective, medical professionals advise that PEP is taken within 72 hours of exposure.[58] The treatment itself usually entails a three drug ART taken over the course of 28 days.[59] If the treatment is properly completed, it can reduce the risk of HIV transmission by over 80%.[60] Unfortunately, studies found that only approximately 57% of people who initiated PEP treatment completed the full course.[61] Furthermore, the limited window of opportunity to effectively engage in PEP treatment limits its use.

Studies of pre-exposure prophylaxis treatments [‘PrEP’]—the use of ART in HIV-negative individuals prior to HIV exposure—began in 2010.[62] The first clinical study on oral PrEP (the iPrEx study) in 2010 focused on MSM.[63] The study concluded that for participants properly taking the drug every day, PrEP lowered the risk of HIV transmission to them by 92%.[64] Further studies found similar results in injecting drug users and heterosexual men and women; consequently, the U.S. Food and Drug Administration approved the use of Truvada—a PrEP drug—in 2012.[65]

---

[55] ILO & WHO, ‘Joint WHO/ILO Guidelines on Post-Exposure Prophylaxis (PEP) to Prevent HIV Infection’ (*WHO*, March 2007) <https://iris.who.int/bitstream/handle/10665/43838/9789241596374_eng.pdf?sequence=1> accessed 31 May 2024, 1.
[56] ibid.
[57] U.S. Centers for Disease Control and Prevention nPEP Guidelines Writing Team, ‘Updated Guidelines for Antiretroviral Postexposure Prophylaxis after Sexual, Injection Drug Use, or Other Nonoccupational Exposure to HIV— United States, 2016 from the Centers for Disease Control and Prevention, U.S. Department of Health and Human Service’ (*CDC.gov*, 2016) <www.cdc.gov/hiv/pdf/programresources/cdc-hiv-npep-guidelines.pdf> accessed 31 May 2024, 8.
[58] ibid at 9.
[59] ibid.
[60] ILO & WHO (n 55) 77.
[61] ibid.
[62] Melanie R Nicol, Jessica L Adams and Angela DM Kashuba, ‘HIV Pre-Exposure Prophylaxis Trials: The Road to Success’ (2013) 3 National Library of Medicine 295.
[63] NIH, ‘Pre-Exposure Prophylaxis (PrEP) to Reduce HIV Risk’ (*Nih.gov*, 16 October 2018) <www.niaid.nih.gov/diseases-conditions/pre-exposure-prophylaxis-prep> accessed 13 April 2025
[64] ibid.
[65] ibid.

PrEP may be taken either regularly or on demand (taken prior to and after a sex act) and remain effective (although on demand dosing has only been studied in MSM).[66] PrEP first became available in the UK in 2017 as a part of several trials.[67] Initially, the National Health Service in England refused to commission PrEP, arguing that they did not have the power to take part in a function that was predominantly focused on prevention instead of treatment.[68] In 2016 The National AIDS Trust successfully challenged this, with the court finding that NHS England did have the power to commission preventative drugs.[69]

Advocacy for PrEP remains strong today, and many see it as an extremely useful tool in preventing the spread of HIV. It should be noted, however, that the use of PrEP is not without its critics. Some fear that widespread use of PrEP will lower the rate of condom use (which prevents other STIs in addition to HIV), and additionally worry about the ability of users to adhere to it in a real-world setting.[70] PrEP proponents argue that evidence so far show no significant changes in condom use by people using PrEP, and that few studies have found an attendant rise in non-HIV STIs.[71]

C. Phylogenetic Analysis

Phylogenetic analysis is a forensic tool which compares different strands of a virus to determine relatedness.[72] In the legal context, prosecutors use it in reckless transmission cases to establish that defendant infected the complainant. Outside of the legal setting, phylogenetic analysis is predominantly used to map a virus across a larger population.[73] The use of phylogenetic analysis in criminal cases is controversial, in large part because—unlike other forensic areas such as DNA testing—it was not designed to compare the strands of two

---

[66] NHS, 'How and When to Take Pre-Exposure Prophylaxis (PrEP)' (*nhs.uk*, 13 March 2023) <www.nhs.uk/medicines/pre-exposure-prophylaxis-prep/how-and-when-to-take-pre-exposure-prophylaxis-prep/> accessed 31 May 2024.
[67] NHS England, 'NHS England Announces World's Largest Single PrEP Implementation Trial to Prevent HIV Infection' (*england.nhs.uk*, 3 August 2017) <www.england.nhs.uk/2017/08/nhs-england-announces-worlds-largest-single-prep-implementation-trial-to-prevent-hiv-infection/#:~:text=From%20September%2C%20pre%2Dexposure%20prophylaxis> accessed 31 May 2024.
[68] *Regina (National Aids Trust) v National Health Service Commissioning Board (NHS England)* [2016] P.T.S.R. 1093, [2].
[69] ibid [111].
[70] Mark Wainberg, 'Pre-Exposure Prophylaxis against HIV: Pros and Cons' (2012) 9 Retrovirology <www.ncbi.nlm.nih.gov/pmc/articles/PMC3360281/> accessed 18 November 2024.
[71] National AIDS Trust, 'WHY IS PrEP NEEDED?' (*NAT*, 2016) <www.nat.org.uk/sites/default/files/Why%20is%20PrEP%20needed.pdf> accessed 31 May 2024.
[72] Bernard, EJ, Y. Azad, AM Vandamme, and others 'HIV Forensics: Pitfalls and Acceptable Standards in the use of Phylogenetic Analysis as Evidence in Criminal Investigations of HIV Transmission' (2007) 8 HIV Medicine, pp. 382-387, 383.
[73] ibid at 384.

different individuals.[74] Phylogenetic testing involves creating phylogenetic trees, with individual strains representing different branches.[75] In criminal cases, the two branches (which represent the complainant's and defendant's respective strains) are compared to a control branch or set of branches to determine if the relevant branches are virologically similar.[76] The first major hurdle faced when relying on phylogenetic analysis is the choice of the control. An inappropriately chosen control may unfairly emphasise a similarity between two strains which may not actually be significant.[77] The second major hurdle with phylogenetic analysis is that it cannot show direction. In other words, if A accuses B of transmitting HIV to them, and phylogenetic analysis confirms that both A and B's strains are uniquely related when compared to a fairly chosen control, then phylogenetic analysis can only indicate that the two strains are similar. It cannot indicate who infected whom; B could have infected A or A could have infected B. Phylogenetic analysis also cannot rule out the possibility that another person was a source of one or both of their viruses. This means that A and B could have separately each had sexual contact with C, who infected both parties with related strains. There could even be a fourth person, D, who originally contracted the virus from C; if D and C engaged in sex acts with A and B respectively, A and B's strains would be related in spite of neither one of them infecting the other.[78] Consequently, while phylogenetic testing can indicate causation, it is not enough on its own to definitively establish it.

While the above is far from an all-encompassing portrayal of the relevant science of HIV, it highlights the main aspects of HIV that will be pertinent in future chapters of this thesis. With the broad strokes of the science of HIV introduced, this chapter will discuss the legal background of criminal HIV transmission in England and Scotland.

III. Where It Started: HIV and the Criminal Law in England and Scotland

There are three possible assault offences that HIV transmission may fall into in England and Wales. The first category, which includes offences that inflict harm which rises to the level of GBH, is the one most commonly cited by current caselaw. These GBH offences include OAPA s. 18, which prohibits intentional harm and reads:

---

[74] ibid.
[75] ibid.
[76] ibid.
[77] ibid.
[78] ibid at 385.

> Whosoever shall unlawfully and maliciously by any means whatsoever wound or cause any grievous bodily harm to any person, . . . with intent, . . . to do some . . . grievous bodily harm to any person, or with intent to resist or prevent the lawful apprehension or detainer of any person, shall be guilty of felony, and being convicted thereof shall be liable . . . to be kept in penal servitude for life.

For the purposes of the analysis in this thesis, section 18 is applicable in cases where a person is alleged to have intentionally transmitted HIV to another person. In other words, they aimed to infect a person with HIV and managed to do so. Section 20 likewise references GBH, and states:

> Whosoever shall unlawfully and maliciously wound or inflict any grievous bodily harm upon any other person, either with or without any weapon or instrument, shall be guilty of a misdemeanor, and being convicted thereof shall be liable . . . to be kept in penal servitude . . .

The main differences between OAPA sections 20 and 18 are the intent and the maximum sentence. Consequently, under the current jurisprudence the Crown could charge a person who recklessly transmitted HIV with subverting section 20 while charging someone who did so intentionally with subverting section 18. Reckless transmission, discussed more thoroughly in Chapter 4, includes situations where a person engages in a sexual act with another person and transmits HIV to them even though that was not their intent. This sort of reckless transmission accounts for almost all of the reported criminal court decisions concerning the transmission of communicable diseases. The most common scenario for reckless transmission involves one person having a sexual relationship with another, not disclosing their HIV status, and transmitting HIV. If a PLWHA has a sexual relationship with a person who is HIV-negative and HIV is not transmitted, that possibly implicates a crime which is referred to as 'HIV exposure.' While HIV exposure does not rise to a criminal offence in England, it does in other jurisdictions including Scotland. These three categories: intentional HIV transmission, reckless HIV transmission, and HIV exposure are the crux of this thesis.

There are two other possible offences that may be implicated in the upcoming discussion. One is OAPA section 47, which references actual bodily harm: 'Whosoever shall be convicted upon an indictment of any assault occasioning actual bodily harm shall be liable . . . to be kept in penal servitude.' Another is common assault, prohibited by the Criminal Justice Act 1998 section 39(1) which states: 'Common assault and battery shall be summary offences and a person guilty of either of them shall be liable to a fine not exceeding

level 5 on the standard scale, to imprisonment for a term not exceeding six months, or to both.' Chapter 5 will discuss these different categories of offences in greater detail.

The advent of HIV brought with it many concerns, both from a legal and public health perspective. Much about the disease was unknown in those early days, and advisory groups were often conflicted on what sort of conduct (if any) should be criminalised. In 1993 the Law Commission issued a report which clearly indicated that OAPA 1861 might apply in situations where disease transmission occurred;[79] five years later, however, the Home Office disagreed and concluded that only cases where the perpetrator intended serious harm should be criminalised.[80] The Home Office specifically recommended against criminalising reckless transmission and the transmission of 'minor diseases' in order to 'strike a balance' between punishing those with harmful intentions while protecting people living with communicable diseases from discrimination.[81] Consequently, the Home Office disagreed with the Law Commission regarding what the law concerning disease transmission should be.

In the end, however, Parliament did not enact a measure to modernise OAPA 1861 and the Crown successfully prosecuted cases involving reckless HIV transmission under OAPA section 20.[82] With the judiciary leading the way on laying the groundwork for the criminalisation of HIV transmission, the voice of advisory groups—who frequently advocated against criminalisation—became less prominent in law as it was applied.[83] All of this solidified in 2004, when the Court of Appeal handed down its judgement in *Dica* – the first reported case in English law concerning reckless HIV transmission. Before discussing *Dica*, however, let us first examine one of the cases the Court of Appeal had first to distinguish: *R v Clarence*.

---

[79] 'Nonetheless, our view remains that the deliberate or reckless causing of disease should not be beyond the reach of the criminal law as restated by clauses 2 to 4 of the Criminal Law Bill.' Law Commission, Legislating the Criminal Code: Offences Against the Person and General Principles (Law Com No 218, 2003) para 15.17.

[80] 'However it is now accepted that the judgement related to one specific offence and to the issue of consent, and that in principle it may well be possible to prosecute individuals for transmitting illness and disease at least when they do so intentionally.' House of Commons, The Anti-Terrorism, Crime and Security Bill: Parts I, II, VIII, IX & XIII: Property, Security & Crime, research paper 01/99 (19 November 2001), citing Home Office, Violence: Reforming the Offences against the Person Act 1861 (1998) para 3.14.

[81] 'The Government therefore proposes that the criminal law should apply only to those whom it can be proved beyond reasonable doubt had deliberately transmitted a disease intending to cause a serious illness. This aims to strike a sensible balance between allowing very serious intentional acts to be punished whilst not rendering individuals liable for prosecution for unintentional or reckless acts, or for the transmission of minor disease.' ibid para 3.18.

[82] Weait (n 1) 26.

[83] ibid.

A. *R v Clarence*

Although *Clarence* was heard in 1888—long before the advent of HIV—it was one of the first cases to address the question of whether or not disease transmission could fall within in the purview of either 'unlawfully and maliciously inflicting grievous bodily harm' or 'assault occasioning actual bodily harm.'[84] Charles James Clarence, while aware that he was infected with gonorrhoea, engaged in sexual intercourse with his wife, Selina, who was unaware of his infection.[85] At the trial level, the court convicted Clarence of violating OAPA sections 20 and 47. At the time, case law largely accepted that a husband could not be guilty of raping his wife. While some—including the court in *Dica*[86]—argued that both the underlying misogyny and inability to recognise marital rape factored into the *Clarence* court's decision, others disagreed and saw it as a case more focused on 'logical formalism and a deference to authority.'[87]

After setting aside the question of whether or not a wife at the time could refuse consent to sexual intercourse with her husband, Wills J questioned the sentiment that 'consent obtained by fraud is no consent at all.'[88] He noted that, if this were true, then any amount of mistruths told in order to gain consent for sex acts—e.g. lying about status or money in order to impress a woman—could itself negate the consent and render the defendant guilty of rape.[89] Wills J stated:

> Where is the difference between consent obtained by the suppression of the fact that the act of intercourse may produce a foul disease, and consent obtained by the suppression of the fact that it will certainly make the woman a concubine, and while destroying her status as a virgin withhold from her the title and rights of a wife? Where is the distinction between the mistake of fact which induces the woman to consent to intercourse with a man supposed to be sound in body, but not really so, and the mistake of fact which induces her to consent to intercourse with a man whom she believes to be her lawful husband but who is none?[90]

Wills J found that the text of the relevant sections of OAPA section 47 could not have been intended to extend to disease transmission cases which do not involve direct violence.[91]

---

[84] *Clarence* (n 11) 23. The judgment lists the offences as falling under the rubric of 24 and 25 Vict. 100, ss 20, 47.
[85] ibid.
[86] *Dica* (n 2) [19].
[87] Weait (n 1) 96.
[88] *Clarence* (n 11) 27.
[89] ibid 28-29.
[90] ibid 30.
[91] ibid 31.

Additionally, he saw no distinction between sexually transmitted infections and other contagions such as small-pox and scarlet fever—contagions which had existed for centuries without the Crown prosecuting their transmission.[92] As for the offence of unlawful or malicious infliction of grievous bodily harm, Wills J determined that an assault was still necessary for the offence to apply; he found that it could not apply to the facts of *Clarence* as there was no intention to commit an act of violence.[93]

Stephen J came to a similar conclusion. He found that there was no notable distinction between diseases transmitted sexually and those transmitted via casual contact; consequently, holding Clarence guilty could lead to benign acts (such as a handshake) rising to the level of assault if performed by a person with any sort of communicable disease.[94] While Stephen J noted that Clarence's conduct was 'abominable,' he carefully distinguished between immoral behaviour and conduct which rose to the level of a crime.[95] Regardless of the applicability of terms such as 'malicious' or 'unlawfully' he found that the conduct did not fall within the purview of causing grievous bodily harm since it did not rise to the level of an assault.[96] He found that the relevant sections of the 1861 Act required an 'immediate and necessary connection' between the *actus reus* and could not have been intended to apply to 'the uncertain and delayed operation of the act by which infection is communicated.'[97] Stephen J found that Clarence's wife s consented knowingly and consciously to the 'nature of the act [and] the identity of the agent', and that although there was an injury caused by a 'suppression of the truth', it was not an assault because the harm (i.e. the transmission of gonorrhoea) was delayed and might not have occurred at all.[98] Stephen J stated:

> [T]here must have been some interval during which it was uncertain whether infection had been communicated or not. During this interval was the man guilty or not? If he

---

[92] ibid 34.
[93] ibid 36-7.
[94] ibid 38-9.
[95] ibid 39. He later says: 'I think that no act can for this purpose be regarded as unlawful merely because it is immoral. It must, I think, be forbidden by some definite law.' ibid 41.
[96] ibid.
[97] ibid. He further notes that the language would not match an infection: 'If a man by a grasp of the hand infects another with small-pox, it is impossible to trace out in detail the connection between the act and the disease, and it would, I think, be an unnatural use of language to say that a man by such an act "inflicted" small-pox on another. It would be wrong in interpreting an Act of Parliament to lay much stress on etymology, but I may just observe that "inflict" is derived from "*infligo*," for which, in Facciolati's Lexicon three Italian and three Latin equivalents are given, all meaning "to strike," viz. "*dare, ferire* and *percuotere*" in Italian, and "*infero, impingo* and *percutio*" in Latin.' ibid 42.
[98] ibid 44-5.

was, it seems extraordinary to say that he had committed an assault from which an event which was not in his power could set him free.[99]

Ultimately, the majority in *Clarence* found that the language of the statute should not be extended to include disease transmission and quashed the convictions under both section 47 (assault occasioning actual bodily harm) and section 20 (unlawfully inflicting GBH). The decision was not without criticism, however. Field, Hawkins, Day, and Charles JJ all dissented. Wills and Stephen JJ's opinions appeared to draw particular sway, with Lord Coleridge CJ specifically concurring with them.[100] The most important aspect of *Clarence* is that, prior to *Dica*, English caselaw held that reckless transmission of a disease could not be an offence under sections 20 or 47 of OAPA 1861.[101] The later case of *R v Ireland*; *R v Burstow*[102] would later establish that physical force was unnecessary for a conviction under sections 47 or 20. In short, *Burstow* established that even purely psychological harm (as opposed to physical) may implicate OAPA section 47.[103] The next major development in the relevant law was *Dica*.

B. *R v Dica*

Mohammad Dica was a Kenyan refugee living in the UK.[104] In 2003 a trial court convicted him of causing harm in violation of OAPA 1861 section 20 in respect to two women who alleged that he transmitted HIV to them.[105] A health practitioner informed Dica of his HIV status in 1995, and he engaged in sexual relationships with the complainants after this time.[106] During the majority of the sexual contacts, condoms were not used.[107] At trial, the judge concluded that it was open to the jury to convict in spite of *R v Clarence* and that the complainants' knowledge of Dica's condition was irrelevant to the question of consent as a

[99] ibid.
[100] ibid 65-66.
[101] Weait (n 1) 96.
[102] [1998] 1 Cr App R 177.
[103] ibid.
[104] Weait (n 1) 27.
[105] *Dica* (n 2) [5]-[9].
[106] ibid [4] – [9].
[107] ibid [11]. The connection between the use of prophylaxis and the *mens rea* of recklessness was moot since Dica did not use protection; however, the court noted as dicta that: 'If protective measures had been taken by the appellant that would have provided material relevant to the jury's decision whether, in all the circumstances, recklessness was proved.' ibid.

defence to an OAPA section 20 charge since *R v Brown*[108] established that one cannot consent to that level of harm.[109]

> On appeal, the Court of Appeal overruled *Clarence*, finding that:
>
> [T]he artificial notion that sexual intercourse forced on an unwilling wife by her husband was nevertheless bound in law to be treated as if it were consensual sexual intercourse permeated much of the reasoning of the majority, and was fundamental to the outcome in relation to both counts.[110]

Judge LJ stated that time had gradually eroded *Clarence*, first in *R v Wilson (Clarence)*[111] and later in cases such as *Burstow* which interpreted 'bodily harm' broadly and found it may encompass cases of psychiatric and other non-physical harms.[112] *Dica* found that this erosion meant that, by that time, there no longer needed to be an 'immediate and necessary connection' between the *actus reus* and the injury.[113] In other words, it no longer mattered that there was a delay between the sex act and the attendant infection. Further bolstering this, *Dica* noted that *Burstow* previously found that *Clarence* no longer assisted with the legal definition of the term 'inflict.'[114]

One of the most significant aspects of *Dica* is its ruling on the interaction between consent and OAPA section 20. As noted earlier, the trial judge did not leave the question of consent to the jury; they found that cases such as *R v Brown* rendered it impossible to consent to that level of harm.[115] On this point, the court in *Dica* disagreed. Judge LJ drew a distinction between situations where a person's aim encompassed sexual gratification that intertwined with a violent harm, and situations where a person's aim encompassed sexual gratification that happened to include an attendant risk of harm.[116] The court noted that sexual acts always included a risk—including pregnancy and sexually transmitted diseases—and that applying the criminal law where someone had 'willingly accepted those risks' would be an overreach of the court's authority and virtually impossible to enforce.[117] As a seeming middle ground

---

[108] [1993] UKHL 19; [1994] 1 AC 212.
[109] *Dica* (n 2) [13].
[110] ibid. [19].
[111] [1984] AC 242; (1983) 77 Cr App R 319. To clarify the term 'eroded,' the court in *Dica* focused on how there was a shift from a strict reading of the OAPA section 20 in *Clarence* regarding the term 'inflict.' Later cases, such as *Wilson* gradually moved away from the requirement of needing of an underlying assault in order for the word 'inflict' to apply.
[112] *Dica* (n 2) [26].
[113] ibid [30].
[114] *Burstow* (n 102) 189.
[115] *Dica* (n 2) [13].
[116] ibid [46]-[47].
[117] ibid [50]-[52].

between the competing interests arguing for and against criminalising reckless HIV transmission, the court agreed that consent to the risk of transmission can provide a defence to a charge in contrivance of OAPA section 20 and that the trial judge was wrong to remove that question from the jury.[118] The case was remitted for a retrial, and—following another conviction—Dica once again appealed, unsuccessfully, in 2005.[119] *Dica*'s approach to harm, recklessness, and consent will be discussed in greater detail in later chapters.

C. R v Konzani

The decision in *Konzani*—a case heard not long after *Dica*—involved a Malawian national living in the UK.[120] who received a positive HIV diagnosis in 2000.[121] Subsequent to his diagnosis, three complainants alleged that he transmitted HIV to them via unprotected sexual intercourse.[122] The trial court convicted him of violating OAPA section 20.

The decision in *Konzani* focused on the question of consent as a defence to OAPA section 20. At trial, the judge informed the jury that 'before the consent of the complainant could provide the appellant with a defence, it was required to be an informed and willing consent to the risk of contracting HIV.'[123] The Court of Appeal ultimately agreed with the lower judge's instructions, and Judge LJ's opinion in *Konzani* attempted to carefully distinguish the difference between running a risk and consenting to running a risk. A detailed analysis of his opinion regarding this is presented in Chapter 4. In brief, *Konzani's* significance lies in its upholding of *Dica* and its elucidation of the role of consent as it relates to reckless transmission.

---

[118] ibid. [59].
[119] [2005] EWCA Crim 2304. The appeal is short and not as in-depth as the 2004 decision. According to the Court of Appeal, the defendant made a 'half-hearted suggestion that maybe the judge [during the retrial] had misdirected the jury in relation to recklessness' which the court quickly dismissed. ibid [5]. The defendant additionally argued for leave to appeal so that the House of Lords could consider the 2004 appellate decision. ibid. The court denied the appeal, noting it was bound that that and other subsequent decisions. ibid. The defendant also appealed the sentence. Regarding that, the appellate court stated that: 'In our judgment this is not a case in which the sentence imposed on the applicant was manifestly excessive. It was a harsh sentence; it was a sentence at the very maximum available to a court; but it is difficult to imagine a case of section 20 of greater seriousness than this.' ibid [11].
[120] *Konzani* (n 12) [15].
[121] ibid [3].
[122] ibid.
[123] ibid [55].

D. Changes Post-*Dica* and *Konzani*: Secondary Sources and Other Significant Events

Before discussing the more recent cases involving reckless transmission, it is important to note other changes subsequent to *Dica* and *Konzani*. After those two cases established that HIV transmission could, in some circumstances, rise to the level of a criminal offence in English law, the Crown Prosecution Service published guidelines setting out their understanding of the law and factors relevant to a decision to prosecute. In 2014, the Crown Office and Procurator Fiscal Service in Scotland issued similar guidelines as relevant to Scottish law. While these guidelines are not a source of law in of themselves, they play a role in later cases and establish how prosecutors are supposed to address offences that involve HIV transmission and exposure. Other relevant changes in the law are likewise addressed below.

1. England

i. Intentional or Reckless Sexual Transmission of Infection: Policy for Prosecuting Cases

In 2008, the Crown Prosecution Service —which operates in England and Wales— issued a set of guidelines regarding how prosecutors should treat cases alleging violations of Sections 18 and 20 of the OAPA 1861.[124] The guidelines are generally helpful in clarifying some of the underlying concerns addressed by many critics of HIV criminalisation. For instance, it acknowledges the need for medical and scientific evidence, while also noting that phylogenetic analysis has limitations as a tool for the prosecution. It states:

> In the case of HIV, phylogenetic analysis can demonstrate with certainty that A did not infect B, excluding the possibility of transmission between two persons where there is no relevant match between the two samples. However, prosecutors should be aware that this analysis, whilst it can prove A did not infect B, cannot prove the contrary (that A did infect B). At best, any match would simply show that it is possible that A passed on the infection to B. Phylogenetic analysis may demonstrate that the strain of the infection in B is consistent with the strain in A, but additional factual evidence is essential to make the case that A was in fact responsible for the B's infection. Phylogenetic or medical evidence alone is insufficient.[125]

The CPS guidelines further recognise that simply having an HIV diagnosis is not necessarily enough to demonstrate the knowledge necessary for recklessness in contrivance

[124] CPS Guidance (n 14).
[125] ibid.

of OAPA section 20 as it relates to sexual disease transmission. Instead, the prosecution will need evidence that 'the suspect really did understand that he/she was infectious to other people, and how the particular infection concerned could be transmitted.'[126] The guidelines note the role that treatment can play in reducing infection, but its framing of how this would interact with the knowledge of the accused in regards to recklessness is unclear. It states:

> Prosecutors should take into account all of the available evidence as to A's state of mind relevant to their intention or capacity for foresight at the time they engaged in sexual activity, when determining this proposition. Where A knows that they have an STI but they go on to engage in sexual activity with B without safeguards there will usually be a sound inference that foresight of the risk of transmission is present. Prosecutors should therefore consider:
>
> - whether A in fact intentionally transmitted the STI or
> - whether A unreasonably took that risk and if so, whether B consented to that risk
>
> Unreasonableness is a matter of fact and degree. Infection can occur even where reasonable and appropriate safeguards have been taken. Not every shortcoming in the safeguards used amounts to recklessness. Further, even where there are shortcomings in the safeguards used, prosecutors will need to take into account what A considered to be the adequacy and appropriateness of the safeguards adopted. Only where it can be shown that A knew that such safeguards were inappropriate will it be likely that the prosecution would be able to prove recklessness. Evidence that A took appropriate safeguards to prevent the transmission of their infection throughout the entire period of sexual activity, and evidence from medical experts that those safeguards would be expected to prevent transmission in light of the nature of the infection, will mean that it will be highly unlikely that the prosecution will be able to demonstrate that A was reckless. Reasonableness is an assessment of fact for the jury but in making their assessment the jury may take into account the evidence they have heard from the experts.[127]

The guidelines list a variety of relevant factors and indicate that they should be 'taken into account in combination.'[128] Worryingly, the guidelines affirm that a section 20 offense may apply to a person without knowledge of their own status ('deliberate closing of the mind'),[129] though it notes that prosecutions involving such should only occur 'in exceptional cases.'[130]

---

[126] ibid.
[127] ibid.
[128] ibid.
[129] This happened once in the matter of *R v Adaye* (2004). The circumstances of that case were unique and will be discussed in Chapter 3.
[130] CPS Guidelines (n 14).

ii. Public Health (Control of Disease) Act 1984

In 2007 the UK Government proposed to reform the Public Health (Control of Disease) 1984 ['PH(CD)A'], and the Department of Health issued a consultation document which caused some to worry regarding how the potential reforms could apply to people living with HIV.[131] Ultimately, the Health and Social Care Act of 2008 ['HSCA 2008'] only replaced Part II of the PH(CD)A.[132] Notably, the HSCA 2008 approaches diseases broadly, and does not specifically reference HIV or AIDS.[133]

The most concerning part of the PH(CD)A is Section 45(G) and the power of Part 2A Orders. These provisions grant broad powers to issue orders to a justice of the peace to take certain actions where a person is or may be infected with a disease which could pose 'significant harm'—a term not further defined.[134] The Health Protection Legislation (England) Guidance 2010 acknowledges that STIs require special considerations, and that generally Part 2A orders should not apply to cases of people living with HIV.[135] The powers granted under the HSCA in Part 2A Orders can restrict liberties, and a person who fails to abide by an order can be fined up to £20,000.[136]

iii. Ancillary Orders

Sexual Harm Prevention Orders ['SHPOs'] confer broad power under the guise of protecting the public. The Anti-social Behaviour, Crime, and Policing Act 2014 amended Part 2 of the Sexual Offences Act 2003 in 2015 regarding SHPOs. The most worrying aspect of the legislation is the power it confers on a court to forbid someone from engaging in (otherwise lawful) sex acts without first disclosing their HIV status. Such orders may be used

---

[131] See, eg, Weait (n 1) 116-7.
[132] The language used is substantially similar to the Welsh guide.
[133] Schedule 1 of The Public Health (Infectious Diseases) Regulations 1988 specifically referred to AIDS and stated it applied to numerous sections.
[134] The 2010 Guidance stated that the evidence needed to show 'significant harm' should include: 'the mechanism by which it spreads; how easily it spreads, and the impact on human health, taking account of symptoms including pain, disability and the likelihood of death.' Health Protection Agency, 'Health Protection Legislation (England) Guidance 2010' (*Health Protection Agency,* 25 March 2010) <www.haringey.gov.uk/sites/haringeygovuk/files/hpa_-_guidance_notes.pdf> accessed 18 November 2024, 83.
[135] 'Local authorities should consider applying for confidentiality measures in relation to any legal proceedings in the exceptional circumstances where an application for a Part 2A Order were made in relation to a person with HIV or another STI'. ibid 81.
[136] ibid 77 (Section 9.1.5).

regardless of evidence that a defendant changed or improved their medication regiment (thus lowering the risk of future transmissions).[137]

2. Scotland

Unlike England, there are no reported criminal cases in Scotland concerning HIV transmission or exposure.[138] Scottish prosecutors have, however, successfully prosecuted both exposure and transmission cases. In Scotland, the relevant offence is the common law crime of culpable and reckless conduct, and exposure without transmission may amount to this offence.

i. Crown Office and Procurator Fiscal Service Policy on Sexual Transmission of Infection

The Crown Office and Procurator Fiscal Service [‘COPFS’] published its relevant prosecution policy in 2012 and updated it in January 2022. Compared to the CPS policy, the Scottish one emphasises behaviour over outcome. In line with this, it confirms the possibility of prosecution for exposure to HIV without transmission, though it states that it is only supposed to be ‘contemplated in exceptional circumstance[s],’ with no further guide on what an ‘exceptional circumstance’ constitutes. Like the CPS policy, it cautions the use of phylogenetic analysis as proof in of itself that the accused infected another person[139] and acknowledges the possibility of a prosecution where an individual was unaware of their status at the relevant time (‘wilful blindness’).

Later updates acknowledge that factors such as medication, medical advice regarding the sex acts which only possess a negligible risk of transmission, the use of prophylaxis, and undetectable viral loads are relevant to considering whether or not the individual has displayed the requisite degree of recklessness required for a charge of culpable and reckless conduct.[140] It states:

---

[137] See, eg, Metro Reporter, ‘Man Jailed for Lying to Girlfriends and Knowingly Infecting Them with HIV’ (*Metro* 21, September 2018) <https://metro.co.uk/2018/09/21/man-jailed-for-lying-to-girlfriends-and-knowingly-infecting-them-with-hiv-7968061/> accessed 18 November 2024. ‘Gavin Holme, defending, said the criminal process made Osei take control of his condition and he did not pose any danger to the public as he was on anti-viral medication.’ ibid.

[138] One prosecution is reported in respect of a contempt of court order, but not in respect of liability for the offence itself: *HM Advocate v M* 2007 SLT 462.

[139] ‘In summary, an expert bacteriologist or virologist‘s expert testimony interpreting phylogenetic analysis can be used to eliminate potential suspects with certainty and can confirm that results are consistent with the accused having transmitted the infection to another but they cannot provide definitive proof of transmission between two specific individuals, nor indicate the direction of transmission.’ COPFS Guidance (n 13).

[140] Note that the 2014 version references an ‘Annex C’ which it lists as S Fidler and others, ‘Position Statement on the Use of Antiretroviral Therapy to Reduce HIV Transmission, January 2013: The British HIV

> In determining whether a person has the necessary recklessness, the totality of all the facts and circumstances must be taken into consideration. Evidence of the following factors will mean that it is unlikely that the requisite degree of recklessness will be established.
>
> - The person infected is receiving treatment and been given medical advice that there is a low risk of transmission or that there was only a negligible risk of transmission in some situations or for certain sexual acts
> - The person infected took appropriate precautions such as using a condom or other safeguards throughout the sexual activity
>
> With regard to HIV, there is a body of medical opinion that there is minimal or negligible risk of transmission when plasma viral load is below 50.[141]

For cases of exposure alone, policy now states that: '…in view of the negligible risk of transmission, there is a very strong presumption against prosecution in these circumstances.'[142]

ii. Public Health etc. (Scotland) Act 2008

Like the English HSCA 2008, the Act itself does not specifically refer to HIV or AIDS at any point. The Guidance—issued in 2009—likewise makes no reference (including the need for special consideration) to cases involving HIV or STIs. Part 4 of the PH(S)A sections 31-71 of the Act allows for orders similar to Part 2A Orders in England and Wales, discussed earlier, but allow the Order to be in place for up to 12 months in exceptional circumstances.[143] Additionally unlike Part 2A Orders, Scottish Part 4 Orders are applicable in situations where there is a 'significant risk to public health'—the English Part 2A Orders only require a showing that a person 'presents or could present significant harm to human health.' The associated implementation guidance document[144] acknowledges the lack of definition, and states that—in lieu of such guidance—'professional judgment is required as to the level and nature of the suspected risk.'[145]

Association (BHIVA) and the Expert Advisory Group on AIDS (EAGA)' (2013) 14 HIV Medicine 259 <https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/193689/Position_statement_on_the_use_of_ART_to_reduce_HIV_transmission__Jan_2013.pdf> accessed 20 July 2022.

[141] COPFS Guidance (n 13).

[142] ibid.

[143] ibid 4[5]. Paragraph 6 on the same page goes on to note the factors that may be involved in defining a significant risk, including: the amount of people currently infected, the potential harm of the infection, and ease of transmission. Part 2a orders are supposed to not exceed 28 days. PH(CD)A Part2 2A §§45L(3).

[144] 'Public Health Etc (Scotland) Act 2008 Implementation Guidance: Parts 3, 4, 5 and 6: Contents' (October 2009).

[145] ibid [5]-[7].

iii. Ancillary Orders

The Sexual Offences Act 2003 section 104 conferred the power for Sexual Offences Prevention Orders ['SOPOs'] to be issued by a competent authority, and the Protection of Children and Prevention of Sexual Offences (Scotland) Act 2005[146] amended the 2003 Act to allowed Scottish courts to issue SOPOs as well. The Abusive Behaviour and Sexual Harm (Scotland) Act 2016 repealed the provisions in the 2003 and 2005 Acts regarding SOPOs,[147] and replaced them with a new scheme of Sexual Harm Prevention Orders and Sexual Risk Orders[148] when it was brought into force.

IV. Rulings in *Marangwanda* and *Golding*[149]

Although neither *Marangwanda* nor *Golding* concerned defendants with HIV, both are modern cases which demonstrate the interplay of the prosecution guidelines on reckless disease transmission with case law. While *Marangwanda* is unique in that its primary focus is more related to the protection of young children, the fact that it involved gonorrhoea—a curable infection—and an alleged means of transmission which should be impossible makes it potentially worrying as precedent. As for *Golding*, which involves the herpes simplex virus ['HSV'] it raises questions on the level of proof needed for transmission as well as the level of harm needed to rise to the level of GBH. Questions of harm, transmission, mental state, and how they relate in detail to these two cases will be discussed in detail in later chapters. For now, the cases will be generally introduced and their approaches towards medical evidence will be highlighted.

A. *R v Peace Marangwanda*

1. Background

In September 2005, Marangwanda moved in with a woman and her two daughters, ages six and four.[150] In November doctors diagnosed him with gonorrhoea, and in December

---

[146] Section 17.
[147] Section 39.
[148] ibid sections 10-36. This was brought into force in 2023.
[149] Although it does not relate to the core questions addressed by this thesis, it is important to note that the 2006 case of *R v B* [2006] EWCA Crim 2945 confirmed that a person failing to disclose their HIV status does not vitiate consent. Consequently, not informing a person of one's HIV status is not tantamount to rape. In *R v Lawrance (Jason)* [2020] EWCA Crim 971, the court affirmed that deception of this sort is likewise not enough to vitiate consent. While that case did not specifically address HIV, it referenced *B* and confirmed that either deception or a failure to disclose a relevant fact is not capable of vitiating consent as long as it does not closely relate to the nature or purpose of the sex act.
[150] *Marangwanda* (n 16) [3].

doctors diagnosed both of the girls with it as well.[151] The older girl stated she was sexually abused by Marangwanda, and in May 2006 police arrested him.[152] Although a jury could not reach a verdict in his January 2007 trial where he was tried with violating sections 9(1) and 9(2) of the Sexual Offences Act 2003,[153] in June he pled guilty during his retrial.[154] His plea involving him admitting to breaching section 20 of the OAPA 1861 on the grounds that he passed gonorrhoea to both girls recklessly and in a non-sexual manner, stating that the transmission occurred through casual contact due to a lack of proper hygiene on his part.[155] His plea further asserted he was aware that transmission could occur in such a manner, and that he failed to 'ensure that he adhered to the proper sanitary and hygienic principles which would have been ordinarily implied.'[156] His sentence entailed two years of prison for each count, a SOPO, disqualification from working with children for life, and a recommendation for deportation.[157]

2. Appeal

Marangwanda appealed on four grounds: (1) the offences as pled were not scientifically possible; (2) even if they were possible, he was not reckless; (3) the basis of the conduct in his plea did not rise to the level of a criminal offence; and (4) his counsel improperly pressured him into accepting the plea.[158] Much of the court's analysis focused on the fourth ground regarding his counsel—it found no basis for the claim.[159]

The court substantially avoided the question of scientific possibility, stating instead that: 'by his plea, the defendant accepted the medical possibility of the transmission of [gonorrhoea].'[160] Beyond the plea, the court asserted that it indicated in the 'course of this judgment… medical evidence of the possibility, albeit the remote possibility of [transmission].'[161] The judgment, however, contains no such evidence. Indeed, the only scientific evidence detailed involved the testimony of a doctor stating that gonorrhoea cannot

[151] ibid.
[152] ibid.
[153] ibid [4].
[154] ibid [5].
[155] ibid.
[156] ibid.
[157] ibid.
[158] ibid [7].
[159] ibid [10]-[11].
[160] ibid [12].
[161] ibid.

be transmitted via non-sexual contact, and that the organism for it cannot survive long outside the body.[162]

The court likewise dismissed the question of recklessness and the existence of a criminal offence in a similar manner, substantially relying on Marangwanda's plea.[163] This means that the court allowed a plea—a plea of a non-medical expert—to not only establish something as medically possible without independent verification of such, but also that his knowledge of this 'remote possibility' rose to the level of criminal recklessness. At its most simple, this means that a court is accepting that criminal recklessness can be established in cases where the potential harm is a 'remote possibility.'[164]

Additionally worrying is the court's assessment as to whether or not a criminal offense occurred at all, stating:

> The other ground of appeal against conviction is that there could be no offence committed in what we will call a familial or domestic setting, but again by virtue of the basis of plea and the applicant's pleas, he must have been accepting the possibility that in a domestic or familial setting the disease could have been transferred. *In such circumstances it would have been his duty to take the necessary protection to ensure there was no transference. We are not persuaded that there is anything in that ground of appeal.*[165]

The last sentence arguably suggests that there is an affirmative duty for a person to prevent the transmission of a disease they are diagnosed with—an obligation which goes beyond the holdings in *Dica* and *Konzani*.[166] Unlike cases where the transmission occurred via sexual contact, there is no specifically identified act here—instead, Marangwanda's plea stated that he transmitted gonorrhoea by generally failing to act hygienically. Consequently, *Marangwanda* exemplifies one of the worries from Stephen J in *Clarence*, namely that benign contact could become criminalised based purely on a person's disease status.[167] Additionally, while steps can be taken to mitigate transference, it would be almost impossible in such a situation to ensure no transmission.

---

[162] ibid [10].
[163] ibid [12]-[13].
[164] ibid [12].
[165] ibid [13] (emphasis added).
[166] Matthew Weait, 'UK: Gonorrhoea Prosecution "a Dangerous Development"' (*Criminal HIV Transmission* 23, April 2009) <http://criminalhivtransmission.blogspot.com/2009/04/uk-gonorrhoea-prosecution-dangerous.html> accessed 2 August 2022.
[167] *Clarence* (n 11) [38]-[39].

The court ultimately ruled against Marangwanda and upheld his conviction, although it did lower his sentence from 24 to 12 months per count.[168] The court additionally upheld the SOPO.[169] The issuance of the SOPO is curious in light of the fact that the guilty plea did not involve any underlying sexual offence. That the court issued the SOPO despite this supports the theory that the court itself did not accept the version of events Mr Marangwanda claimed occurred in his plea. Instead, the court merely noted that gonorrhoea is 'clearly a serious sexual harm' and that the purpose of SOPOs is to prevent such harm.[170]

3. Significance

The court did not fully address the question of transmission—both generally and specific to this case—nor the question of Marangwanda's knowledge. Should a person be able to plead to something which is not medically possible, or so medically unlikely that the possibility of a harm remains negligible? If so, how is the knowledge of something that is, at best, a 'remote possibility'[171] ever supposed to rise to the level of the knowledge necessary for recklessness? This is concerning for cases involving HIV where the possibility of transmission could be a fraction of a percent. *Marangwanda*'s potential impact on issues concerning recklessness and harm will be discussed in later chapters.

B. *R v David Golding*

1. Background

In July 2009 Golding—a man previously diagnosed with herpes[172]—met and entered into a relationship with a woman identified as CS with whom he did not disclose his herpes status.[173] In September of that year CS's doctors diagnosed her with type 2 genital herpes simplex virus ['HSV-2'], from which she suffered additional outbreaks in October and November.[174] Medical experts testified that herpes—which is incurable and can lead to outbreaks throughout a person's life—generally becomes more mild and outbreaks will occur less frequently over time.[175] While CS's outbreaks were not discussed at length beyond the first few, she testified that significant pain accompanied her initial outbreak.[176]

---

[168] *Marangwanda* (n 16) [5].
[169] ibid. [16].
[170] ibid.
[171] ibid. [15].
[172] *Golding* (n 17) [18].
[173] ibid [3].
[174] ibid.
[175] ibid [20].
[176] ibid [57].

Golding at first denied responsibility for the transmission,[177] but later admitted responsibility to the police[178] and to CS via a note.[179] While Golding was initially diagnosed with herpes in April 2008, it remained unclear throughout the proceedings whether he had type 1 or 2 herpes.[180] Transmission cannot have occurred between two people when their strains are discordant (e.g. a person with HSV-1 cannot be the source of infection for someone with HSV-2 and vice versa).[181] The nature of the advice given to Golding regarding transmissibility was likewise unclear, particularly regarding the transmissibility of herpes when an individual is not experiencing an outbreak.[182]

Counsel for Golding requested a *Goodyear* indication[183] on the day of trial, during which the judge indicated that a OAPA section 20 plea (regarding grievous bodily harm) was more appropriate than a section 47 one (regarding assault occasioning bodily harm).[184] Although Golding hoped to plea to the less severe section 47 charge,[185] he ultimately pled guilty to a section 20 offense based on five terms: (1) that he met CS in the summer 2009; (2) that he had herpes previously which he knew to be a lifelong STI; (3) that he did not tell CS about his diagnosis; (4) that CS acquired herpes as a result of sexual intercourse during the course of their relationship; and (5) that he behaved recklessly and as a result 'assaulted her occasioning her actual bodily harm.'[186] The Court ultimately sentenced Golding to 14 months' imprisonment.[187]

2. Appeal

Approximately three weeks after sentencing, the Crown sought a report from a medical consultant regarding the nature of the harm caused by herpes and the sufficiency of the evidence without lab tests.[188] After the Crown disclosed these reports, Golding filed his

---

[177] ibid [4].
[178] ibid [6].
[179] ibid [26].
[180] ibid [18].
[181] ibid.
[182] ibid [22]-[23].
[183] A *Goodyear* is essentially an indication of what the sentence would be if the defendant entered a guilty plea as established per *R v Goodyear* [2005] EWCA Crim 888. See Crown Prosecution Service, 'Sentencing – Overview, General Principles and Mandatory Custodial Sentences' (*Cps.gov.uk*, 14 June 2023) <www.cps.gov.uk/legal-guidance/sentencing-overview-general-principles-and-mandatory-custodial-sentences> accessed 6 May 2025.
[184] *Golding* (n 17) [28].
[185] ibid [8].
[186] ibid [7].
[187] ibid [2].
[188] ibid [9].

appeal based on five grounds: (1) the Crown failed to follow its own CPS guidelines regarding STI transmissions; (2) Golding's counsel failed to adequately represent him by failing to challenge the irregularities with the CPS guidelines and failing to request certain records; (3) the guilty plea was not informed and voluntary; (4) the medical evidence—including the fresh evidence—failed to show that herpes rose to the level of harm required under section 20; and (5) the evidence in the case failed to sufficiently show Golding infected CS 'recklessly or at all.'[189]

i. CPS Guidelines

The two aspects of the Guidelines at issue were the requirements for the Director of Public Prosecutions' ['DPP'] principal legal adviser to be notified prior to charging decisions[190] and—crucially—the failure of the prosecutors to follow the scientific and medical standards detailed in the guidelines. The guidelines state that a case should not proceed unless there is sufficient medical/scientific evidence, and that this evidence is necessary to meet the 'evidential stage of the code test' regardless of whether or not a suspect admits to transmission.[191] This further applies to pleas, which likewise require corroborating scientific and medical evidence in order to be considered informed.[192] The guidelines specially state that evidence must rule out the possibility of another person as the cause of infection in order to be considered sufficient.[193] Golding did not argue that the failure to follow the CPS guidelines was in itself sufficient to overturn his plea; rather, he argued that the failure of the Crown to follow its own evidentiary guidelines indicated that his plea was not properly informed and thus not safe.[194]

The court quickly dismissed the Crown's failure to refer the case to the principal legal advisor as irrelevant and focused instead on the evidence as it related to the plea.[195] Ultimately, the court found that—although the Crown failed to obtain the evidence required

[189] ibid [14].
[190] ibid [49].
[191] ibid [50].
[192] ibid [51].
[193] ibid [52].
[194] ibid [53]. The court clarified that, had the case proceeded to trial, the failure to follow the guidelines could have been a way to challenge the evidence. ibid [55]. On appeal, however, the focus was on the evidence as it related to the informed status of the plea. ibid.
[195] ibid [55].

in the guidelines[196] —the evidence gathered sufficed to raise a *prima facie* case under section 20, and thus the plea was voluntary and informed.[197]

ii. Elements of OAPA Section 20

The court analysed the sufficiency of the evidence by breaking down the elements of a section 20 offence into three prongs: actual infliction, severity of harm, and a reckless state of mind.[198] Even without a lab report, the court found that the evidence of the timing of CS's infection—along with her credible testimony as to her lack of other partners—sufficiently indicated that Golding infected her.

Regarding the sufficiency of the evidence for grievous bodily harm and recklessness, the court reiterated on multiple occasions that it found CS credible[199] and Golding not.[200] Although the reports of two medical experts conflicted as to whether or not herpes rose to the level of grievous bodily harm in their opinion,[201] the court ultimately considered that CS's testimony as to the pain she endured plus the lack of the cure for herpes could lead a jury to find the harm as sufficiently serious.[202] The court specifically emphasised that the level of a harm in that sort of case was a matter for a jury to decide and not experts.[203]

As to Golding's state of mind regarding recklessness, the court ignored the lack of evidence regarding the advice Golding's medical provider issued to him regarding transmissibility.[204] Instead, the court focused on Golding's plea and other instances where he stated he was aware that herpes could be transmitted and that he felt guilty for not informing CS of his herpes status prior to beginning their relationship.[205]

3. Significance

Golding is one of the very few cases which dealt with the question of harm. The findings of *Golding,* particularly as it relates to questions of recklessness and harm, will be discussed in later chapters.

---

[196] ibid.
[197] ibid [74]. While not addressed in detail here, the court found the testimony of Golding's former solicitor credible and that his actions did not rise to a level to affect Golding's plea. ibid.
[198] ibid [75]-[83].
[199] See, eg, ibid [46].
[200] See, eg, ibid [45].
[201] ibid [77].
[202] ibid [62].
[203] ibid [77].
[204] ibid [82].
[205] ibid [78]-[83].

V. Intentional Transmission and the Case of Daryll Rowe

The case of Daryll Rowe (frequently spelled as 'Darryl Rowe'[206]) is notable not just because it was the first case to involve an individual prosecuted for intentional transmission of HIV in the UK, but also because the matter drew massive attention from around the world. The facts alleged in the case, combined with the number of complainants and complainers in both England and Scotland, depicted a scenario that captivated the media and fed into the stereotype that criminalisation laws are necessary to stop people who, as the BBC phrased it, use HIV as a weapon.[207]

While the media coverage surrounding Rowe is vast, the legal discussions surrounding the Scottish and English cases are sparse. Rowe will likely remain a unique case in terms of how unusual the situation involved was; however, the response of the courts clarifies not only how the law may work in future cases of intentional transmission, but also how it interacts with certain changing medical advancements.

A. Background

Daryll Rowe's last known negative HIV test took place in 2014 in Edinburgh; in April of 2015 a sexual health centre informed him that he had sexual contact with someone with HIV.[208] Following another HIV test, a medical professional informed him that he was HIV-positive.[209] The facts alleged that he received leaflets and other information about preventing the spread of HIV, and that he declined both treatment and the opportunity for the centre to contact partners he had sexual encounters with.[210] In his defence in the English case, Rowe alleged that he 'believed he had cured his HIV by using urine therapy and other alternative therapies that he had researched online.'[211]

Little information is available regarding Rowe's conduct in Scotland. By January 2016, however, Sussex police received information regarding him from Scottish police concerning allegations of intentional transmission.[212] In the winter of 2015, Rowe met LR—one of the complainants in England—on a dating app.[213] LR made it clear in his messages that

---

[206] The sentencing statement for the Scottish case spelled it 'Darryl' as well.
[207] Harvey Day, 'Why Did Daryll Rowe Use HIV as a Weapon?' (*BBC News*, 15 March 2019) <www.bbc.co.uk/news/resources/idt-sh/Why_Did_Daryll_Rowe_Use_HIV_As_A_Weapon> accessed 2 August 2022.
[208] *Rowe* (n 18) [4].
[209] ibid.
[210] ibid.
[211] ibid [30].
[212] ibid [6].
[213] Day (n 207).

he would only agree to protected sex, and Rowe agreed.[214] Although Rowe was reluctant to wear a condom when the two actually met, LR claimed he witnessed him putting it on.[215] After the encounter, LR stated that Rowe sent him menacing messages and ultimately told him over the phone: 'You can't get rid of me. You're gonna burn. I ripped the condom. You're stupid. I got you.'[216] Shortly after that, LR tested positive for HIV and informed the police about Rowe. The police had, by that point, received one prior complaint regarding Rowe from an individual identified as AV. AV stated that he believed he contracted HIV from him in spite of previously trusting that Rowe had used a condom.[217]

In February 2016 police arrested Rowe and, during his interview, Rowe denied both being HIV-positive and knowing the complainants.[218] Around that time a health centre, whom Rowe had contacted for advice, informed him that his viral load was extremely high.[219] The health centre gave Rowe medication and informed him that not taking the medication properly could actually increase his infectiousness.[220]

Meanwhile, further complainants came forward. LA met Rowe in November 2015 and engaged in unprotected sex with him after Rowe claimed to have tested HIV-negative.[221] Rowe later texted LA: 'You may have the fever because I comed [sic] inside you and I have HIV. LOL. Whoops.' [222] He later stated that he was actually HIV-negative, however LA received an HIV-positive diagnosis in January 2016.[223] Three other complainants, JN, BR, and AB likewise engaged in unprotected anal sex with Rowe and tested positive in early 2016.[224]

Yet another complainant, DM, engaged in unprotected anal sex with Rowe in January 2016 and tested positive for two strands of HIV (which indicated he had been infected by at least one other person who was not Rowe).[225] Consequently, the Crown only charged Rowe with attempting to cause grievous bodily harm with intent in contrivance of OAPA section 18

---

[214] ibid.
[215] ibid.
[216] ibid.
[217] *Rowe* (n 18) [6]-[8]. AV stated that he had not had penetrative sex with anyone other than Rowe since his last negative HIV test. ibid [7].
[218] ibid [9].
[219] ibid [10].
[220] ibid.
[221] ibid [13].
[222] ibid.
[223] ibid.
[224] ibid [14]-[16].
[225] ibid [17].

for this count.[226] The Crown brought another attempt count regarding JA, a complainant who met Rowe in 2016 through Grindr.[227] Rowe brought and used a condom for sex, however it was later revealed that the top part of the condom was missing.[228] Rowe subsequently messaged JA and stated he was 'riddled' with STIs and had ejaculated inside him.[229] JA received PEP and ultimately tested negative for HIV.[230]

After being interviewed twice more, the police released Rowe to his parents on bail.[231] Shortly after, however, he fled. During the search for him, Scottish police found a tent containing his belongings, including several bottles of old, apparently unused HIV medication.[232] By November 2016, police in both Scotland and England were searching for Rowe; the media speculated that at least 22 men had spoken to the police about him.[233] Rowe made his way to Newcastle, adopted the name 'Gary Cole,' and lived with two different men with whom he engaged in sexual acts with but did not transmit HIV to: TA and GH.[234] In both cases Rowe failed to disclose his HIV status and was later charged with attempting to cause grievous bodily harm contrary to section 18 of the OAPA.[235] Notably, TA gave the police a bag of Rowe's belongings which contained condoms that, although apparently unused at first glance, had actually had their tips removed.[236] In November 2017 Rowe was convicted at the Lewes Crown Court of five counts of grievous bodily harm with intent in contrivance of OAPA section 18 and five counts of attempting to do so.[237] In April 2017, the trial judge sentenced Rowe to life imprisonment.[238]

Less information is available regarding the complainers in the Scottish prosecution. What is known is that he faced 10 charges—four counts of rape and six counts of culpable and reckless conduct—in connection to events which occurred in Edinburgh in 2015.[239] The prosecution levied rape charges on the grounds that the consent the complainers provided to

---

[226] ibid [18].
[227] ibid.
[228] ibid.
[229] ibid.
[230] ibid.
[231] Day (n 206).
[232] ibid.
[233] ibid.
[234] *Rowe* (n 18) [19].
[235] ibid.
[236] Day (n 207).
[237] *Rowe* (n 18) [1].
[238] ibid [2].
[239] Patrick Strudwick, 'Man Charged with Rape and Possible Transmission of HIV to Men in Edinburgh' (*BuzzFeed News*, 25 February 2016) <www.buzzfeednews.com/article/patrickstrudwick/man-charged-with-rape-and-possible-transmission-of-hiv> accessed 8 November 2022.

Rowe was predicated on the condition that he used a condom, which he did not.[240] Consequently, prosecutors alleged that this amounted to sexual intercourse by deception, and therefore rape under section 1 of the Sexual Offences (Scotland) Act 2009.[241] The prosecutors also brought culpable and reckless conduct charges in connection to him exposing others to the risk of HIV without disclosing his status on six occasions with five individuals.[242] In May 2018 Rowe pleaded guilty to culpable and reckless conduct for infecting one man and three counts of exposing others to the risk of infection.[243] The court sentenced Rowe to eight years imprisonment, and confirmed that he would be a lifelong registered sex offender due to the 'significant sexual aspect' of the case.[244]

B. Expert Evidence

The evidence regarding Rowe being the source of transmission in the English case focused strongly on phylogenetic analysis.[245] While both the prosecution and defence consulted expert witnesses, only the prosecution's expert gave evidence in court.[246] The main scientific evidence relied on involved the strain of HIV involved. In this case, all the infected complainants had HIV-1 as opposed to HIV-2, and the virus was the most common sub-group for all of them, sub-group M.[247] Within sub-group M are nine further sub-types, and all of the infected complaints had the same sub-type (sub-type B).[248] In the appellate decision, no further information is given on the likelihood of each of the complainants possessing the same strain, sub-group, and sub-type, although phylogenetic analysis showed the strains to be closely related.[249]

The defence on appeal contested the use of phylogenetic analysis in that case, not only addressing the fact that it can only show similarity in strains, but also questioning the use of phylogenetic science broadly in criminal transmission cases.[250] This argument, along with many of the arguments brought forth by the defence, connected less with the facts of the

---

[240] ibid.
[241] ibid. Specifically, 13(2)(d) of the Act states that there is not free agreement to a sex act 'where B agrees or submits to the conduct because B is mistaken, as a result of deception by A, as to the nature or purpose of the conduct.'
[242] Strudwick (n 239)
[243] BBC, 'Daryll Rowe Admitted Infecting Men with HIV in Edinburgh' (n 20).
[244] ibid.
[245] *Rowe* (n 18) [27],
[246] ibid [21].
[247] ibid [23].
[248] ibid.
[249] ibid.
[250] ibid [38].

case itself and more generally with concerns many have over HIV criminalisation laws in general. Consequently, *Rowe* provides a rare opportunity to see how a court responded to many of those concerns.

The defence's arguments regarding phylogenetic analysis were, as the court stated, 'doomed to fail.'[251] The arguments raised were not brought up at trial and were unlikely to succeed for that reason alone.[252] Regardless, the opinion of the Court of Appeal clearly sets out the role phylogenetic evidence plays in criminalisation cases—namely, it is potentially admissible if it is presented to the jury along with the descriptions of its limitations (e.g. not proving direction, not 100% certain, etc).[253] From there, it is up to the jury to determine the weight such evidence should hold regarding causation.[254]

The scientific evidence likewise interplayed with another significant aspect of the case: namely, the proof of intent. English law requires that intention is shown either by: (a) demonstrating that it was the defendant's purpose (here, to infect), or (b) inferring from the facts that the result in question was a substantial risk 'virtually certain to occur.'[255] On appeal, the defence asserted that the evidence could not show this 'virtual certainty,' since Rowe himself allegedly believed the risk to be negligible.[256] The text messages and damaged condoms, the defence asserted, only evidenced a desire for unprotected sex.[257]

Based on the scientific and other evidence in the case, the court asserted that a jury could infer that there was a 'high risk' involved with unprotected sex, and that Rowe could not have seen the risk as negligible.[258] If knowledge of a high risk is enough to meet the standard for intention, then the scope of intentional cases could grow vastly. Instead of delving more into this, the judgment switched from the 'virtually certain' prong to the 'purposive' prong and asserted that Rowe had the intention to infect.[259] The court stated: '[T]he applicant's words and deeds indicated his clear intention. He has provided no credible explanation for his cutting the tops of the condoms other than that he intended to spread the

[251] ibid [60].
[252] ibid.
[253] ibid [61].
[254] ibid.
[255] *R v Woolin* [1999] AC 82, 95-6.
[256] *Rowe* (n 18) [39].
[257] ibid [40].
[258] ibid [57].
[259] ibid.

virus. He lied to his partners about his HIV status and taunted some with the fact he had infected them.'[260]

While the texts and tampered condoms seem the most obviously damning evidence of intent, the court relied on one other piece of evidence as well: Rowe's failure to take medication. The defence counsel asserted that the summing-up's focus on the sex acts overlooked the actual *actus reus* of the case: the transmission of HIV.[261] The defence argued that a person could not be in control of transmission; instead, they could only be in control of the acts they engage in and the accompanying risks.[262] 'Risk and possible foresight' should not, the defence asserted, be equated with intention.[263] While it is incontrovertible that during the relevant period of time the defendant was not on a consistent medication regiment, Rowe alleged that he relied upon alternative therapies which he believed cured him.[264]

This judgment failed to address this argument in detail. It found that Rowe 'could have asserted control over the virus, for example, by taking the medication regularly, by using undamaged condoms and by disclosing his status to his partners so that they could decide whether to take the risk and whether to take the medication if exposed to the risk.'[265] While true that an individual has a degree of control over the virus, that degree can never be complete.[266] Factors such as medication can certainly significantly mitigate the risk, however no specific form of protection is 100%.

Notably, the logic the judgment provided regarding the *actus reus* could equally apply to cases of reckless transmission. If failing to take medication or use other prophylaxes is evidence of intention (by virtue of it posing a substantial risk), then the line between section 18 and section 20 OAPA violations is substantially blurred.

In the end, the court's discussion of this aspect of the case is curious in light of the fact that, in the judgment itself, it referred to this line of logic as being more or less irrelevant to the case at hand. The court stated:

> With respect to [Rowe's counsel], her submissions on the issue of intent also failed to acknowledge the Crown's case or the strength of it. The Crown nailed their colours to the mast of alleging the applicant had embarked on a deliberate campaign to infect men with HIV. They did not assert that he engaged in risky behaviour and therefore

[260] ibid.
[261] ibid [41].
[262] ibid.
[263] ibid.
[264] ibid [60]
[265] ibid [58].
[266] ibid [53].

must have had the intent. They alleged he had the intent. Nor did the Crown contend that the jury could infer intention from the fact that transmission of the virus was a certain or virtually certain consequence. [267]

Consequently, the court rejected the defence's argument.

C. HIV Criminalisation

On appeal, Rowe's counsel made a variety of arguments in favour of her client, including several addressing the role of the criminal law in transmission cases more broadly. Her arguments included international guidelines which discourage the criminalisation of HIV transmission/exposure generally, and additionally questioned if HIV should rise to the level of seriousness required for grievous bodily harm.[268]

1. HIV Criminalisation Generally

In response to the controversy surrounding laws criminalising HIV transmission or exposure, the court threw its support behind the CPS guidelines.[269] Parties previously raised the guidelines in section 20 cases,[270] with the response generally being that any failure on the part of the prosecution to obey the guidelines is irrelevant absent misconduct.[271] In *Rowe*, the appellate court saw the Crown's compliance with the guidelines as evidence that the system is more or less fair, and that the question of whether HIV transmission should be criminalised remained outside its jurisdiction.[272] While it is interesting to see a court's direct remarks on this point, it is unsurprising that the judge responded as they did.

2. HIV as Grievous Bodily Harm

The other more general argument advanced by the defence was the notion that HIV is serious, but not at the level of GBH.[273] The defence's point rested largely on the Irish civil case of *Child and Family Agency v AA*.[274] In *AA,* the court had to decide whether a doctor could break confidentiality and disclose a patient's HIV status to a person the doctor believed

---

[267] ibid [61]
[268] ibid [33]-[37].
[269] ibid [50].
[270] See, eg, *Golding* (n 17) [14].
[271] ibid [54]: 'The task of the Crown Court, and this court if the matter goes to appeal, is to deal with the case on the merits. If the failure to adhere to policy guidance means that there is an insufficiency of evidence, then the remedy is in the court's hands.'
[272] 'Accordingly, we are satisfied our law, principles and policy are clear and fair, fair to the alleged perpetrator and fair to the victim. Even if we had the jurisdiction, therefore, we would decline Ms Gerry's invitation to review the law and policy of England and Wales in this area and we see no reason to question the CPS' charging policy.' *Rowe* (n 18) [53].
[273] ibid [47].
[274] ibid [48] citing [2018] IEHC 112.

the patient was having unprotected sex with.[275] The balancing test in that case was whether 'the failure to breach patient confidentiality creates a significant risk of death or very serious harm to an innocent third party.'[276] The court in *AA* concluded that there was not sufficient evidence of any sex acts with the third party in question, but that even if that were not the case (and unprotected sex was occurring), that HIV 'although a significant condition, is no longer a terminal condition, but rather a chronic and lifelong condition that can be managed. Accordingly, it is not a 'very serious harm' to justify a breach of patient confidentiality.'[277]

The defence argued, in light of *AA*, that HIV was not GBH.[278] The appellate court, however, was entirely unconvinced by that argument, stating that it derived 'no assistance from [*AA*] at all.'[279] The court found that the differences in the nature of the underlying issues (criminal culpability versus a patient's right to confidentiality) rendered *AA* totally irrelevant to *Rowe*.[280] It further noted that previous cases (going back to *Dica*) confirmed the status of HIV infection as GBH.[281]

The court's discussion of the harm posed by HIV is disappointing and seemed to miss the major points brought up by the defence. This aspect of *Rowe* will be discussed further in Chapter 5.

D. Attempted Intentional Transmission

Half of the counts the Crown charged Rowe with were attempting to cause GBH with intent. The attempt counts included:

1. JN – Rowe allegedly told JN he was 'clean' and had unprotected anal sex with him twice.[282] While JN tested positive for HIV the evidence could not show that Rowe was definitively the source of the virus.[283]

---

[275] *AA* (n 274) [1].
[276] ibid [4].
[277] ibid [6].
[278] *Rowe* (n 18) [47].
[279] ibid [67].
[280] ibid.
[281] ibid.
[282] ibid [14].
[283] ibid. The specifics of this are not clear in the judgment. It appears that JN testified that he had protected sex with all but two of his partners. ibid [14]. The court said: 'Expert evidence revealed the applicant may not have been the source of the virus.' ibid. This probably means that the other person whom JN engaged in unprotected sex with was either of the same subtype as Rowe, or could not be located. Ultimately, it is unclear why the experts determined Rowe might not be the source of JN's HIV.

2. DM – Similarly to JN, Rowe and DM had unprotected sex after Rowe claimed to be HIV-negative.[284] DM tested positive with two strains of HIV—only one of which was a strain similar to Rowe's.[285]

3. JA – Rowe provided a condom, however the condom was apparently tampered with. JA obtained PEP treatment and tested negative for HIV.[286]

4. GH – Lived briefly with Rowe, unclear as to whether or not the sex acts were protected and GH's status.[287]

5. TA – Also lived briefly with Rowe, sex acts likewise unclear as to whether or not they were protected.[288] Ultimately tested negative for HIV.[289]

Out of these five cases, only that of JA demonstrated direct intent, since Rowe apparently sabotaged the condom and taunted JA later via text.[290] The rest, however, fall into the type of conduct which, in other cases,[291] is consistent with recklessness where transmission occurred. In those cases, while the respective defendants misrepresented their HIV status, they were charged with reckless and not intentional transmission.[292] With JA, the evidence of Rowe tampering with the condoms (and later taunting JA) show an intent not just to engage in unprotected sex, but specifically sex which the protection used was designed to fail in a way which would render HIV more likely to be transmitted. The other four cases, with the evidence provided, only show a desire for unprotected sex in spite of the risks of transmission. Even so, the prosecutors alleged that Rowe had the requisite intent and were able to prove such during the trial.[293]

VI. Conclusion

This thesis aims to assess if the criminal laws regarding HIV transmission are being predicated on accurate and up to date science. In furtherance of this, this chapter aimed to lay

---

[284] ibid [17].
[285] ibid.
[286] ibid [18].
[287] ibid [19].
[288] ibid.
[289] Day (n 207).
[290] *Rowe* (n 18) [18].
[291] See, eg, *Konzani* (n 12); *Dica* (n 2).
[292] ibid.
[293] The facts of *Rowe* also indicate the practice of 'stealthing', or secretly removing a condom before or during a sex act without the consent or knowledge of the other party. *Assange v Sweden* [2011] EWHC 2849 (Admin) confirmed that such an act could potentially implicate the Sexual Offences Act 2003 section 74. Consequently, prosecutors potentially could have chosen to pursue sexual assault charges as well. It should be again noted that the court in *R v B* (n 149) concluded that failing to reveal one's HIV status prior to sexual contact does not vitiate consent.

the foundation by addressing what the relevant science and law actually are. While the science of HIV is far too broad of a subject to fully delve into, this chapter began by giving a general overview of the history of HIV and some of the relevant modern advancements which will colour the discussion going forward. The first major case concerning disease transmission, *R v Clarence*, set the stage in highlighting what would continue to be some of the major questions concerning the criminalisation of STI transmission. This is particularly true regarding questions of consent, causation, harm, recklessness, and how all of this balances with the notion of fairness and personal autonomy. All of this came to a head once again over a century later in *Dica*. *Dica* found that decisions subsequent to *Clarence* established that there could be a delay between the act and the harm, and that a harm no longer needed to be physical in nature to meet the definition found in the law.[294] *Konzani* – heard shortly after *Dica*—upheld the findings in *Dica* and clarified the role of consent as a defence in cases of reckless transmission cases.

Combined, *Marangwanda* and *Golding* weakened the safeguards that the CPS guidelines were supposed to impose in order to ensure individuals were not falsely accused of recklessly transmitting a disease. The court missed the opportunity in both cases to clarify what infections rise to the level of GBH required by Section 20 of the OAPA, and allowed for a low evidentiary standard regarding both causation and the knowledge prong of recklessness. To whatever extent the Crown designed the guidelines to assure the community that people would only be charged with reckless transmission in exceptional cases with solid evidence, *Golding* and *Marangwanda* undermined that. Instead the two cases demonstrated that—at least in cases involving a plea—the guidelines may not be as impactful as some hoped. Both cases likewise indicate that the OAPA's encompassment of diseases is limited to STIs specifically, further marginalizing those living with such infections.

The case of *Rowe* is significant for being the first of its kind to implicate intentional transmission. While it addressed some significant concerns regarding the evidence necessary to show transmission, it did not delve deeply into the broader question as to whether or not HIV should still rise to the level of GBH in light of modern medical advancements. Although the case will likely remain exceptional in light of the underlying facts, the possible legal implications may be immense.

---

[294] *Dica* (n 2) [26].

While this chapter provides a basic overview of the law as it concerns HIV transmissions or exposure cases, it is not the whole story. How do courts respond to evidence concerning HIV? What sort of instructions do judges provide to juries in transmission or exposure cases? How are the harms or risks of HIV actually being framed? The next chapter builds upon this one by examining a selection of transcripts from cases concerning HIV transmission and exposure.

Chapter 3. Transcript Review: Looking Beyond the Reported Judgements

I. Introduction

With few exceptions, the details of cases involving HIV transmission or exposure are rarely reported. While the media will publish information about some of the cases, this information is often sensationalised and lacking in nuance. Few cases regarding this area of law are formally reported, and the material that is available will often gloss over the details of prior hearings and submissions. Fortunately, the National AIDS Trust in London possessed a selection of transcripts. While transcripts were not available for every potentially relevant case nor for every single transcribed hearing on those matters, a significant sample was able to be reviewed. They include an array of case-related transcripts, including summings up, evidentiary hearings, and other matters. This chapter discusses the relevant segments of those transcripts in relation to the science of HIV as it relates to questions of diagnosis, transmission, risk of transmission, and harm. While the transcripts in question are not binding law because they are often from cases of first instance, they are useful for several reasons: first, they provide a glimpse into the cases that did not result in reported judgments. Consequently, this means that there is a greater number of examples to draw from, including those from Scotland. Second, they show how judges and lawyers actually frame the evidence, both in hearings and in addressing the jury.

As of the date of writing there are only three HIV-transmission cases with substantive reported judgments: *R v Dica*,[1] *R v Konzani*,[2] and the intentional transmission case of *R v Rowe*.[3] Since this a limited selection of cases, opening the analysis to include transcripts of unreported cases allows for a greater number of data points to draw upon. The second utility of this transcript analysis is to see in greater detail how medical evidence is presented in court and how judges respond to such evidence. Was the information presented accurate according to either medical evidence at the time or modern understandings? What evidence was influential, particularly regarding questions of harm, risk, and transmission? With the limited exception of *Rowe* such points were not major issues in the reported judgments. Finally, an assessment of the relevant transcripts allows for greater visibility surrounding the narrative of these cases as they were taking shape. Since this sort of narrative could be influential both on

[1] [2004] EWCA Crim 1103; [2004] QB 1257 (CA (Crim Div)).
[2] [2005] EWCA Crim 706; [2005] 2 Cr App R 14 (CA (Crim Div)).
[3] [2018] EWCA Crim 2688; [2019] 1 Cr App R (S) 38.

rulings and a jury's assessment of the facts, seeing exactly how trial courts approach HIV highlight aspects of the case not available through reported judgments.

This chapter will begin by detailing the methodology for how the transcripts were obtained. Following that, this chapter will discuss some of the early cases. Although *Dica* and *Konzani* are the most well-known HIV-transmission related cases, a Scottish case—*HMA v Kelly*[4]—was the first such conviction in the UK. *Kelly* showed not only some of the early uses of phylogenetic analysis, it also highlighted another issue not addressed by any other cases: namely, questions regarding the ethics of using medical diagnoses obtained in confidence against a person. *Kelly* demonstrated some of the very early perceptions towards HIV criminalisation in Scotland and provided information on the Scottish law approach to the crime of culpable and reckless conduct. The transcripts for several of the hearings in *Dica*, one of the most notable cases, are further illuminating. The transcripts, which include those from the 2005 retrial hearings, address in greater detail the approaches taken towards questions regarding the medical basis for assessing both harm and the risk of harm.

This chapter will go on to discuss the transcripts in several of the later cases as well. Some of those cases addressed questions not relevant to any of the reported cases. In *R v Adaye*,[5] for instance, there was no evidence that the defendant actually received an HIV-positive diagnosis. Instead, the Crown prosecuted Adaye based on evidence that the defendant should have been aware that he was HIV-positive. *Adaye* demonstrated what evidence may suffice to establish that the defendant was reckless even without proof of diagnosis. In *R v Collins*,[6] meanwhile, the defence asserted a more critical approach to the limitations of phylogenetic analysis and thus secured the first acquittal in a HIV transmission case. Unlike the other reported recklessness cases, the related hearings delve in detail into the role of phylogenetic analysis as well as the necessity for having a significant degree of context for reviewing such evidence.

This chapter will discuss several different cases, some in great detail and some less so. This variation will be due to both the extent of available transcripts for any given case as well as the topical relevance of the scientific evidence in that case. There are two broad conclusions to be drawn from the analysis performed in this chapter: the first is that a common narrative is present in these cases. This narrative is focused on the betrayal of trust,

[4] [2001] ScotHC 7 (unreported).
[5] [2004] Liverpool County Court, Case No T20037703.
[6] [2006] The Crown Court at Kingston Upon Thames, Case No T2040664.

and frequently pits a 'pure' and 'innocent' complainant/complainer against a deceitful defendant. This narrative does appear to have an impact in the actual approach courts take to reckless HIV transmission cases. Where this 'pure' versus 'deceitful' narrative is subverted by the complainant themselves having an array of sexual partners, there appears to be a more critical approach to phylogenetic analysis and its limitations on showing directionality of transmission. When the more typical narrative is present, phylogenetic analysis, and thus proof of causation, appears to be more readily accepted.

It is submitted that this 'betrayal of trust' narrative can be derived from reading the relevant transcripts and the reported cases; the narrative is further highlighted when compared to civil cases (discussed in Chapter 6) where the modes of actual or possible transmission were not sexual in nature. Several transcripts, as discussed below, explicitly describe the defendant's actions as a form of betrayal and emphasise the emotional harm in summings up and sentencing—consequently, the language used by judges towards defendants can conflate the harm of HIV with the harm of a romantic betrayal. Later chapters will argue that this narrative increases the risk of certain cognitive biases which likewise may factor in the outcome of these cases. The second conclusion which this chapter draws is that there is a concerning lack of consistency with trial courts' approaches towards questions regarding the risks of transmission in particular and harm to a lesser degree. This lack of consistency towards *what* behaviour is sufficiently risky to meet the standard of recklessness and a resistance to reassessing the harm of HIV in light of modern HIV advancements creates a gap between the medical and legal realm.

II. Methodology

The transcripts analysed in this chapter were not publicly available and difficult to locate. That they existed in any reviewable state only came to light after an abstract entitled 'What do court transcripts reveal about judges' understanding of the medical impact of HIV infection and what are the implications for healthcare professionals giving advice to the court?' was located online.[7] The author, Dr Robert James, was contacted via e-mail[8] and confirmed in response that he authored the abstract for a poster presentation and compiled a

[7] Robert James, 'What Do Court Transcripts Reveal about Judges' Understanding of the Medical Impact of HIV Infection and What Are the Implications for Healthcare Professionals Giving Advice to the Court?' (2009) 10(S1) HIV Medicine 17 <https://onlinelibrary.wiley.com/toc/14681293/2009/10/s1> accessed 06 May 2025.
[8] E-mail from author to Dr Robert James (07 February 2019).

selection of transcripts for the National AIDS Trust ['NAT'].[9] His response further included a table of HIV transmission cases as an attachment. Dr James kindly recommended contacting NAT to request access to the transcripts.

A request to NAT was made[10] and the director of NAT, Dr Yusef Azad, confirmed via e-mail that they possessed a selection of transcripts, extracts, and other documents for 23 relevant cases.[11] NAT and Dr Azad graciously allowed the transcripts to be reviewed, and on 04 June 2019 the transcripts were accessed in NAT's office in London with permission. The transcripts were scanned electronically and reviewed at a later date.[12] The transcripts included a variety of documents, although most were summings up, charges to the jury, or hearings. Not all of the transcripts scanned are referenced in this chapter; many simply did not contain information relevant to this thesis. The arguments of this thesis, including the existence and influence of a 'betrayal of trust' narrative, were formulated through analysing the transcripts, the reported criminal and civil cases, and relevant literature. The selection of pertinent transcripts, discussed below, will be addressed chronologically.[13]

III. Early Cases

The earliest cases involving HIV transmission laid the legal groundwork for later prosecutions and provided noteworthy case law which still governs this area. Full discussions of these cases occur in other chapters of this thesis. This section will instead focus on the specific language used in hearing transcripts to analyse lesser-discussed aspects of these matters.

A. *HMA v Kelly*

While *Dica* and *Konzani* are the most commonly referenced cases involving reckless HIV transmission, *HMA v Kelly*, a Scottish case, actually pre-dated those cases by several years. Although it did not result in a reported judgment on the central issue of liability as in *Dica* and *Konzani*, and represented Scots law instead of English law, the charge to the jury revealed a similar legal approach. *Kelly,* in brief, involved a man living with HIV who engaged in sexual intercourse with a woman—['C']—and was found to have transmitted HIV

[9] E-mail from Dr Robert James to author (08 February 2019).
[10] E-mail from author to Dr Yusef Azad (01 March 2019).
[11] E-mail from Dr Yusef Azad to author (23 April 2019).
[12] Thirty-eight documents in total were scanned. Some cases included multiple transcripts or other documents.
[13] The documents frequently contained redactions regarding complainant or witness information. Although there were several instances where a redaction was seemingly mistakenly omitted, this chapter does not include any such information out of respect for NAT and the court system.

to her in 1994.[14] Kelly became HIV-positive in 1993 in Glenochil Prison due to sharing needles with fellow inmates for the purpose of injecting heroin.[15] Following his HIV diagnosis, Kelly received harm reduction counselling from a nurse.[16] After his release from prison, he entered a sexual relationship with C and did not inform her of his HIV status; furthermore, he specifically indicated that condoms were unnecessary for their relationship.[17] Controversially, the prosecution obtained evidence regarding Kelly's HIV status from a confidential clinical study that he had entered into.[18] The study, which examined HIV transmission between 1993 and 1995, anonymised the blood submissions received by attaching all blood samples to a patient codes.[19] The participants in the study agreed to do so under the premise that the samples would all remain anonymous.[20] The investigating police officers accessed the anonymous codes and used them to analyse Kelly's HIV strain and compare it to C's.[21] The comparison revealed similarities between the two HIV strains, and the High Court of Justiciary in Glasgow ultimately convicted Kelly of the offence of culpable and reckless conduct in 2001.[22]

1. Notable Aspects

In contrast to the English cases, prosecutors charged Kelly under the Scottish common law crime of 'culpable and reckless conduct.'[23] The charge to the jury clarifies that the offence is one which may or may not involve an injury, thus highlighting the possibility (which later occurred) of charges which could relate to exposure as opposed to actual transmission.[24] The jury charge highlighted several themes which appear to be common through virtually all of the relevant caselaw: treating HIV transmission as serious without detailing fully why, and a repeated focus on the violation of trust. In the *Kelly* jury charge, the other examples of culpable and reckless conduct included deliberate acts (e.g. selling glue

[14] *Kelly* (n 4) 23 Feb 2001 Long Charge to Jury 25.
[15] Damian Warburton, 'A Critical Review of English Law in Respect of Criminalising Blameworthy Behaviour by HIV+ Individuals' (2004) 68 The Journal of Criminal Law 55, 67.
[16] J Chalmers, "The Criminalisation of HIV Transmission" (2002) 28 J Med Ethics 160–163, 160.
[17] ibid.
[18] Kirsty Scott, 'HIV Man Jailed for Knowingly Infecting Lover' (*The Guardian*, 19 March 2001) <www.theguardian.com/society/2001/mar/19/publichealth> accessed 7 May 2025.
[19] Steve Connor, '"Anonymous" Research Data Used in Prosecution' (*Independent,* 25 August 2003) <www.independent.co.uk/news/uk/crime/anonymous-research-data-used-in-prosecution-101735.html> accessed 16 September 2024.
[20] Clare Dyer, 'Use of Confidential HIV Data Helps Convict Former Prisoner' (2001) 322 BMJ 322, 322.
[21] Chalmers (n 16) at 160.
[22] ibid.
[23] *Kelly* Long Charge (n 14) 25.
[24] ibid 15.

sniffing kits to children, contaminating bottles of tonic water and placing them on the shelf at supermarkets, killing someone by injecting them with heroin and other drugs).[25] The court did not appear to address at all the question of whether and to what extent HIV is considered a harm, telling the jury that: '[while] it would be open to you to hold that it constituted permanent impairment, [t]he terms, to the danger of her health and to the danger of her life, I think are self-explanatory.'[26]

The breach of trust is another very common theme in cases involving HIV transmission. In *Kelly*, unlike other cases, the violation of trust is not emphasised in the same way. The charge to the jury mentions at multiple times that the accused 'pretended to [C] that he was not infected with the virus,' sometimes using it in connection with her state of mind[27] and sometimes not.[28] While the complainer's state of mind is relevant in the case law set out in *Dica*, its use in *Kelly* is less clear—the court specifically mentioned that the consent of the victim 'is of no importance at all to the commission of the crime' regarding culpable and reckless conduct.[29]

Beyond the relevance of the defence of consent, much of the criminal elements required for culpable and reckless conduct are similar to those in *Dica* and *Konzani*, namely that an accused must: be HIV positive, be aware that HIV can be transmitted via sexual conduct, and that the accused engaged in sexual intercourse with that knowledge.[30]

2. Medical or Scientific Evidence

Kelly, as with many of the early cases, did not appear to rely on much scientific evidence based on the documents examined. The one exception to this concerned the blood evidence the Crown obtained. As discussed above, the prosecution obtained the blood samples from a laboratory which performed HIV and Hepatitis B and C tests in Glenochil Prison at the behest of the prison authorities over concerns regarding intravenous drug use.[31]

---

[25] ibid 26-7. In 2001 there was no relevant caselaw addressing whether there were circumstances where transmitting HIV could have a defence of consent or if it was entirely illegal. Regardless, the other examples given all related to acts which could impute other criminal laws.
[26] ibid 39.
[27] ibid 38.
[28] ibid 29.
[29] ibid 27.
[30] ibid 29. Here it mentioned that the complainer became HIV positive, but, as noted previously, the common law allows for exposure to be an offense as well.
[31] *Kelly* (n 4), Opinion of the Rt Hon. Lord Mackay of Drumadoon (20 February 2001) available at <www.scotcourts.gov.uk/search-judgments/judgment?id=034f87a6-8980-69d2-b500-ff0000d74aa7> accessed 12 May 2024.

The tests were voluntary and the medical workers 'stressed that the service was confidential' and separate from any prison-based authorities.[32] The prisoners were told that any results would be 'treated as confidential between the Ruchill team and the prisoner.'[33] Because the tests occurred in response to a potential public health crisis, confidentiality was a priority for the lab in order to ensure that prisoners would actually participate.[34] The witnesses for the lab and relevant social workers could not specifically recall what they stated to Kelly at the time of the first blood sample,[35] however there was evidence of a meeting with a counsellor during his second sample which again emphasised that the testing was only for HIV or Hepatitis and the submissions were anonymous.[36] When the Ruchill counselling team informed Kelly he was HIV-positive, he agreed to inform the prison medical authorities of his status.[37]

In the hearing on the admissibility of the blood evidence in 2001—which is available on the Scottish judicial website though not reported in the law reports—the counsel for the accused argued that it would unfair to admit the blood evidence due to the circumstances in which the samples were obtained[38] in addition to arguing that the samples should be barred on grounds of medical privilege[39] and the privilege against self-incrimination.[40] While the arguments regarding Kelly's assertion that the Crown's use of the blood evidence breached his medical confidentiality were straight-forward, the court re-asserted the position in Scottish law that '[a]ny bond of confidentiality between doctor and patient and patient does not permit the doctor to decline to give evidence that may incriminate his patient.'[41] The court was additionally influenced by Kelly's decision to share the results of the testing with the prison medical authorities, stating that once he shared that information, it became akin to any other medical information held by the prison's medical team.[42] The court issued a judgment on the issue of admissibility, ruling in favour of the Crown and finding the samples admissible.[43] Regarding the privilege against self-incrimination, Kelly's counsel argued that in 1993—when Kelly submitted his blood samples—the police did not have the power to

[32] ibid.
[33] ibid.
[34] ibid.
[35] ibid [8].
[36] ibid [9].
[37] ibid [11].
[38] ibid [5].
[39] ibid [17].
[40] ibid [15].
[41] ibid [16]
[42] ibid.
[43] ibid [17].

compel blood tests from the accused.[44] The court responded by relying on *Brown v Stott*[45] and noted that the privilege against self-incrimination does not come into play until after a crime was committed;[46] in that case, Kelly did not even meet the complainant until after the blood tests took place.[47] While the court in its judgment agreed that the means by which the Crown recovered the blood evidence was irregular, it determined on balance that the blood evidence was admissible.[48] The exact role of the blood evidence in the trial is not entirely clear, though most likely the Crown relied on it to prove that Kelly was HIV positive and had knowledge of his status when he engaged in sex acts with C. It was also potentially used to show a tie between his strain and C's via phylogenetic analysis. Even outside of that, however, C testified that she had not engaged in sexual activity with anyone other than Kelly since 1990 when she separated from her husband.[49]

Though not widespread, the court's ruling on the blood evidence drew some criticisms. Some worried that the fact that a prosecutor could access and use blood samples from a confidential and voluntary test might lead to a decrease in testing, and that even a small drop in testing could lead to a significant uptick in new infections.[50] The case law both at time and now remains unclear on whether someone who refused to test for HIV could be held criminally liable in Scotland, and the court's judgment undermined assurances that counsellors and medical professionals could give to potential clients regarding how confidential their results may be.[51] Additionally, since the court indicated that it was influenced by Kelly's decision to inform the prison medical authorities of his test results, prisoners in similar situations may opt not to do so even though that would mean not initiating ART and having a higher viral load (with an attendant heightened risk of transmissibility) as a result. It is unclear whether the defence raised these larger public health concerns regarding both prison populations and the general public, but they do not seem to be a significant factor in the court's judgment. The court clearly considered HIV to be a significant harm, describing C's transmission as one that caused her to become 'infected with

[44] ibid [15].
[45] 2001 SLT 59.
[46] *Kelly* Opinion (n 31) [17].
[47] ibid [15].
[48] ibid [17].
[49] Sheila Bird and Andrew Leigh Brown, 'Criminalisation of HIV Transmission: Implications for Public Health in Scotland' (2001) 323 BMJ 1174, 1174.
[50] ibid 1175.
[51] ibid 1176.

HIV to her permanent impairment,[52] to the danger of her health and to the danger of her life.'[53] On balance, the court likely ruled in favour of admitting the blood evidence because of the perceived gravity of the harm; ironically, the ruling risked causing a downturn in testing which could lead to a rise in infections. Fortunately, such a downturn did not take place.[54]

B. ***R v Dica***

Dica is the leading HIV transmission case in English law and is most notable for not only specifying the elements that implicate OAPA section 20, but also for clarifying the role that consent may pose as a defence. The trial court initially convicted Dica, however he won his appeal and a court heard the retrial in 2005 which allowed the defence to argue that the complainant consented to the risk of HIV.[55] The summing up in that subsequent trial, heard in 2005, applies the guidance of the 2004 appellate judgment.[56] This thesis discusses the reported decision in *Dica* in detail in several chapters; here, the focus will be on the unreported aspects of the case along with the 2005 retrial. As with *Kelly*, the question of the level of harm posed by HIV did not appear to be at issue in any of the relevant reviewed documents, and it was again taken for granted that the jury would agree that HIV amounts to serious harm. The judge in the 2005 retrial charged the jury that: 'I anticipate that you will have no difficulty coming to the conclusion that transmitting the HIV virus to someone amounts to inflicting serious bodily harm, for after all it is potentially life-threatening.'[57] Further emphasising the betrayal of trust which underlay the case, the judge commented at sentencing:

> 'I simply say now that you demonstrated a cynical disregard for the consequences of your acts, consequences which you really appreciated were likely to follow. It is not too dramatic to say that you have condemned your victim to the likelihood of an early death, knowing that [she] was the mother of two small children. As soon as you knew she was showing the signs of early illness, you disappeared from her life, leaving your fatal legacy behind. No doubt you hoped she would pass out of your life and you would hear no more about it. You simply left her to suffer. The degree of suffering,

---

[52] The 'permanent impairment' does not appear to relate to solely to HIV specifically, but rather from an attendant health concern. In the Charge to the Jury, the judge referenced evidence that C suffered arthritis which occurred in connection to her HIV diagnosis. Based on that, the prosecutor argued that it constituted a permanent impairment. *Kelly* Long Charge to Jury (n 14) 39.
[53] ibid 29.
[54] Aidsmap, 'No Decline in HIV Testing in Scotland Following Stephen Kelly Case' (*aidsmap.com*, 10 July 2002) <www.aidsmap.com/news/jul-2002/no-decline-hiv-testing-scotland-following-stephen-kelly-case> accessed 13 November 2024
[55] *Dica* (n 1) [47].
[56] *R v Dica* [2005] The Central Criminal Court, Case No T20047961, Summing-Up.
[57] ibid 5-6.

> both mental and physical, is obvious, not least from the appearance in the witness box here. What you have done is cruelty almost beyond description.'[58]

The 'betrayal of trust' narrative as used in this thesis can be seen in this statement. The harm identified was not just the equation of HIV with death, but also the harm of him abruptly leaving her. Whether or not he stayed with the complainant in a romantic relationship should have no bearing on sentencing or the analysis of the harm of HIV. Instead, the reference to him suddenly leaving her after discussing her status as a mother of young children paints a clear image of her as an innocent mother and him as a cold villain who transmitted HIV to a woman and abandoned her. In the context of sentencing, it conflates the physical harm of HIV with the emotional pain of being abandoned in a relationship. It appears additionally possible that this emotionally charged narrative affected the judge's assessment of recklessness as well. Shortly after the above statement, the judge noted: 'recklessness in the context of this case and in the context of this behaviour, in my judgment, carries with it a high degree of culpability'.[59]

The judge ultimately imposed an identical sentence to the one given at the first trial—four and a half years made consecutive to a sentence of three and a half years,[60] though they indicated that they believed 'the sentence passed for this offence is too short because of the consequences of what you have done are so devastating.'[61] While an assessment of the level of harm of HIV is discussed in the historical context at the time in Chapter 6, even in the context for HIV treatment at the time the judge's view of HIV appears harsh. Even though treatment was not as advanced in 2005 as it is today, there had been vast improvements by that point and medication and the life expectancy of people living with HIV had vastly improved.[62] In the end, it is unclear what information concerning the harm of HIV the parties presented. In 2005 several HIV-related organisations, including the National AIDS Trust, the Terrence Higgins Trust, and the George House Trust, submitted an application for leave to intervene. Although the results of the application are not clear, the leave was previously

---

[58] *R v Dica* [2005] The Central Criminal Court, Case No T20047961, Sentencing Remarks, 2.
[59] ibid.
[60] There were two sentences because there were two complaints and thus two counts of violating OAPA section 20.
[61] ibid
[62] See Janna Lawrence, 'A History of HIV Survival in the UK' (*The Pharmaceutical Journal*, 26 November 2015) <https://pharmaceutical-journal.com/article/infographics/a-history-of-hiv-survival-in-the-uk> accessed 16 September 2024.

granted in the 2004 case.[63] While the intervenors in their application focused on the defence of consent, they likewise addressed the decrease in AIDS-related deaths[64] and the role that early versus late detection plays in the lifespan of someone infected.[65] Although it is unclear what information the was specifically presented to the court in the 2005 jury trial, the judge's view of the harm of HIV was rather archaic even for the time.

1. Notable Aspects

As discussed above, *Dica* set out the foundation for much of the later cases. One interesting aspect of the second trial, however, is its discussion of recklessness. The 2005 summing up left open the possibility of an individual being found reckless when condoms were used. The trial judge noted that, while it was most likely that Dica transmitted HIV during an act of unprotected sex, there was a 10% chance (per the evidence at the trial) that it occurred during protected sex.[66] The judge stated:

> [Y]ou have to be sure that he was reckless when sexual intercourse was protected by a condom…In other words, you have to be sure before you can convict him that he was reckless at the time of every act of sexual intercourse whether or not it was protected because it is not possible to say for certain which act transferred the virus, if he transferred it.[67]

In this case, the fact that Dica used condoms some of the time weighed against him, since the prosecution suggested that the instances where he did so were only at the complainant's insistence and not because he wanted to take steps to prevent transmission.[68]

2. Medical or Scientific Evidence

The court in *Dica* relied on phylogenetic analysis. The medical experts discussed the subtypes of HIV between the parties, however the court seemed hesitant to emphasise it, noting:

> [Expert Evidence] is quite usual in a criminal trial…but you [must] see it as part of the evidence as a whole to assist you. In particular here, about when [the complainant] contracted the HIV virus and whether or not it was likely to have been from the defendant. That is what this evidence is aimed at, but you see it in conjunction with her evidence too.[69]

---

[63] *Dica* (n 1).
[64] *R v Dica* [2005] Cr App, Case No 2005 02161, Application for Leave to Intervene [8].
[65] ibid [11].
[66] *Dica* Summing Up (n 56) 7.
[67] ibid 7-8.
[68] ibid 8-9.
[69] ibid 16-17.

The judge likewise noted some of the limitations of phylogenetic analysis, including that it only can show consistencies (not certainties) and that it does not indicate the direction which the virus was transmitted.[70] Several experts testified, including a Professor Simmond who spoke of the role of phylogenetic analysis,[71] and Dr Lynn who spoke about seroconversion and how it is possible for the symptoms of seroconversion to re-appear if the affected individual stops taking their medication.[72]

The court likewise admitted evidence regarding the timing of seroconversion, again noting that it could not pinpoint a date exactly.[73] Dr Lynn provided an estimated seroconversion date for one of the complainants based on their medical records; that estimated date coincided with the time she engaged in sexual contact with Dica.[74] As with the discussion of recklessness, the court once again relied on expert testimony that condoms lowered the risk of infection by approximately 90%.[75] While the court acknowledged the expert testimony which stated transmission was unlikely to have occurred during the two instances of protected intercourse, its discussion on recklessness in instances of condom usage rendered it unclear how it would have approached the case had condoms been used consistently.[76]

C. Additional Cases Prior to 2006

The 2006 cases, and particularly the case of Matthew Collins, display a more in-depth analysis of the evidence of transmission. The remaining cases in 2004 through 2005, however, still present several interesting approaches which will be discussed below. With the exception of *Konzani*, none of the referenced cases involved reported decisions.

1. *R v Adaye*

The case of *Adaye*, unlike *Dica*, included charges unrelated to HIV, including bigamy and other offences.[77] Adaye moved to the UK in 1999 from South Africa (though he was born in the Ivory Coast) and applied for asylum.[78] The Home Office denied his initial request, and his solicitors filed an appeal.[79] He lived off an assumed French identity for a period of

[70] ibid 32.
[71] ibid 30-5.
[72] ibid 36.
[73] ibid 38.
[74] ibid 40-1.
[75] ibid 39.
[76] ibid.
[77] *Adaye* (n 5) 12 Jan 2004 Whole Hearing 2.
[78] ibid 4.
[79] ibid.

time, and collected approximately £12K in benefits through illegal means.[80] He engaged in sexual relationships with several women, and ultimately married a widow in England in spite of having a legal wife in South Africa.[81] He continued having multiple sexual partners even after his second, unlawful, marriage.[82] The second wife started having doubts about Adaye's identity, and in the process of investigating him received advice to undergo HIV testing, which came back positive.[83] In April 2003 she informed Adaye that she was HIV-positive; he had not been using prophylaxis with her or the other women he engaged in sexual conduct with.[84]

While the trial judge referred to 'medical evidence,'[85] it is unclear if that is a reference to phylogenetic analysis showing similarity in strains. More interesting in *Adaye* is the approach taken to knowledge. In *Adaye*, a doctor in South Africa told Adaye circa 1997/1998 that, due to his history with frequent STIs, that 'if he was not already HIV positive he soon would be because of the history she saw.'[86] More relevant still was the information Adaye received in April 2003 regarding his wife's HIV-positive status.[87] After receiving that information and learning that he was a potential carrier of HIV, he engaged in unprotected sex acts with another woman.[88]

In spite of this, there was no evidence that Adaye received a positive diagnosis himself during the relevant point of time.[89] Here, unlike other cases, the issue concerned whether or not the defendant was reckless even though he may not have been aware he was HIV-positive. On this point, the defence noted that 'at the time although he did not know that he was HIV positive, he was reckless as to whether he was or not.'[90] Consequently, *Adaye* raises the possibility of a conviction for reckless transmission when the facts suggest that the person should have been aware of their status, even if the evidence does not show they were in fact aware. Because Adaye pled guilty to both bigamy and inflicting grievous bodily harm

[80] ibid 5.
[81] ibid 7-8.
[82] ibid.
[83] ibid 9-10.
[84] ibid.
[85] *Adaye* (n 5) 9 Jan 2004 Whole Hearing 7.
[86] *Adaye* 12 January Hearing (n 78) 10.
[87] ibid.
[88] ibid.
[89] ibid 17.
[90] ibid.

contrary to OAPA section 20, how a trial court would approach this fact pattern without a plea remains unclear.[91]

2. *R v Konzani*

Many legal scholars read *Dica* and *Konzani* in tandem, since the latter attempts to apply the approach used in *Dica* regarding consent.[92] As with *Dica*, this section will focus on the unreported aspects of the case; the reported judgment in *Konzani* is discussed in detail in several other chapters. Notably, the trial judge's charge asked the jury to consider four things: First, whether Konzani infected the complainant with HIV.[93] Second, that 'doing so amounts to inflicting grievous bodily harm. That is really serious harm.'[94] 'Third, that he did so recklessly, that is to say that he knew he had [HIV] and not taking safe sex precautions realised he might pass it on.'[95] Finally, the judge asked the jury to determine whether or not the young woman willingly consented 'to the risk of suffering that infection…it is whether she consented to that risk, not consented to being given the disease.'[96] According to the summing up, the only question for the jury to consider was the last one regarding the defence of consent.[97] The first three issues were not in dispute.

The summing up attempted to address the connection between knowledge and consent, noting that while a complainant's knowledge of a defendant's infection would be strong evidence for demonstrating that she was willingly running the risk of infection, knowledge may still be separate from the question as to whether she consented to running the risk.[98] *Konzani* did show a more modern approach towards the use of condoms when considering recklessness than the 2005 trial court in *Dica*. Although both trials were heard around the same time, the court in *Dica* in 2005 specifically noted that a jury could still find that the defendant was reckless even if he used condoms;[99] the charge in *Konzani*, however, stated that engaging with safe sex precautions could preclude a finding of recklessness.[100]

---

[91] ibid 2.
[92] The *Dica* appeal judgment was issued on 5 May 2004, while the summing up in *Konzani* was on 6 May 2004. The *Konzani* summing up was consistent with the approach in *Dica*.
[93] *Konzani* (n 2) 6-14 May 2004 Summing-Up to Verdict Page 6.
[94] ibid.
[95] ibid.
[96] ibid 7.
[97] ibid 6.
[98] ibid 7.
[99] *Dica* Summing Up (n 56) 6-7.
[100] *Konzani* Summing Up (n 94) 6.

IV. Later Cases

The transcripts from cases in 2006 marked a turning point regarding the approach taken towards medical evidence. While *Dica*'s summing generally downplayed the role of phylogenetic analysis[101] and other medical testing, these later cases treated it as increasingly essential, particularly in terms of securing a guilty plea.

A. *R v Porter*[102]

Although not a case that focused heavily on medical evidence, *Porter* is worth mentioning because it is one of the few cases involving a female defendant and it had a strong narrative stance present both in the relevant court document and the media surrounding it.[103] Porter entered into a relationship with the complainant ['J'] in 2001.[104] She and J were together for approximately two years.[105] The two discussed STIs and she denied having any infection of that nature.[106] At sentencing, the court repeatedly focused on the breach of trust, specifically noting that J learned about Porter's serostatus from a friend rather than her, and that:

> [H]e was devastated that the person that he loved and respected, you, had lied to him time and time in words and by your actions. Taking one phrase [out of J's witness impact statement], he says, "Her cruelty and dishonesty made me feel so worthless." Even then, being the sort of person he clearly is, he was more sorry for you than he was for himself…He tried to ease it, the pain of knowing that he had this disease and had been infected by the one he loved, he tried to drown his feelings in alcohol and cocaine. He started to pull himself together and get some counselling. During the period after he learned what had happened, and after it had sunk into him, he says he was even– lost his control [sic], because he was still with you, and for the first time ever felt violence towards a partner.[107]

The only other harms mentioned in the sentencing transcript were the anxiety of going to the hospital for blood tests every three months for an unspecified period of time and that 'He does not know how long he has to live and does not particularly want to ask.'[108] By 2006 HIV was not a death sentence, and the transcript provided no evidence that this fear was remotely

---

[101] *Dica* Summing Up (n 49) 16-17.
[102] [2006] Inner London Crown Court ,T20060260 (unreported).
[103] See Hannah Azieb Pool, 'Porter's Real Crime: She Slept with Black Men' (*The Guardian*, 20 June 2006) <www.theguardian.com/world/2006/jun/21/aids.hannahpool> accessed 19 November 2024.
[104] Porter (n 103) Sentence 2.
[105] BBC, 'Woman Jailed for Giving Lover HIV' (*BBC News*, 19 June 2006) <http://news.bbc.co.uk/1/hi/5094708.stm> accessed 16 September 2024.
[106] *Porter* Sentence (n 105) 2.
[107] See, eg, ibid 3-4.
[108] ibid 4. It is unclear what the blood tests would have been for.

well-founded. The court additionally made a point of comparing Porter's conduct to J's actions in his later relationship.[109] The language the court used drew a clear distinction between Porter as the cold vixen and J as the innocent victim, going so far as to evidently remove any responsibility of J towards his own foray into drugs, alcohol, and feelings of violence towards women.

The significant focus of the sentencing hearing was not the harm of HIV nor Porter's recklessness, but her betrayal. The language used in the *Porter* transcript exemplifies the 'betrayal of trust' narrative and genuinely begs the question of whether the underlying harm was the transmission of HIV or the deceit—a feeling made even more potent since the defendant was a woman and the complainant a man. The court stated 'Of course, the remarks that J makes about your cruelty and dishonesty are, regrettably, feelings that the court and any members of the public must have as well.'[110] The court was correct, as the media's reaction towards Porter was particularly vicious,[111] often portraying her as a 'siren' luring men towards their physical and psychological ruin.[112] Porter pled guilty and the court sentenced her to 32 months' imprisonment.[113]

B. *R v Mark James*

While all the cases discussed to this point involved male/female transmission, Mark James was the first man convicted in the UK of transmitting HIV to another man.[114] Doctors diagnosed James with both HIV and syphilis in April 2004.[115] James lived with the complainant—his former partner—in Brentford during that time,[116] and continued to engage in unprotected sexual conduct with him after his diagnosis.[117] He may have told the complainant that he was diagnosed with syphilis initially, but later backtracked and told him

---

[109] ibid 4. 'Emotionally things have somewhat improved; has met a new partner. He, of course, has told her the position. She is understanding and loving and they are engaged to be married. One problem is that after marriage she is desperate for a family and there is obviously problems in that aspect of their marriage.' 4-5
[110] ibid 5.
[111] See Matthew Weait, *Intimacy and Responsibility* (Routledge 2007) 133-140.
[112] ibid 140.
[113] *Porter* Sentence (n 105) 7.
[114] Michael Carter, '40 Month Sentence in First Gay Case of Reckless HIV Transmission in England' (*aidsmap.com*, 4 August 2006) <www.aidsmap.com/news/aug-2006/40-month-sentence-first-gay-case-reckless-hiv-transmission-england> accessed 16 September 2024.
[115] Miles Godfrey, 'Search Widens for Man Who Gave Lover HIV' (*The Argus*, 25 September 2006) <www.theargus.co.uk/news/936455.search-widens-for-man-who-gave-lover-hiv/> accessed 16 September 2024.
[116] Paul Teed, 'Mark James due to Appear at Isleworth Crown Court for Sentencing' (*Richmond and Twickenham Times*, 12 February 2010) < www.richmondandtwickenhamtimes.co.uk/news/5004755.gay-man-passed-hiv-lover-arrested-three-years-run/> accessed 16 September 2024.
[117] ibid.

that the doctor diagnosed him with shingles; he allegedly never told his partner that he was HIV-positive.[118] The complainant was initially screened at his health check-up, but it is not clear if they specifically tested for HIV; regardless, he was told he was healthy and continued to have a sexual relationship with James.[119] The complainant only learned that he had contracted HIV when he became ill and went to be seen at a hospital several months later.[120] The Crown Court at Isleworth heard the matter in 2006, and the acquisition of medical evidence appeared key in securing a guilty plea .[121] The prosecution claimed that James was the complainant's only sexual partner and that there was 'very little dispute' as to the scientific and medical evidence relevant to the matter.[122] James ultimately pled guilty to the charges in April 2006,[123] though he later sought to change his plea to not guilty on the grounds of a lack of evidence; the judge refused to change his plea.[124] He failed to appear at his sentencing hearing in September of the same year,[125] and authorities believed that he spent the next several years hiding in France before he was forced to return to the UK for cancer treatment.[126] The court sentenced him to three years and four months for the reckless transmission and an additional ten months for fleeing the country while on bail.[127] A more nuanced approach towards expert evidence is addressed in *R v. Matthew Collins*, the first case to result in an acquittal.

C. *R v Matthew Collins*

In *Collins*, virological evidence played a major role. The defendant and the complainant ['C'], both frequented gay clubs in London and had common social scenes.[128] Collins likely became HIV positive in around 1999;[129] he and C began a sexual relationship in July 2004.[130] The only certainties regarding the timing of C's seroconversion was that it

---

[118] ibid.
[119] ibid.
[120] ibid.
[121] *R v Mark James* [2006] Crown Court at Isleworth, Case No T20050467, All Proceedings. The trial had initiated before James ultimate entered his guilty plea.
[122] ibid 14. The exact nature of the 'scientific and medical evidence' is unclear. In context, it likely relates the similarities between the viral strains, but it could also be in reference to the medical harm suffered by the complainant or another unaddressed factor.
[123] ibid 18.
[124] Weait (n 112) 32.
[125] Godfrey (n 116) 93.
[126] Ben Parsons, 'Brighton Man Who Intentionally Infected Partner with HIV Jailed' (*The Argus*, 18 February 2010) <www.theargus.co.uk/news/5013575.brighton-man-who-intentionally-infected-partner-with-hiv-jailed/> accessed 16 September 2024.
[127] ibid.
[128] *Collins* (n 6) 7 August 2006 Submissions at Close of Prosecution Case 13.
[129] ibid 12.
[130] ibid 14.

occurred at some point between a 1999 negative HIV test and a 2004 positive one.[131] In this case, the evidence of viral strains, phylogenetic trees of the relevant population, means of transmission, and other evidence related to seroconversion proved extremely important.

The defence counsel based their arguments heavily on the possibility that a third party could not be ruled out as a source of the infection.[132] While the relevant transcripts do not discuss transmission risks in detail, defence counsel argued that, while transmission from oral sex 'carries a medium to low risk,' the possibility still existed of that being a means of transmission.[133] The complainant in this case, per his medical notes, admitted to having at least one partner who he engaged in unprotected oral sexual intercourse with, and appeared to have persistently engaged in unprotected anal intercourse with at least one partner who was not Collins.[134] He additionally, per his medical notes, had approximately '24 partners between July and October 1999 and then another 20-odd between October 1999 and April 2004.'[135] Consequently, the defence counsel focused heavily on attempting to pinpoint the timing of C's seroconversion illness to a point prior to meeting Collins[136] as well as showing how other sources were not investigated and could not be ruled out.[137]

Seroconversion illness—the illness that a person may experience when first infected with HIV—can take many forms. Flu-like symptoms are common, as are sensations of lethargy—that said, some people may not experience seroconversion illness at all.[138] C experienced flu-like symptoms in September 2004 which may have been a symptom of seroconversion, but he did not seek medical assistance at the time.[139] He was also ill in March of that year[140]—an illness that at the time his doctors considered a medication-based reaction—and reported tiredness in March 2003.[141] All of those instances occurred prior to C entering into a sexual relationship with Collins and were possible indicators of seroconversion. The fact that none of the experts could pinpoint the timing of the

---

[131] *Collins* (n 6) 9 August 2006 Judge's Ruling at the End of Closing Speeches 3.
[132] *Collins* Submissions (n 129) 3.
[133] ibid 4.
[134] ibid.
[135] ibid 8.
[136] ibid 9-10.
[137] ibid 5.
[138] ibid 5-6.
[139] ibid.
[140] It is unclear if this March 2004 or 2005, the context suggests 2004.
[141] ibid 12.

seroconversion illness with certainty to a time after C and Collins met served as a starting point for the defence to show uncertainty in the Crown's case.

The prosecution's response, in addition to casting doubt on the credibility of one of the experts, focused on the testimony of C's own belief as to when he experienced seroconversion,[142] along with his CD-4 count. C's CD-4 count fell from 768 in May 2004 to 503 in February 2005;[143] this, the Crown asserted, was consistent with a more recent seroconversion. The defence countered by noting that CD-4 counts can remain high or constant for years and then experience drops of varying degrees.[144] With such uncertainty regarding the timing of seroconversion, phylogenetic analysis played a major role in the positions of both sides.

1. Phylogenetic Analysis

Phylogenetic analysis and comparisons of viral strains in this case were used by both the defence and prosecution. The evidence at the time focused on phylogenetic trees—scientific evidence which analysed the different strains of HIV found in specific areas at a set point in time.[145] By concluding that C's HIV strain fell on a different evolutionary line than some of his other partners, while likewise determining that his strain was similar to Collins's, the prosecution sought to narrow the potential pool of individuals who could have served as the source of C's infection while bolstering their claim against Collins.[146] The defence, however, countered this by noting that the phylogenetic analysis did not exclude someone else with a strain similar to Collins as the source, particularly since the defence asserted that the two individuals shared similar social circles.[147] Because if they moved in overlapping groups, it was possible that a third party outside of Collins and C's relationship was the source of both of their infections. Similarly, it was possible that, even if the complainant and defendant did not contract HIV from the same sexual partner, that they each became exposed to the virus from two different third parties who happened to have similar strains. Without a definite window of time establishing C's seroconversion, defence counsel argued that the number of partners who could not be ruled out as the source of C's HIV status numbered over 20, and thus cast doubt on Collins's role as the cause of C's infection.[148] Bolstering this claim

[142] ibid.
[143] ibid 18.
[144] ibid. 33
[145] ibid 6.
[146] *Collins* (n 6) 8 August 2006 Proceedings, 37.
[147] *Collins* Submissions (n 129) 7.
[148] ibid 9.

was the evidence of both expert witnesses who could not say with certainty that Collins infected C.[149]

The prosecution countered this by proffering evidence regarding 'genetic drift.'[150] Essentially, the prosecution noted that HIV evolves over time, and samples from Collins from 2003 and 2004 showed how his specific viral strain changed over the course of a year.[151] Genetic similarities existed between Collins's 2004 sample and C's strain; based on this, Crown argued that the window of seroconversion had to be limited to the time period C had relations with Collins and not prior.[152] Since Collins was infected with HIV in 2000, the Crown argued that if the same person who had infected Collins in 2000 had infected C in 2003 (or re-infected him in 2003), then C's strain should have shown evidence of evolutionary drift just as Collins's had.[153] Instead, C's strain showed no drift and was more similar to Collins's 2004 sample than his from 2003; because of this, the Crown argued that transmission had to be recent.[154] With regards to the fact that neither expert could definitively say, based on the phylogenetic analysis, that Collins infected C, the prosecutor noted: 'The experts are only experts in their particular fields...their evidence therefor may or may not be of value to the jury in looking at all of the evidence in the case. Neither of the experts listened to [C's] evidence, for example.'[155]

The defence counsel responded by arguing that there was not sufficient expert data to support the Crown's claims regarding genetic drift, and that 'one doesn't know, first of all, whether any drift occurs at all in every case.'[156] Additionally, the defence alleged that the Crown had not sufficiently investigated genetic drifts, nor inquired as to the timing, degree, and nature of Collins's drifts.[157] Consequently, the lack of investigation into genetic drifts and the existing science at the time could not, according to the defence, indicate anything about transmission.[158]

---

[149] ibid 10. The experts did, however, disagree as to the likelihoods. ibid
[150] *Collins* Proceedings (n 147) 37-8.
[151] ibid 38.
[152] ibid. This was a complicated argument that the Crown did not appear to fully flesh out.
[153] ibid.
[154] ibid.
[155] *Collins* Submissions (n 129) 19. The full name of the complainant was redacted in the transcript.
[156] ibid 30.
[157] ibid.
[158] ibid.

2. Underlying Narrative

While the phylogenetic trees could show a certain amount of correlation between strains, the Crown's case appeared weakened by what the judge referred to as a lack of fidelity[159]—referring to the amount of partners the relevant parties engaged in sexual acts with—as well as the lack of evidence regarding the HIV status of several other members of the pertinent social circle who may have served as the source of C's infection. Where, in other transmission cases, infidelity and frequently changing partners underscore a lack of trustworthiness which implicates the accused, here it was used against the complainant. Both the judge and the defence counsel highlighted not only the relatively high number of sexual partners C allegedly had, but also his own infidelity in another relationship.[160] While the number of partners, and particularly those who remained unidentified with unknown serostatuses, was certainly relevant to the defence's position, the case also lacked the same narrative of a 'betrayal of trust' that many of the other cases had. Whether or not it was because both parties changed partners relatively frequently or because, unlike many of the other notable cases, the case involved men who identified as homosexual, the judge's comments in this case do not reflect the same level of sympathy towards the complainant found in most to all the other cases. Indeed, in his closing arguments, the defence counsel stated that the case was novel, because: 'it is the first contested case to come before the courts involving homosexual infection in what is, I am sorry to say, a pretty promiscuous London society.'[161]

Additionally, the fact that the case relied heavily on scientific evidence and expert opinions sets *Collins* apart from other prior cases both generally and narratively. As stated repeatedly above, most of the other cases involved the Crown creating a narrative which focused heavily on the betrayal of trust, largely because the relevant medical evidence was uncontested based on the medical knowledge available at that time. This sort of narrative can draw a strong emotional response from jurors, many of whom possibly had similar experiences with betrayal. Because the defence focused heavily on the scientific evidence establishing causation, this further removed the narrative of betrayal and framed the case in a more cold and logical light. As such, it was likely easier for the judge (and the jury, had they come to a decision outside of the direction of the judge) to side with the defendant since the

[159] ibid 8.
[160] ibid 34.
[161] *Collins* Proceedings (n 147) 46.

medical evidence was not particularly strong for the prosecution. Consequently, this case stands out not only because of its heavy reliance on scientific evidence, but also in the ways it does not fit into the narrative described in the other cases.

The judge in this case ultimately directed the jury to acquit.[162] The judge based this on the 'live possibility' of another individual being the source of infection and the lack of clarity regarding the timing of seroconversion.[163]

3. Significance

This case remains the only known reckless transmission case involving a trial which resulted in an acquittal. While other cases certainly involved phylogenetic analysis and scientific evidence, this case showed how the same evidence could be argued to lead to different results. The complainant's belief about the timing of his seroconversion wound up being weighed against the expert evidence which cast doubt not on his subjective belief, but on the objective facts regarding the timing. The medical evidence and its use in this case is significant, but also must be considered in light of the fact that this matter represented a departure from the narratives of the prior cases in terms of both the genders of the respective parties and the fidelity of those involved.

D. *R v Michael Fielder*[164]

In the case of *R v Fielder*, as in *Collins*, the judge granted an application to dismiss the charges regarding OAPA section 20 due to a lack of evidence supporting the allegations that the defendant infected the complainant.[165] Unlike *Collins,* however, the allegations regarding transmission was one of three counts on which the Crown sought a conviction. The other two charges involved sexual acts with a fifteen-year-old.[166] The defendant ultimately pled guilty to buggery[167] and received a suspended sentence of six months.[168] The defendant was a 51-year-old man at the time the case was heard in 2007, and lived as a businessman in the Blackpool area with interests in several hotels and other properties.[169] He was diagnosed with HIV in January 2000.[170] He became friendly with the complainant— ['C']—through his

[162] *Collins* Judge's Ruling (n 132) 3.
[163] ibid 2-3.
[164] [2007] The Crown Court at Preston, Case No T 20060473 (unreported).
[165] *Fielder* (n 156) 14 Feb 2007 Rulings 4.
[166] *Fielder* (n 165) 30 March 2007 Proceedings 3.
[167] ibid.
[168] ibid 16.
[169] ibid.
[170] ibid 11.

mother who socialised at one of the hotels Fielder had a connection to in June 2000.[171] The hotel was known to be friendly to the gay community, and C began frequenting there and ultimately met Fielder in the bar area.[172] C admitted to Fielder that he was only 15 in their early interactions, and Fielder proceeded to give him alcohol.[173] The two ultimately went back to Fielder's room and the defendant engaged in penetrative anal sex with him—at first Fielder used a condom, but he removed it halfway through without C's knowledge.[174] Fielder offered him £500 for further sex acts, which C refused.[175]

After his relationship with the defendant, C engaged in sexual relationships with at least two other people – CB and OM—in 2000.[176] C tested positive for HIV in April 2001.[177] While the evidence ruled out OM as a source of C's infection, CB tested positive at approximately the same time as C, though he possibly tested negative in October or November 2000.[178] CB admitted in a medical examination to having repeatedly engaged in unprotected sex with a partner whom he knew to be HIV-positive over the course of six weeks and to having multiple other partners after his most recent prior HIV test.[179] As with *Collins*, the exact date of CB's seroconversion was not certain and doubt existed over the veracity of some of his statements. Ultimately, he could not be ruled out as the source of C's infection. While the comparison of Fielder's and C's strains showed similarities, the court accepted the possibility that another third party with a similar strain, or two third parties with similar strains, were the source of the similarities.[180]

Although the judge dismissed the charge relating to the HIV transmission, the case is notable for the court's troubling treatment of HIV as it related to the underlying charges which Fielder pled guilty to. The judge stated to the defendant:

> Knowing he was under sixteen, you had full sexual relations with him. I accept at once that you used a condom. You were HIV positive. I do not sentence you on the basis that you caused the victim to become HIV positive, but having sex, even protected sex, with a partner when HIV positive involves some risk so it is to some degree an aggravating factor.[181]

---

[171] ibid 16.
[172] ibid 4.
[173] ibid.
[174] ibid 11.
[175] ibid 4.
[176] *Fielder* Rulings (n 166) 3.
[177] ibid.
[178] ibid 4.
[179] ibid.
[180] ibid 3.
[181] ibid 15.

Most concerning is the judge's approach to HIV being an aggravating factor even in the event of condom use, which would significantly reduce the risk of transmission. While there is not enough case law on the issue of HIV being an aggravating factor regardless of condom usage, the inclination for a court to treat it as aggravating regardless of this is notable. Although Fielder was not found guilty of any offence related to HIV transmission, he pled guilty to committing an offence of buggery and received a six-month sentence suspended for two years.[182] The leniency in sentencing likely reflected the removal of the OAPA section 20 charge and the fact that Fielder was living as a partial quadriplegic in poor health at the time.[183]

E. *HMA v Giovanni Mola*

This Scottish case involved a conviction of culpable and reckless conduct regarding the transmission of both HIV and Hepatitis C.[184] Mola was an Italian national who claimed to have over 200 lovers and received the dual diagnoses in 2000.[185] He met the complainer in 2003 and began a sexual relationship with her without using prophylaxis.[186] He did not tell the complainer ['Miss X'] of either of his diagnoses and refused to wear a condom at her insistence.[187] At trial, Mola admitted to all but one charge and denied that he refused to wear a condom.[188] Miss X claimed to be a virgin prior to meeting Mola, and tested positive for both HIV and hepatitis C after their relationship ended.[189] After being arrested for culpable and reckless conduct, Mola fled to Italy before being extradited back to Scotland.[190] Although there was no reported judgment on the substantive aspects of *Mola*, there was one on an incidental issue. Lord Hodge—the trial judge—issued an order prohibiting the media from

---

[182] HIV Justice Network, 'UK: Michael Fielder Sentenced (UK Reckless Transmission Case Thrown out due to Lack of Evidence)' (*HIV Justice Network*, 14 July 2007) <www.hivjustice.net/cases/uk-michael-fielder-sentenced-uk-reckless-transmission-case-thrown-out-due-to-lack-of-evidence/> accessed 16 September 2024.
[183] ibid. A subsequent challenge to the sentence by the Attorney-General, arguing that it was unduly lenient, failed: *Attorney-General's Reference (No 51 of 2007)* [2007] EWCA Crim 1752.
[184] *R v Mola* [2007] HCJ 02 Sentencing Statement 2 available at <http://news.bbc.co.uk/1/shared/bsp/hi/pdfs/05_04_07_mola.pdf> accessed 22 November 2024.
[185] BBC, 'Man Jailed after Passing on HIV' (*BBC News,* 5 April 2007) <http://news.bbc.co.uk/1/hi/scotland/edinburgh_and_east/6528885.stm> accessed 16 September 2024.
[186] ibid
[187] *Mola* Sentencing Statement (n 185).
[188] Edwin Bernard, 'Scottish Sexual HIV/HCV Transmission Trial Ends with Guilty Verdict' (*aidsmap.com*, 7 February 2007) <www.aidsmap.com/news/feb-2007/scottish-sexual-hivhcv-transmission-trial-ends-guilty-verdict> accessed 16 September 2024.
[189] The Herald Staff, 'Italian Guilty of Passing HIV Virus onto Girlfriend' (*The Herald*, 8 February 2007) <www.heraldscotland.com/default_content/12757528.italian-guilty-passing-hiv-virus-onto-girlfriend/> accessed 16 September 2024.
[190] ibid.

reporting on the details of Miss X in the case, including her name, ethnicity, nationality, age, and employment.[191] A media organisation initially sought to challenge the order, but ultimately refrained from doing so.[192] Since concerns were raised to Lord Hodge about the scope and competency of the order, he issued an opinion on the topic.[193]

Aggravating factors in the substantive case included not only the transmission of two diseases, but also the complainer allegedly having been a virgin prior to her sexual encounters with the defendant.[194] In another example of the notion of the betrayal of trust coming into play in transmission cases, the judge noted that, as a virgin, Miss X had relied on the Mola's sexual experience and he abused that trust.[195] The court likewise considered the defendant's repeated refusal to wear a condom as aggravating as well, and acknowledged that they 'expose a partner to a relatively small risk of infection.'[196] While this case still left many questions open, including his culpability had he worn a condom, it remains a notable Scottish case defining the parameters of culpable and reckless conduct in cases of STIs. Similarly, it reflects a trend in Scotland of high sentences when compared to England and Wales—whereas most English sentences have been between one and four years, the court in *Mola* sentenced him to nine years.[197] Because the complainant was allegedly a virgin before she met Mola, and Mola himself claimed to be highly experienced with a multitude of partners, this case played very much into the repeatedly seen narrative in successful HIV transmission cases involving a betrayal of trust.

F. *R v Edmore Tobaiwa*[198]

In the 2008 case of *Tobaiwa*, the prosecution alleged that the defendant transmitted HIV to the complainant ['Ms Q'] in 2007. Tobaiwa was aware of his HIV-positive status in 2001, but only knew his status definitively through tests in the UK in September 2005.[199] In this case, Ms Q admitted to having a total of nine sexual partners in her life.[200] Of those nine,

---

[191] *HM Advocate v M* 2007 SLT 462 [1].
[192] ibid [2].
[193] ibid.
[194] *Mola* Sentencing Statement (n 175).
[195] ibid. 'There is also the fact that your victim, as she told you, had no previous sexual experience and relied on your judgment as a sexually experienced person. You abused her trust.'
[196] ibid.
[197] ibid. Stephen Kelly received a five-year sentence and Mark Deveraux (discussed below) received a ten-year sentence that was ultimately lowered on appeal to eight. Darryl Rowe, tried in both England and Scotland, received a life sentence from England and a sentence of eight years in Scotland.
[198] [2008] Crown Court at Manchester (Crown Square) Case No T077617.
[199] *Tobaiwa* (n 200) 11 February 2008 Ruling 1.
[200] ibid.

two were in Russia, one was her husband, two were unknown men with whom she said she had protected sex with; three were identified, and one was the defendant.[201] The relations she had with the last six men occurred during a time when she was married to her husband.[202] The three named individuals she had relations with in the United Kingdom tested negative for HIV, however there was no information as to the men in Russia nor the men she could not identify.[203] Additionally, the timing of the tests for two of the men who were tested may have been too early to definitively determine infection.[204] The defence relied upon the judgments and arguments used in *Fielder* and *Collins* to address the issues that concerned causation.[205]

Most notable in this case is the judge's consideration of the Code for Crown Prosecutors and a set of extrajudicial guidelines.[206] While the judge noted that they were not bound by it, the court appeared moved by the sections which stated 'that prosecutors should be alive to the need to exclude other possible forms or routes of infection' and engage in 'scientific analysis of the strain of HIV itself.'[207]

Although the judge acknowledged that phylogenetic analysis was not conclusive, the judge opined: 'But here we have not the slightest information as to the strains in question at all, coupled with the other possible but unlikely sources of infection, but not impossible sources of infection.'[208] Based on this, the court found that there was not enough evidence to convict and dismissed the indictment.[209]

Consequently, *Tobaiwa* not only demonstrated a court giving weight to the prosecution guidelines, it indicated that at least preliminary virological evidence may be necessary in order to indict. Narratively, *Tobaiwa* falls in line with the previous cases discussed. Like *Fielder* and *Collins*—which also involved a dismissal and directed acquittal respectively—the court in *Tobaiwa* likewise focused on the lack of definitive medical evidence ruling out other sources for the complainant's infection as the foundation for

---

[201] ibid.
[202] ibid.
[203] ibid 2.
[204] ibid 2-3.
[205] *Tobaiwa* (n 200) 5 January 2008 Skeleton Argument on Behalf of the Defendant in an Application to Dismiss [3].
[206] The court did not specify what document the 'guidance' in question referred to, but the language of the text appears to be some sort of academic or government-based recommendations for the use of phylogenetic analysis in cases involving HIV transmission. Other than indicating a paragraph from section 3.5 of the 'guidance' and noting that it was submitted on behalf of the defendant the court did not clarify what the 'guidance' in question was.
[207] *Tobaiwa* Ruling (n 201) 3.
[208] ibid 4.
[209] ibid 5.

dismissing the case. Unlike the other two cases, *Tobaiwa* involved a case of male/female transmission. Even so, the complainant in *Tobaiwa*—like those in *Fielder* and *Collins*—allegedly had sexual encounters with several other men.[210] When the fidelity of the complainant is not at issue the courts show a stronger focus on a narrative of a betrayal of trust that simply does not exist when the complainant likewise has a history of multiple sexual partners.

G. *R v Cawley*[211]

Another case circa 2007/2008, *Cawley*, is notable because, unlike the other referenced cases, the defendant acquired HIV due to a blood transfusion at 16.[212] Cawley met the complainant ['Ms C'] in 1993, and engaged in an on and off relationship with her for several years.[213] During that time he never informed her of his HIV status.[214] Between 1996 and 1999 the couple took a break from each other, and during that time Ms C engaged in an 18-month relationship with a male ['Mr X'].[215] In May 2000 a friend informed Ms C that Cawley was HIV-positive.[216] Cawley initially denied the accusation, but later admitted it with the reassurance that she could not have contracted it.[217] After becoming ill in August 2000, Ms C sought medical assistance who informed her she was HIV-positive.[218] Mr X, whom Ms C had sexual relations with, ultimately tested positive in 2005.[219] Cawley maintained that he always wore a condom during sex, however he may have admitted to unprotected sex with Ms C in the course of the proceedings or alongside his plea.[220]

The Crown presented evidence (the exact nature of which remained unclear in the examined transcript) which it argued demonstrated that Ms C contracted HIV from Cawley,

---

[210] To a lesser degree in *Fielder* since the complainant was a teen and allegedly had only two other sexual partners

[211] [2008] The Crown Court at Preston, Case No T20070539.

[212] *Cawley* (n 213) 21 November 2008 Proceedings 5.

[213] ibid.

[214] ibid.

[215] ibid.

[216] ibid 6.

[217] ibid.

[218] ibid.

[219] ibid 5.

[220] ibid. 'At first, it's right to say that they used a condom, but as the relationship developed, they regularly had unprotected sex, and I should note that within the pre-sentence report the defendant himself suggests that they only had protected sex, and it must have been because of a faulty condom. That is specifically rejected by the Crown. The Crown say, and have done from the outset, that after an initial period of protected sex, they engaged in unprotected sex throughout.' ibid. It appears he later may have admitted to engaging in unprotected sex with her alongside his plea, but it is unclear. The court stated: 'To start with, those sexual relations were with a protective condom, but thereafter, as you now accept, without; so you had sexual intercourse on a regular basis without protection.' ibid 22.

and then passed it on to her boyfriend, Mr X.[221] Due to the break in the chain of causation, the prosecution ultimately declined to charge the defendant with Mr X's transmission;[222] the Crown did, however, allege it to be an aggravating feature.

Cawley ultimately pled guilty, and during his sentencing, the judge specifically noted how he acquired HIV, stating:

> Well the first and most obvious deduction that I have to make is that you started off as a victim. You are and were a haemophiliac, and that is not of your own making, and you are HIV positive, and that is not of your making either and it is a tragedy that I have to be sentencing you at all because there is no correct answer in a case like this.[223]

The phrasing of this supports another narrative aspect underlying HIV generally, namely that there is an 'innocent' way to contract HIV (e.g. through a blood transmission) and a 'guilty' one (e.g. through sex acts or needle sharing). As noted above, the judge considered Mr X's seroconversion an aggravating factor, and sentenced Cawley to twelve months' imprisonment.

Cawley suggests that a defendant is only liable towards people the defendant directly passed HIV to, and not to individuals who may have been infected further down the line. The means by which an individual acquired HIV and the existence of people who were later infected may, however, play a role in sentencing.

H. *HMA v Mark Richard Deveraux*[224]

Another Scottish case, *Deveraux* represents the first instance where a court sentenced an individual for exposing a person to HIV even though transmission did not occur. The case involved four separate complainers, all women. While one of the women ['Ms A'] alleged she contracted HIV from Deveraux, the other three did not and only alleged exposure.[225] Deveraux received his HIV diagnosis in 1994, though he may have been infected as early as 1992.[226] Deveraux and Ms A began a relationship in 2003, and in 2008 she came upon a letter indicating that Deveraux was HIV-positive.[227] Subsequent medical tests revealed not only that she too contracted the virus, but also that she was pregnant.[228] In light of the HIV

---

[221] ibid.
[222] ibid 6.
[223] ibid 24.
[224] [2010] Edinburgh High Court, Case No 38/10.
[225] *Devereaux* (n 226) 19 Jan 2010 All Proceedings 3.
[226] ibid 4.
[227] ibid 5.
[228] ibid.

diagnosis, she terminated the pregnancy.[229] Ms A filed a complaint with the police, who in turn interviewed Deveraux and contacted the remaining three women whom Deveraux admitted to having unprotected sex with.[230]

Deveraux pled guilty. In discussing the complainers he exposed HIV to (without transmission) the judge stated:

> Those of your victims whom you did not infect were nonetheless each exposed to a considerable risk of contracting the virus. It seems to me that you callously and cruelly betrayed the trust placed in you by each of your partners and that you deceived them for your own self-centred reasons…[They] suffered great distress and anxiety on learning the truth about you and your deceitful and reprehensible conduct towards them[231]

This is yet another example of the 'betrayal of trust narrative,' particularly since the harm in exposure cases is more difficult to pinpoint. Based on the language in *Deveraux,* the harm in such cases is the general distress of possibly having HIV in addition to the pain of romantic deceit. The court initially sentenced Mr Deveraux to ten years' imprisonment (discounted for a guilty plea from 13 years),[232] however an appellate court shortened the length to eight years.[233]

This case is notable as the first of its kind to involve allegations of HIV exposure in addition to transmission. As with the other Scottish cases, it likewise involved a comparatively high sentence compared to equivalent cases in England and Wales,[234] and a strong emphasis on the narrative involving a betrayal of trust.

I. *R v Simon McClure*[235]

In *McClure*, the defendant and the complaint ['Ms C'] entered into a relationship in October 2008.[236] They had unprotected penetrative sex on approximately four occasions until Christmas of that year, and subsequently broke up.[237] In March 2009 Ms C realized she was pregnant, and during the relevant blood tests she discovered she was HIV-positive.[238] Ms C's

---

[229] ibid.
[230] ibid 6-7.
[231] *Devereaux* (n 226) 25 February 2010 All Proceedings 21.
[232] ibid 22-23.
[233] *Devereaux v HMA* [2010] Appeal Court, High Court of Justiciary, Appeal Against Sentence by Mark Richard Deveraux against Her Majesty's Advocate, Case No XC185/10 [4].
[234] See n 199.
[235] [2011] In the Crown Court at Teesside, Case No T20110659 (unreported).
[236] *McClure* (n 237) 4 October 2011 Proceedings 3.
[237] ibid.
[238] ibid. Her daughter was born prematurely but otherwise tested negative for HIV. ibid.

sexual partners were all tested with the exception of McClure, who refused testing.[239] Upon further investigation, the police found a blood sample retained by authorities in Newcastle.[240] The sample tested HIV-positive and contained the same HIV strain as Ms C.[241] McClure had contracted HIV at some point prior to 2005, and learned of his diagnosis in 2006.[242] The court accepted evidence that his practitioner counselled him on the importance of safe sex on several occasions.[243] The Crown initially wanted to prosecute McClure in 2009, but he refused to provide a comparative blood sample and there was no way to compel him to do so at that time.[244] It took until 2011 for the police to obtain McClure's blood evidence.[245]

An interesting point here is the judge's position as to the number of times the two individuals engaged in sexual contact. They noted:

> [The relationship with Ms C] continued perhaps for only a relatively short time until Christmas, but during that time sexual intercourse took place in an unprotected way on three or four occasions...once would have been enough, but to repeat this act on three or four occasions just smacks of a greater degree of recklessness.[246]

Many of the other cases involved individuals who engaged in sex acts many times, sometimes over the course of years. Approximately four sex acts is relatively few compared to similar cases, making it somewhat strange that the judge in *McClure* considered it to be extreme enough to add to the degree of culpability in sentencing.[247] It also addressed a question hitherto not discussed in detail: should the degree to which someone exposes another person be taken into consideration? Should someone who transmitted HIV after a one-night stand be held as accountable as someone who transmitted it at some point during a multi-year sexual relationship? If further exposure through repeated sex acts leads to greater culpability, should the nature of the sex act and the risk it entails be relevant as well?

The court in *McClure* once again emphasises the betrayal of trust, noting: 'Any form of intimate sexual relationship has a degree of mutual trust and you breached it by what you

---

[239] ibid 5.
[240] ibid.
[241] ibid.
[242] ibid 3.
[243] ibid 9.
[244] Gareth Lightfoot, 'Virus Fears as Middlesbrough HIV Man Jailed' (*TeessideLive*, 5 October 2011) <www.gazettelive.co.uk/news/local-news/virus-fears-middlesbrough-hiv-man-3680067> accessed 16 September 2024.
[245] ibid.
[246] *McClure* Proceedings (n 238) 9.
[247] ibid 10.

did.'[248] Additionally potentially aggravating were the circumstances surrounding the infant. The complainant learned of her HIV status one day before going into early labour, and the court heard evidence that complications regarding the virus may have resulted in the premature birth.[249] When discussing McClure's sentence, the judge specifically noted the child's premature birth along with the fact that the complainant was initially afraid that her daughter may also have contracted HIV (the infant ultimately tested HIV-negative).[250] The court further detailed the ongoing concerns of the complainant regarding accidentally exposing her daughter to HIV.[251]

Interestingly, *McClure*, unlike other cases where the complainant had multiple partners, did not appear to involve a more negative tone towards the complainant because of it. The court instead found it an aggravating factor since 'three other innocent partners [had] to be investigated in order to try to rule them out with a view to trying to prosecute you.'[252] While this could certainly evidence a switch in how the courts view complainant's that may be described as 'promiscuous,' it could also be other factors, including the fact that the complainant could identify all of her sex partners for the relevant period (unlike *Tobaiwa*), or that she was heterosexual, or a mother of a young child.

J. *R v Pringle*[253]

In May 2003 medical practitioners informed Pringle that he was HIV positive; they further told him that while all forms of sexual contact without protection carried risk, anal intercourse carried a greater one.[254] In October 2004 Pringle began a relationship with the complainant ['Ms X'] which lasted until February 2007.[255] He did not inform her of her HIV status and hid his medications from her.[256] During the course of their relationship Pringle and Ms X engaged in multiple forms of intercourse, including acts of anal intercourse which involved her bleeding.[257] Pringle stopped taking his medication regularly between April 2005 and March 2006 which increased his viral load; during that period of time, he engaged in

[248] ibid.
[249] ibid 4.
[250] ibid 10.
[251] ibid 10-11.
[252] ibid 11.
[253] [2012] In the Crown Court at Newcastle Upon Tyne, Case No: T20120437 (unreported).
[254] *Pringle* (n 255) 26 November 2012 Proceedings 5.
[255] ibid 6.
[256] ibid.
[257] ibid.

unprotected anal sex with Ms X.[258] By March, Ms X became ill with symptoms consistent with seroconversion, although she did not discover she was HIV-positive until September 2009.[259]

Pringle pled guilty and the court sentenced him to three and a half years imprisonment.[260] Like the court in *McClure*, the court in *Pringle* found the repeated instances of exposure aggravating, although the number of exposures in *Pringle* were significantly higher. [261] Unlike *McClure*, however, the references to Pringle's viral load suggested that the degree of exposure referenced by the court may have gone beyond the number of sexual instances and instead considered the heightened risk of not only the sex acts involved (specifically unprotective anal sex), as well as Pringle's viral load. Once again, the court noted the 'gross breach of trust' involved in the case as an aggravating factor, in addition to Pringle's failure to follow medical advice.[262]

V. Conclusion

The aim of this chapter was two-fold. First, it aimed to build upon the previous chapter by providing additional reference points for how courts approach questions concerning the medical evidence associated with HIV transmission and exposure. Second, it provided a greater degree of insight into how courts and prosecutors actually frame HIV, its transmission, the risks associated with it, and the harm it poses. The cases outlined above will be a part of the upcoming analyses.

One theme repeatedly seen through examining court documents is a narrative which repeatedly rears its head—one that focuses on the betrayal of trust, of one good person and one wicked one, one 'clean' person and one 'dirty' one, one loyal person and one straying one. With the qualified exception of the complaint in *McClure*—where other factors supported a narrative of sympathy—the courts were noticeably less narratively focused when the complainant likewise displayed any sort of promiscuity, such as in *Collins* and *Tobaiwa*. This sort of Madonna-whore complex was most exemplified in *Mola*, which involved a highly experienced man with a purportedly virginal woman, as well as in *Porter*, which

[258] ibid.
[259] ibid 6-7.
[260] ibid 8.
[261] ibid.
[262] ibid.

involved a woman who exposed several different men to HIV. Several cases specifically referenced a betrayal of trust, including *Dica*, *Mola*, *Deveraux*, *Porter*, *McClure*, and *Pringle*.

This thesis argues that this narrative has an actual impact on the underlying cases. The anecdotal bias can cause people to be more swayed by narratives over statistical data, and studies have found that heightened emotions can increase the prevalence of this bias.[263] Health-related concerns, such as HIV, can have a particularly profound impact on the anecdotal bias[264] The narratives in these cases thus heighten emotions in two senses: first by relating to a health concern, and second by involving a poignant story that involves a fear most people have: romantic betrayal. With emotions elevated, people are more likely to ignore cold statistical data over enticing anecdotes, and as a consequence both the risks and harms associated with HIV may be perceived as greater than they are. As a result, modern scientific evidence has not played as significant a role in cases involving HIV transmission as it is submitted it should have. The intentions of those moved by the anecdotal bias may not be malicious, but harm can nevertheless result. The relevance of this narrative and the impact it may have are made clearer in Chapter 6, when this thesis examines civil cases which largely lack the betrayal of trust narrative.

The above chapter likewise introduced another argument that will appear throughout this thesis: the lack of consistency in how courts approach the question of risk. Several of the cases discussed in this chapter presented competing analyses on what factors exacerbate recklessness. This question, as well as questions regarding risk, consent, knowledge, and recklessness more generally, will be discussed in the next chapter.

---

[263] Traci H Freling and others, 'When Poignant Stories Outweigh Cold Hard Facts: A Meta-Analysis of the Anecdotal Bias' (2020) 160 Organizational Behavior and Human Decision Processes 51.
[264] ibid 60. 'In sum, we posit that when an issue involves a severe threat, pertains to oneself, or relates to health, that decision is likely to induce stronger emotional engagement, leading to greater reliance on anecdotal (vs. statistical) information.' ibid.

Chapter 4. Recklessness, Knowledge, and Consent: An Interplay

I. Introduction

There are numerous ways that changing medical advancements may alter the legal landscape relating to criminal HIV transmission. The potential role such advancements could play in reckless transmission or exposure cases may prove significant. These advancements—such as PrEP and medication which renders an individual's viral load undetectable—may impact what a person knows as well as their risk of transmission: two factors which are key in assessing recklessness in transmission cases. Successful prosecutions for the reckless transmission of HIV under section 20 of the OAPA require demonstrating that the defendant 'foresaw that the complainant might [contract HIV][1] and chose to take the risk that she would.'[2] In practice, this means the prosecution must establish that the accused (1) knew or had reason to believe they were HIV-positive, and (2) foresaw that their actions could lead to their partner contracting HIV.[3] Changes in both medicine and available prophylaxes may lead to additional questions about what it actually means to have such awareness. Could, for instance, an individual who incorrectly believed they possessed an undetectable (and thus untransmittable) viral load, and transmitted the virus, be considered reckless? What if an individual believed their partner was regularly taking PrEP and that their partner was therefore protected against transmission: could such a person be said to have the knowledge required for the second prong?

Another key question surrounding HIV transmission concerns recklessness broadly. How risky does an act need to be in order for a court to deem it reckless? Is that number anything above zero, or should marginal risks be considered acceptable? If so, what is that number, and what factors influence it? These questions, including how the courts will interact with PrEP and how the legal system assesses risk, emphasise the importance of the law having an open and ongoing dialogue with changing medical standards. Innovations in both prevention and treatment, in addition to growing understandings of the risks associated with potential transmissions, have advanced significantly over the last several decades. This

[1] The question of whether or not HIV/AIDS rises to the level of grievous bodily harm, in light of modern medicine, will be discussed in the next chapter.
[2] *R v Konzani (Feston)* [2005] EWCA Crim 706; [2005] 2 Cr App R 14 (CA (Crim Div)) [2005] EWHC 1676 (Fam) [37].
[3] This chapter will focus on transmission via sexual conduct, as opposed to needle-based or other transmission means.

chapter will discuss recklessness, consent, and their interplay with knowledge to highlight how courts have thus far not fully engaged with up-to-date medical advancements.

Consent to the risk of transmission, as a potential defence in reckless transmission cases, likewise has a complex relationship with knowledge. In fact, the relationship between consent and assault or battery charges more broadly is a matter for debate. In *R v Brown*,[4] the court was split between viewing consent as a potential defence or a factor which negated the offence.[5] Others later argued that consent more properly operated as an element of the offence, since assaults and batteries must in themselves be unlawful conduct.[6] While the notion of 'consent' may seem straightforward, the legal role that consent plays in an act which contains a risk of harm depends on multiple factors. The role of consent can thus vary depending on factors such as: the nature of the harm, the risk of the harm, the knowledge of the person accused of inflicting the harm, and the knowledge of the person allegedly consenting to the risk of harm. Where HIV transmission is concerned, consent played a critical role in both *R v Dica* and *R v Konzani*. In both cases, the court found that consent could be used as a defence to a charge under section 20 of the OAPA in a way distinct from other cases where harm occurred during consensual sexual acts: specifically, while one cannot generally consent to bodily harm that reaches a certain degree of severity,[7] one can consent to the *risk* of harm.[8] This means that, while there is not technically a legal obligation to disclose one's HIV status, in practice, the defence of consent is available only in extremely limited circumstances if the defendant did not directly divulge their status.[9] But what does it

[4] [1993] UKHL 19; [1994] 1 AC 212.
[5] David Ormerod, Karl Laird and Matthew Gibson, *Smith, Hogan, and Ormerod's Criminal Law.* (17th edn., Oxford Univ Press 2024) 716.
[6] ibid.
[7] One can consent in certain lawful situations, such as surgeries. *Brown* (n 4) [219].
[8] *Konzani* (n 2) at [47].
[9] Samantha Ryan, "Disclosure and HIV Transmission" (2015) 79(6) J Crim L 395, 396. At the time of writing, the defence of consent has not been successfully argued where there was no direct disclosure of a complainant's HIV status. The *Konzani* court, however, noted that there may be some situations where consent might be established out with of direct disclosure: [W]e accept that there may be circumstances in which it would be open to the jury to infer that, notwithstanding that the defendant was reckless and concealed his condition from the complainant, she may nevertheless have given an informed consent to the risk of contracting the HIV virus. By way of example, an individual with HIV may develop a sexual relationship with someone who knew him while he was in hospital, receiving treatment for the condition. If so, her informed consent, if it were indeed informed, would remain a defence, to be disproved by the prosecution, even if the defendant had not personally informed her of his condition. Even if she did not in fact consent, this example would illustrate the basis for an argument that he honestly believed in her informed consent. Alternatively, he may honestly believe that his new sexual partner was told of his condition by someone known to them both. *Konzani* (n 2) [44].

mean to consent to a *risk* of a harm? Whose perspective is the risk judged from—the accused or the accuser?

This chapter seeks to discuss these questions, and in doing so argues that courts should approach questions of recklessness by assessing it both objectively and subjectively. The objective prong would filter out cases where the underlying risk was simply too remote to rise to the level of recklessness. Assuming that the objective prong is met and a court or jury found the act objectively sufficing in terms of risk, then a subjective analysis would examine whether the defendant themselves believed they engaged in a sufficiently risky act. This objective/subjective analysis would mirror how courts should likewise approach questions of consent—is there objective evidence that the complainant gave overt consent to the risk of transmission? If not, is there subjective evidence that supports that the defendant believed the complainant gave such consent?

First, recklessness as a concept will be introduced and discussed. While criminal recklessness lacks a codified definition in English law,[10] existing case law generally references the definition provided in two seminal cases: *R v Cunningham*[11] and *R v G and Another.*[12] Next, recklessness in HIV-specific cases will be discussed. While there are only two reported English cases regarding the reckless transmission of HIV—*Konzani* and *Dica*—unreported cases also provide guidance, as do cases relating to transmission of diseases other than HIV.[13] The role of the defendant's knowledge (or awareness) of their HIV diagnosis will be discussed first. While this was not an issue in *Konzani or Dica*, an unreported case from 2004—*R v Adaye*—is illuminating.[14] *Adaye* –a case involving a man who had not received an HIV diagnosis at the relevant time—provides an example of what evidence may be required in order to establish that a defendant should have been aware of his own HIV-positive status. Next, awareness of the severity of harm posed by HIV will be discussed,[15] followed by a discussion of the defendant's knowledge of the risk.

The risk of HIV transmission changes greatly depending on a multitude of factors, including the specific sex act engaged in, the viral load of the defendant, the health of both

---

[10] Findlay Stark, *Culpable Carelessness: Recklessness and Negligence in the Criminal* Law (Cambridge University Press 2016), 27.
[11] [1957] 2 QB 396
[12] [2003] UKHL 50; Stark (n 10) 27.
[13] See, eg, *R v Golding* [2014] EWCA Crim 889.
[14] *R v Adaye* (unreported) 12 Jan 2004 Whole Hearing Transcript, 10.
[15] Chapter 5 will discuss the question of grievous bodily harm. This chapter focuses on the more limited question of the defendant's awareness of the harm.

the defendant and the complainant, the use of prophylaxes, and other circumstances.[16] The actual risk aside, courts may assess the defendant's knowledge of that risk via the number of times they engaged in the sex act[17] or a whether any type of prophylaxis was used.[18] The question of whether the risk taken was of adequate magnitude leads into the next possibility: are there times when the risk taken is justified? While the definitions of recklessness relied upon by courts generally include a carveout for reasonable or justified risk taking, existing case law has thus far failed to fully elucidate what facts are relevant in determining such justifiability.[19] Similar approaches—with a similar gap—appear in HIV transmission cases as well.[20] While case law[21] in both England and Scotland suggests that adhering to professional medical advice may be relevant to the question whether a risk is justifiable or reasonable, courts have thus far not fully clarified how subjectively or objectively recklessness should be assessed.

Finally, this chapter will discuss the role of knowledge and awareness as it relates to consent. Consent to grievous bodily harm during sex acts will first be discussed more generally by juxtaposing HIV transmission cases with cases that involved consensual sadomasochism and horseplay. After that, the question of indirect disclosure will be addressed. The role of consent in reckless transmission cases is tied closely with the disclosure of the defendant's serostatus: however, *Konzani* left open the possibility for consent to be established in spite of nondisclosure.[22] While—to date—disclosure is not formally required, an examination of the carveout for indirect disclosure in *Konzani* shows that meeting the criteria for justified non-disclosure[23] is extremely difficult. Other situations, such as those involving roughhousing or horseplay, allow for courts to establish consent

[16] See Pragna Patel and others, 'Estimating Per-Act HIV Transmission Risk' (2014) 28 AIDS 1509 <www.ncbi.nlm.nih.gov/pmc/articles/PMC6195215/> accessed 31 May 2024.
[17] See *R v McClure* (unreported), 4 October 2011 Proceedings, In the Crown Court at Teesside, Ref: T20110659.
[18] See *R v Konzani*, 14 May 2004 Summing Up to Verdict, In the Crown Court at Teesside, Ref: 200403166dD*2.
[19] Stark (n 10) 11.
[20] Samantha Ryan, 'Risk-Taking, Recklessness and HIV Transmission: Accommodating the Reality of Sexual Transmission of HIV within a Justifiable Approach to Criminal Liability' (2007) 28 Liverpool Law Review 215, 218.
[21] See, eg, *R v Rowe* [2018] EWCA Crim 2688; [2019] 1 Cr App R (S) 38; see also and *R v Mola* (unreported) [2007] HCJ 02.
[22] *Konzani* (n 2) [44].
[23] 'Justified non-disclosure' as used here refers to situations where consent is established in the absence of the defendant directly disclosing their HIV status. See Ryan, 'Disclosure and HIV Transmission' (n 9) 409.

despite the complainant not explicitly providing such due to the nature of the underlying acts.[24]

While recklessness is a broad topic with numerous definitions and applications, its interplay with HIV in particular highlights some of the difficulties which accompany the lack of a unified definition. That said, even with a unified definition the current approach taken by courts towards cases involving disease transmission have not fully addressed relevant changes in medical science. This is particularly true when assessing the defendant's awareness of a risk, as well as with determining whether or not the action in question was reasonable. While most of the caselaw on the subject has not tackled the question of the defendant's knowledge of their serostatus, the degree of harm, or the risk of harm in depth—as it was not a major issue in *Konzani* or *Dica*—changes in modern medicine, combined with the dicta in *Rowe*[25] render it possible that this could be a point of discussion in later cases.

Modern scientific knowledge has changed significantly since *Dica* and *Konzani* yet the legal approach towards reckless transmission cases has not evolved accordingly. To remedy this, this chapter argues that courts assessing recklessness in the future should do so in two stages: first objectively and second subjectively. The objective assessment would acknowledge that there are some situations where—even though a harm occurred—the likelihood of that risk actuating was insufficiently high to implicate recklessness. This objective prong would rely heavily on scientific evidence. If this prong is met, then courts should engage in a subjective analysis aimed to assess whether there was adequate evidence establishing how risky the defendant perceived their actions. This balanced approach would acknowledge that different factors can affect transmission and would prevent cases where transmission occurred in spite of it being a negligible risk while still accounting for the defendant's subjective perspective.

II. Recklessness Generally

The *mens rea* of 'recklessness,' along with the *mens rea* of 'negligence', involves culpability for unjustified risk taking. While no legislative definition of recklessness exists in English law, the decisions in *R v Cunningham* and *R v G and Another* provide some guidance. In the former case, the court defined recklessness as the *mens rea* for a

[24] David Gurnham, 'Risky sex and 'manly diversions': contours of consent in HIV transmission and rough horseplay cases' in Amel Alghrani, Rebecca Bennett and Suzanne Ost, *Bioethics, Medicine, and the Criminal Law. Volume I, the Criminal Law and Bioethical Conflict: Walking the Tightrope* (Cambridge University Press 2013).
[25] *Rowe* (n 21).

circumstance where the defendant had 'foreseen that the particular kind of harm might be done' and chose to act in spite of the risk.[26] This definition, which focuses more on the potential harm, does not discuss the level of foreseeability required for that risk nor the level of harm that may be caused.

The later case of *R v G and Another* provides a second definition of recklessness and is frequently relied upon by modern courts.[27] In that case, the House of Lords adopted the Law Commission's definition, stating that:

> A person acts recklessly ... with respect to (i) a circumstance when he is aware of a risk that it exists or will exist; (ii) a result when he is aware of a risk that it will occur; and it is, in the circumstances known to him, unreasonable to take the risk.[28]

Unlike *R v Cunningham*, the second prong—introducing the term 'unreasonable'—makes explicit that recklessness requires a certain threshold of risk to be met. It further highlights the fact that not all risks which may lead to harm are criminal and emphasises that the defendant's perspective regarding the facts is relevant to the question of reasonableness. This possibility of reasonable or justified risk taking will be discussed further below.

Both *Cunningham* and *G and Another* underline the need for one's awareness of a risk, but neither case addresses what that actually means.[29] While *Cunningham* found that a defendant who deliberately closed his mind to a risk would potentially meet the threshold required for recklessness, other courts have yet to discuss the extent to which the defendant's awareness of a risk must be at the forefront of their mind.[30] Although some areas of law do not embrace this awareness-based model, those that do not are fairly rare.[31] Reckless HIV transmission falls into the more general category requiring foreseeability from the perspective of the defendant; however, as discussed further below, reckless transmission cases present unique challenges when assessing criminal culpability.

Beyond how aware a person must be to meet the threshold of 'aware', the very definition of the word itself is unclear—does it mean that the defendant must 'know' of the risk, or is it enough to look at what they believe?[32] While 'knowledge' and 'belief' are often

---

[26] Stark (n 10) citing *R v Cunningham* [1957] 2 QB 396, 399-400.
[27] See, eg, *Canada Square Operations Ltd v Mrs Beverley Potter* [2021] EWCA Civ 339, [87]-[88].
[28] *R v G and Another* [2003] UKHL 50 [41] citing Law Commission, A Criminal Code for England and Wales / Vol. 2, Commentary on Draft Criminal Code Bill, vol 1. (Law Com No 177, 1989).
[29] Stark (n 10) 28.
[30] ibid citing *R v. Murphy* [1980] QB 434, 440.
[31] ibid 29.
[32] ibid 124.

grouped together in offences,[33] the terms are distinct. Unlike knowledge, a belief may or may not be true. If a person engages in objectively reckless behaviour that they subjectively do not believe poses a risk, then the relevance of that belief depends on how subjective or objective one's approach to recklessness is. If a person is told by a medical professional that there is a risk and they do not believe that risk exists, or believe that there is a way to mitigate that risk that is actually untrue, then there can be a tension between what counts as knowledge and what counts as belief. In the case of *Rowe,* for instance, the defence argued that the defendant believed he cured his HIV through alternative therapies.[34] The prosecution highlighted the numerous instances of advice *Rowe* received about his increased viral load, additional STIs, and other factors which medical providers informed him would increase his transmissibility.[35] On one hand he 'knew' of the risks because of his medical provider's advice, on the other hand he 'believed' he cured his HIV. The court sided with the Crown, stating that '[h]e could not have perceived the risk to be negligible . . . in the light of the information and advice he had received.'[36] *Rowe*, the facts of which were discussed in Chapter 2, exhibited numerous other factors that likely influenced the court's dismissal of Rowe's claims that he believed he cured his HIV. That said, it demonstrates a situation where knowledge may be assessed in terms of the advice received and deemed distinct from belief.

Further complicating this discussion is the connection between 'awareness' and 'knowledge.' For some courts, the equation between knowledge and awareness is taken as read, with little analysis given to that proposition.[37] While the definition in *R v G & Another* references 'awareness' and not 'knowledge,' courts and legal scholars have conflated the two terms.[38] The exact definition of 'knowledge' as a type of *mens rea*, however, is in itself unclear and lives in an awkward relationship with the (less common) *mens rea* of 'belief.' Some theories on the subject posit that knowledge, by definition, is simply a belief that a proposition is true to a specific degree of probability—one that often coincides with virtual certainty.[39] A consequent danger of this is that a person may 'know' things which are not

---

[33] See, eg, the Criminal Law Act 1967 s.4(1): 'Where a person has committed an arrestable offence, any other person who, knowing or believing him to be guilty of the offence or of some other arrestable offence, does without lawful authority or reasonable excuse any act with intent to impede his apprehension or prosecution shall be guilty of an offence'. Stephen Shute, 'Knowledge and Belief in the Criminal Law.' In Stephen Shute and AP Simester, *Criminal Law Theory: Doctrines of the General Part* (Oxford University Press 2005).
[34] *Rowe* (n 21) [30].
[35] ibid [4]-[10].
[36] ibid [57].
[37] Stark (n 10) 124 citing *Atwal v. Massey* [1971] 3 All ER 881.
[38] ibid.
[39] ibid 126.

possible.[40] Since 'false knowledge' is a conceptually difficult notion, it can lead to potentially absurd conclusions.[41]

A countervailing definition of awareness postulates that it should be understood as a 'justified true belief'—in other words, '[t]o constitute awareness of risk, the defendant's belief that there is a risk must also be justified and true.'[42] While this definitions remedies some of the conceptual difficulties that come with a more subjective approach to a defendant's mental state when addressing recklessness—such as beliefs which could not be reasonably understood to be founded in fact—this definition faces other hurdles.[43] Specifically, the requirement of 'justification' may complicate an already complex issue, and may detract from the more broad question of the defendant's motivation.[44] Instead, equating 'awareness' to 'simple belief' in terms of recklessness arguably leads to the most logically sound conclusions.[45] Still, how 'aware' a person must be remains an open issue, as is the question of whether 'awareness' is more properly equated to 'knowledge', 'belief', or something else. Some argue that the 'awareness' requires the knowledge or belief to be 'at the forefront of the defendant's conscious mind' while others argue that even a 'modest degree of awareness' is sufficient.[46] What this argument breaks down to is a question of how aware a defendant must be to be deemed reckless in a set of circumstances, in addition to how objectively or subjectively such awareness should be assessed: by a more subjective state of belief or a more objective state of true knowledge. How this debate relates to cases involving HIV transmission, and how changing medical advancements can affect recklessness assessments will be discussed next.

III. An Examination of HIV and Recklessness

On appeal, the court in *Konzani* stated: '[the] appellant behaved recklessly on the basis that knowing that he was suffering from the HIV virus, and its consequences, and knowing the risks of its transmission to a sexual partner, he concealed his condition from the

---

[40] ibid. Though this specific issue was not raised, the case of *Marangwanda* involved a plea of recklessly transmitting a disease by a means which is considered scientifically near impossible. *R v Marangwanda* [2009] EWCA Crim 60.
[41] Stark (n 10) 127.
[42] ibid 128. Shute argues that belief is a necessary, but not sufficient, condition for knowledge and that knowledge further requires that it be justifiably and sincerely held as well as based on a true proposition, Shute (n 33) 184.
[43] Stark (n 10) 129.
[44] ibid.
[45] ibid 140.
[46] Shute (n 33) 198, citing Law Commission, Legislating the Criminal Code: Offences against the Person and General Principles (Law Comm No 218, 1993) para. 14.24.

complainants, leaving them ignorant of it.'[47] This leaves three separate areas where the knowledge or awareness of the accused may be pertinent: knowledge of their own HIV status, knowledge of the severity of HIV, and knowledge of the risk of transmission.

A. Knowledge of One's HIV Diagnosis

In both *Dica*[48] and *Konzani*[49] the HIV statuses of the defendants were not in dispute, and as such neither court spent significant time discussing whether that knowledge must be directly established via an official medical diagnosis or if something short of that could suffice. In other words, must an individual *know* their status, or is it enough that they *should have known*? This was briefly and indirectly brought up in *Dica* when addressing an article by Spencer. When discussing recklessness, the court quoted his conclusion that:

> To infect an unsuspecting person with a grave disease you *know you have, or may have*, by behaviour that you know involves a risk of transmission, and that you know you could easily modify to reduce or eliminate the risk, criminal liability is justified unless there are strong countervailing reasons.'[50]

The court did not specifically discuss the notion of indirect knowledge,[51] and neglected to include any reference to a person who may not know (but may suspect) their HIV status when discussing its holding:

> The effect of this judgment in relation to s.20 is to remove some of the outdated restrictions against the successful prosecution of those who, *knowing that* they are suffering HIV or some other serious sexual disease, recklessly transmit it through consensual sexual intercourse, and inflict grievous bodily harm on a person from whom the risk is concealed and who is not consenting to it[52]

Since this was not a point at issue in *Dica*, it is unlikely that the court consciously intended to limit reckless transmission cases to ones where the diagnosis was received via an official medical test; in other words, it would go too far to suggest that *Dica* settled the issue of whether knowledge of one's positive serostatus could be established indirectly.

The CPS guidelines, as of the date of writing, suggest that indirect knowledge may suffice in establishing recklessness for an OAPA section 20 offence in 'exceptional cases.' While they state, on one hand, that prosecutors must 'look for evidence that the suspect knew

---

[47] *Konzani* (n 2) [41].
[48] *R v Dica (Mohammed)* [2004] EWCA Crim 1103; [2004] QB 1257 (CA (Crim Div))[59].
[49] *Konzani* (n 2) [41].
[50] *Dica* (n 48) [55] citing John Spencer, 'Liability for Reckless Infection' (2004) 154 New Law Journal 384.
[51] In other words, someone learning of their HIV status through a means that was not being directly informed to them by a medical professional.
[52] ibid [59] (emphasis added).

that he/she had a sexually transmissible infection,'[53] they also state that '[a] deliberate closing of the mind by not undergoing testing may be a factor that a jury can take into account when deciding the question of the defendant's knowledge.'[54] The CPS guidelines suggest that evidence of this sort of indirect knowledge may include things such as: a preliminary diagnosis (without confirmatory testing), exhibitions of clear symptoms, or a prior sexual partner with a positive diagnosis.[55] While no reported cases explore whether indirect knowledge may be sufficient, an unreported 2004 Liverpool case casts light on how the prosecution may approach such matters.

In *R v. Adaye*, discussed briefly in the previous chapter, the prosecution adduced evidence that—due to numerous prior diagnoses of sexually transmitted infections—a doctor in South Africa previously told the defendant that 'if he was not already HIV positive he soon would be because of the history she saw.'[56] Evidence that Adaye's wife informed him of her HIV-positive status in 2003 further weighed heavily against him.[57] Even so, no evidence existed that Adaye himself received a positive HIV diagnosis from a medical professional during the relevant period of time.[58] In spite of this, the prosecution asserted that, although at the time of the *actus reus* 'he did not know that he was HIV positive, he was reckless as to whether he was or not.'[59] Since Adaye pled guilty, it remains unclear how a court would treat such an allegation should the matter proceed to trial. *Adaye* demonstrated the likely upper bounds of what a deliberate closing of the mind may look in a future case where such an allegation was at issue, and from it one can infer that a high evidentiary bar is needed in order for prosecution to proceed. Had *Adaye* proceeded to trial, the combination of the numerous prior sexually transmitted diseases, the statement from the South African doctor, and the evidence of his wife's positive status would likely all have been highly influential in persuading a court that the defendant should have known about his HIV status. Whether or not this would still be the case if the complainant was taking PrEP (and thus was unlikely to seroconvert) remains to be seen. Since PrEP is generally only administered to people already assessed as engaging in risk factors relevant to HIV and usually involves frequent testing,

---

[53] Crown Prosecution Service, 'Intentional or Reckless Sexual Transmission of Infection' (*Cps.gov.uk*, 13 December 2019) <www.cps.gov.uk/legal-guidance/intentional-or-reckless-sexual-transmission-infection> accessed 6 May 2025.
[54] ibid.
[55] ibid.
[56] *Adaye* (n 14) 10.
[57] ibid.
[58] ibid 17.
[59] ibid. Note that a plea is mentioned, but it is unclear what exactly he pled to in terms of his status.

there would be potential arguments that could relate to both the recklessness of the behaviour generally as well as to the question of consent. Both of these issues will be discussed in further detail below.

Overall, the issues relating to the defendant's knowledge of their own HIV status have not been significantly affected by changing medical science. This is, of course, not to say that there have not been advancements in that area. HIV testing technology is currently in its fifth generation and there have been massive improvements in both accuracy and the speed at which the tests are able to detect HIV.[60] That said, the question of whether the defendant knew of their status was not at issue in any of the reported cases, and only at-issue in one unreported case. The facts such as those in *Adaye* are unusual, and would not likely be affected by changing medical advancements.[61]

B. Knowledge of the Severity of HIV

The question of whether or not HIV *is* serious enough to rise to the level necessary for 'grievous bodily harm' has not been adequately addressed by a modern court.[62] The broader question as to the harm of HIV will be discussed in the subsequent chapter; for present purposes, the question is not whether HIV is actually a grievous harm, instead it is whether the defendant knew of the severity of HIV. *Konzani* stated that the defendant 'behaved recklessly on the basis that knowing that he was suffering from the HIV virus, *and its consequence*' engaged in sexual relations with the complainant.[63] In context, the 'consequence' in question must be the harm of HIV.[64] To date, English and Scottish courts

---

[60] Thomas S Alexander, 'Human Immunodeficiency Virus Diagnostic Testing: 30 Years of Evolution' (2016) 23 Clinical and Vaccine Immunology 249 <https://cvi.asm.org/content/23/4/249> accessed 6 May 2025.

[61] The focus of this thesis is on whether the law has kept pace with scientific advancements, and since the accuracy of HIV tests has not been at issue in any past cases there is little to comment on with regards to whether the medical science of HIV testing in prior cases remains applicable. As a matter of curiosity, could a false positive or a false negative be relevant to a reckless transmission case? It would depend on the facts. A false negative would almost certainly undercut any accusations of recklessness, since the defendant received a negative test and it is unlikely that a person would assume that to be false. A false positive would probably undercut the necessary *actus reus*. In England transmission must occur in order for OAPA section 20 to apply, and a false positive would indicate that transmission did not and could not occur from the defendant to the complainant. In Scotland, the answer might be a bit more interesting since exposure is an offence under the law. That said, since there is no actual danger of harm in the event of a false positive, it is unlikely to meet the threshold for culpable and reckless conduct even with the requisite *mens rea*.

[62] In *R v Rowe* the defendant made this argument, however the court rejected it based on *R v. Dica*, noting that '[the level of harm posed by HIV] was not at issue at trial for good reason.' (n 21) [67]. This question—whether HIV should rise to the level of GBH in light of modern medical advancements—will be discussed further in Chapter 5.

[63] *Konzani* (n 2) [4] (emphasis added).

[64] *Konzani* also stated: 'In short, if he knew or foresaw that the complainant might suffer bodily harm and chose to take the risk that she would, recklessness sufficient for the purposes of the *mens rea* for s.20 was

have not grappled in-depth with the question of the evidence needed to show that the defendant was aware of the severity of HIV in cases of reckless transmission. The lack of discussion on this question suggests that, in the known reckless transmission cases, the Crown adduced evidence which either showed that the seriousness of HIV was relayed to the defendant at the time the medical diagnosis was given, or that the seriousness of HIV is something which is broadly assumed to just be known, or that the issue was not in dispute at trial.

It is possible a defendant could plead special facts that show that they did not believe HIV to be sufficiently severe – perhaps, for instance, by claiming to hold or have held the misguided belief that HIV is not connected to AIDS, or that it can be cured. Whether such an argument would succeed would depend in part on the definition of awareness—per the definition of recklessness set out in *G and Another*—embraced by the court as well as the degree to which the defendant sincerely held such a belief. If awareness (as discussed above) is equated with knowledge, and the 'knowledge' is accepted as belief that something exists to a degree that is subjectively near certainty,[65] then, assuming the defendant sufficiently held such beliefs, criminal recklessness could not be shown based on the defendant's subjective awareness.[66] Similar results would be reached if awareness is equated to simple belief. If the court defines 'awareness' as a belief which is justified and true, however, then the defendant's beliefs would be irrelevant since they are not true, and criminal recklessness may be found in spite of their subjective belief. Regardless, as of the date of writing, no court has encountered such a fact pattern in a case concerning reckless transmission.[67]

Could innovations in medical science affect the question of the defendant's awareness of the severity of HIV? Such a question would heavily depend on the facts of the case. A defendant could potentially put forth evidence that, because there have been such improvements in HIV treatment, that they did not consider HIV to be a severe ailment. Assuming the defendant could provide some evidence to support this contention, whether this argument would succeed would depend not only on whether the prosecution could adduce evidence to counter the conclusion that such a position was truly the defendant's, as well as

established.' ibid [37]. In the context of HIV, this would mean the defendant would have to know that HIV is a bodily harm.

[65] Stark (n 10) 126.

[66] Discussed above. To clarify, if a defendant asserted that he did not believe HIV to be severe, and the court accepted that the level of awareness required for the *mens rea* of recklessness was simple belief, then it cannot be said that he was aware of a risk (since his subjective belief did not see HIV as a risk) or acted unjustifiably.

[67] As stated above, this fact pattern somewhat arose in *Rowe*.

the court's position on how objectively or subjectively knowledge is established. If the court chose a more objective position, the success of such an argument would depend on level of harm of court considers HIV to be more broadly as well as possibly the advice the defendant received. A discussion on HIV and harm will be addressed in the next chapter. If the court embraced a more subjective opinion, then evidence that a defendant did not believe that HIV was a harm or was not a serious harm may undercut allegations of recklessness.

C. Knowledge of Risk of Transmission

The court in *Konzani* found that recklessness was established on the basis that 'knowing that he was suffering from the HIV virus, and its consequences, and *knowing the risks of its transmission* to a sexual partner, he concealed his condition from the complainants.'[68] What it actually means to 'know the risks,' however, remains unclear. At the very least, *Konzani* suggests that riskiness has two facets: a subjective and an objective one. The subjective aspect is clearly indicated in *Konzani*, and the objective aspect follows as a logical consequence, since a situation with no risk would not amount to an *actus reus*. In *Konzani* the court established this by finding that Konzani had been 'specifically informed of the risks of passing the infection on to any sexual partners, and its dire consequences.'[69] The exact nature of what the medical provider told him was left vague, and there is no indication that there was any discussion regarding what situations could lead to an increased risk. In *Dica*, although the issue regarding his awareness of risks is not specifically addressed in the judgment, a 2003 summing up stated: 'On 18 December 1995, the defendant was told he was HIV positive…You may think it to be certain at that stage he would have been warned about his sexual conduct and the dangers it carried for others.'[70] Consequently, his full knowledge of the risks was simply assumed to follow automatically from his diagnosis. Many other cases, including *R v Golding*, included an admission from the defendant of the requisite knowledge,[71] and thus did not delve further into the question.

When it comes to sex acts between HIV discordant partners,[72] the degree of risk entailed depends heavily on numerous factors. While some courts previously noted[73] that

---

[68] *Konzani* (n 2) [41].
[69] ibid [3].
[70] 13 October 2003 Summing Up, Ref: T20037541, 22.
[71] *R v Golding* (n 13) [59]. Golding notably related to transmission of herpes, not HIV.
[72] In other words, one HIV positive partner and one HIV negative partner.
[73] See, eg, *R v Pringle* (unreported) 26 Nov 2012 Proceedings. Crown Court at Newcastle Upon Tyne, Ref: T20120437. During sentencing, Judge Sloan highlighted that the defendant was informed that different sex acts entailed different risks, and that bleeding during those acts could heighted that risk further. The defendant

different acts that may lead to different risks in a superficial manner, there is not a clear consensus regarding the question of whether the degree of the risk of transmission should be relevant in determining recklessness.

1. The Degrees of Risk

As discussed in Chapter 2, the factors which can impact whether or not transmission occurs include: the sex act engaged in, the health status of the individuals, whether or not prophylaxes were used, and the number of times they engaged in sex acts.[74] It is widely accepted that unprotected receptive anal intercourse is the riskiest activity to engage in, with each individual contact[75] with a person living with HIV (with a detectable viral load) carrying an estimated risk of 0.8-3.2% for transmission.[76] Vaginal sex carries an estimated risk for male to female transmission of approximately 0.08% per act,[77] and for female to male transmission of approximately 0.04% per act.[78] While the per contact risk may be low, those engaging in risky behaviour repeatedly expose themselves to repeated risks, and a low risk is not synonymous with no risk. Furthermore, other factors can increase the risk of transmission, including: the presence of other STDs, an inconsistent antiretroviral treatment, micro-trauma or bleeding, or the presence of a more infectious strain.[79]

When considering whether a defendant was reckless, do courts look holistically at repeated acts, or at each act individually? As addressed in the previous chapter, the results are inconsistent. In *Dica*, some of the sex acts were protected though most were not.[80] In summing up, the judge stated that while there was a 10% chance that the transmission occurred during one of the instances where the defendant had protected intercourse with one

---

engaged in numerous sex acts with the complainant including unprotected anal sex—which he had been informed was the most risky—and continued even though she bled from the act each time. ibid 5-6.

[74] See E Vitinghoff and others, 'Per-Contact Risk of Human Immunodeficiency Virus Transmission between Male Sexual Partners' (1999) 150 American Journal of Epidemiology 306; Marie-Claude Boily and others, 'Heterosexual Risk of HIV-1 Infection per Sexual Act: Systematic Review and Meta-Analysis of Observational Studies' (2009) 9 The Lancet Infectious Diseases 118.

[75] None of the figures discussed here factor in the use of PrEP. The use of PrEP, if taken correctly, is estimated to further lower the risk of HIV transmission via sex acts by 99%. U.S. Centers for Disease Control and Prevention, 'Pre-Exposure Prophylaxis (PrEP) | HIV Risk and Prevention | HIV/AIDS | CDC' (*CDC.gov,* 4 June 2020) <www.cdc.gov/hiv/risk/prep/index.html#:~:text=Pre%2Dexposure%20prophylaxis%20(or%20PrEP> accessed 17 June 2024.

[76] Vitinghoff et al (n 74) 310

[77] Boily et al (n 74) 124.

[78] ibid 118.

[79] Vitinghoff (n 74) 311.

[80] *Dica* Summing Up (n 70) 8-11.

of the complainants, Dica could still be convicted of reckless transmission even if he had been wearing a condom on the occasion when transmission occurred.[81] The judge noted:

> '[Y]ou have to be sure that he was reckless when sexual intercourse was protected by a condom…In other words, you have to be sure before you can convict him that he was reckless at the time of every act of sexual intercourse whether or not it was protected because it is not possible to say for certain which act transferred the virus, if he transferred it.'[82]

This instruction is interesting, since it indicates that, since the timing of the *actus reus* of transmission was unknown, he had to be reckless in each one of his sexual encounters with the complainant. Aside from the problematic notion that this means that recklessness may be found regardless of prophylaxis usage, it suggests another possible defence: that a defendant was not reckless in all of his sexual encounters with the defendant. Taken to its logical conclusion, if Dica and the complainant engaged in 10 sexual encounters and he was not reckless (perhaps by using a condom) during one of the acts, he could not be found guilty since it was unclear if the transmission occurred during one of the times he was reckless (a violation of OAPA 1861) or during the one time he was not reckless. Since transmission itself is not enough to amount to an offence without the accompanying *mens rea* of recklessness or intention, then claiming that only some of the sex acts were reckless could amount to a plausible defence. Under this approach, each sex act must be assessed separately.

A 2011 unreported case, *R v McClure,*[83] looked at the sex acts more holistically as a series than as separate acts. In *McClure*, the complainant accused the defendant of transmitting HIV to her during a short relationship where they engaged in unprotected intercourse approximately four times.[84] There, the court stated: '[one unprotected sex act] would have been enough, but to repeat this act on three or four occasions just smacks of a greater degree of recklessness.'[85] The court in *McClure* did not have to address the question of occasional protected intercourse as the court in *Dica* did, and thus the discussion of the degree of risk of one act versus a series of acts is odd in light of the precedent. While the implication of both *Dica* and *McClure* is that one instance of recklessness could be enough, *McClure* suggests that a court may look at a relationship holistically and find a greater degree of risk-taking based on the course of the relationship as a whole. While the court in *Dica* did

---

[81] ibid 7-8.
[82] ibid.
[83] *R v McClure* [2011] In the Crown Court at Teesside, Case No T20110659 (unreported).
[84] ibid 4 October 2010 Proceedings 3.
[85] ibid.

not explicitly engage in such reasoning, a court approaching a similar fact pattern (where some of the acts were protected and some were not) could potentially infer a reckless *mens rea* in the time times prophylaxis was used by instances where it was not used.

Assessing risk by individual instances, rather than holistically, may fail to take into account the actual likelihood of transmission based on each act. If a defendant engages in an act that has a risk of harm that is under 0.1%—as with male to female transmission[86]—then the bar for how likely a harm needs to be in order rise to the level of criminal recklessness is extremely low. If, instead, the acts are viewed as a singular series, then shorter relationships with less sexual contact may be considered less risky, and possibly less reckless. Even so, this avoids the question of exactly how risky an act needs to be in order for the law to deem it 'reckless.'

How risky a risk needs to be for recklessness remains unclear. In *Dica*, the court referred to Spencer's statement that:

> "To infect an unsuspecting person with a grave disease you know you have, or may have, by behaviour that you know involves a risk of transmission, and that you know you could easily modify to reduce or eliminate the risk, is to harm another in a way that is both needless and callous. For that reason, criminal liability is justified unless there are strong countervailing reasons. In my view there are not."[87]

While the court does not explicitly endorse Spencer's statement, it did notice it as an 'illuminating conclusion on the question of recklessness.'[88] However, Spencer's statement simply references 'a' risk of transmission and does not distinguish between high risk and low risk activities. If any level of risk is enough to constitute recklessness, then even a HIV-positive defendant who only engages in sex acts with individuals on PrEP could be said to be reckless during those acts if transmission occurs since the risk is negligible but not zero.[89] Although Spencer referred more to modifications on the part of the defendant and not the complainant, could using PrEP fall into the category of modifications referenced by Spencer? Arguably yes, although it again remains unclear the extent to which a risk would need to be modified to be considered relevant.[90]

---

[86] Boily and other (n 74) 124.
[87] *Dica* (n 48) [55] citing Spencer (n 50).
[88] ibid.
[89] A conviction in such a case would, of course, still need to meet the subjective prong set out in *G and Another* (i.e. that sex with a condom made the risk one which was reasonable to take).
[90] There is currently no way to ensure the risk of HIV transmission is fully eliminated when engaging in sex acts, even though there are ways of making it negligible.

The other major issue with Spencer's argument that recklessness can be determined by the available modifications is that it is at risk of falling prey to cognitive biases. The hindsight bias posits that people are more likely to view a probability as likely when they already know the outcome actuated.[91] In other words, knowing that a defendant transmitted HIV to someone distorts a viewer's perspective on how likely the acts that led to the transmission actually were. Relatedly, the outcome bias (also known as the outcome effect) colours a person's perspective of the quality of another individual's decision based on the outcome of that decision.[92] Combined, this means that a judge or juror in a reckless transmission case may be prone to thinking that HIV is more transmittable than it is (the hindsight bias), while viewing decisions such as not wearing a condom as more negative (the outcome bias) because they know that transmission occurred. While Spencer's argument may sound straightforward, it may only appear that way because the outcome is known. What modifications are sufficiently mitigating the undermine an assessment that an individual acted recklessly? If a person with HIV does not use a condom but chooses to only engage in vaginal rather than anal sex because they know it to be less risky, is that mitigating enough or not? Is this mitigation subjective from the viewpoint of the defendant, or objectively assessed? In other words, could a person who incorrectly believed that they were engaging in a mitigating act suffice in Spencer's view? If transmission had not occurred, would the defendant's decision to not wear a condom be viewed as negatively? Consequently, while Spencer's arguments provide some guidance, there remain numerous open questions. Beyond the question of disease transmission, framing recklessness in terms of the available modifications may impart a far-reaching impact on criminal liability as a whole. Where a harm occurred, there are potentially numerous scenarios one may identify as an avenue a defendant could have taken to modify the harm after the fact. At the time that the appellate court heard *Dica* in 2004 most people did not know how to prevent HIV sexually except through the use of condoms; now, however, recent scientific studies have highlighted additional relevant factors that can impact transmission. Even so, the analysis of recklessness has not changed significantly since the era of *Dica*.

---

[91] Baruch Fischhoff, 'Hindsight Is Not Equal to Foresight: The Effect of Outcome Knowledge on Judgment under Uncertainty.' (1975) 1 Journal of Experimental Psychology: Human Perception and Performance 288, 297.

[92] Niek Strohmaier and others, 'Hindsight Bias and Outcome Bias in Judging Directors' Liability and the Role of Free Will Beliefs' (2020) 51 Journal of Applied Social Psychology 141, 143.

Other courts imply that the risk of harm needs to at least be 'significant,'[93] although the exact level of risk for that likewise remains unclear. Additionally pertinent to this is the question of perspective: is the assessment of that risk objective or subjective? Could taking a risk be considered justified?

2. Justified Risk Taking

In *R v G and Another*, Lord Bingham eloquently recounted some of the history of the complicated nature of recklessness in criminal law.[94] That case, which involved minors accidentally starting a fire,[95] considered arguments regarding whether recklessness should be assessed subjectively. Although Lord Bingham expressly limited his opinion to section 1 of the Criminal Damage Act 1971,[96] his conclusion regarding recklessness is enlightening. Lord Bingham's definition of 'recklessness,' based on a Law Commission report,[97] stated that a person is reckless where they are aware of a risk, and 'it is, in the circumstances known to him, unreasonable to take the risk.'[98] If an act is reckless when the risk taken is 'unreasonable,' it stands to reason that a risk which is 'reasonable' may not be reckless. 'Reasonable' as used here, is often equated in English courts to 'justified' and is commonly featured in definitions of recklessness.[99] Even so, there is very little judicial guidance available to determine what circumstances make a risk more or less justified.[100]

To date, none of the English cases involving reckless transmission have delved into any significant analysis regarding whether or not the risk taken was possibly reasonable or justified.[101] As noted by Ryan in her paper discussing the concept of justified risk taking, the question of what is justified depends upon a variety of factors, including: the harm, its likelihood, the available precautions, the social value imputed to the conduct, and several other factors.[102] 'Although recklessness may involve a mix of subjective and objective analysis, factors regarding justifiability are assessed more objectively,'[103] and the defendant's perspective on the justification is 'relevant but not determinative.'[104] With regards to disease

---

[93] *R v G and Another* (n 12) [32].
[94] ibid.
[95] ibid [2].
[96] ibid [28].
[97] 18(c) of the Criminal Code Bill annexed by the Law Commission (n 45).
[98] *R v G and Another* (n12) [41].
[99] Stark (n 10) 10.
[100] ibid 11.
[101] Ryan 'Risk-Taking' (n 20) 218.
[102] ibid 223-4.
[103] ibid.
[104] Stark (n 10) 275.

transmission, the focus on the nature of the harm in *Konzani* and *Dica* indicates that the level of harm posed by HIV outweigh other relevant factors, including—possibly—the level of per contact risk and the social value of sexual gratification and expression.[105] If one accepts that how justifiable actions are depends on the gravity of the harm, then an accurate analysis of the harm posed by HIV is critical.[106] Alternatively, justifiability may turn on how substantial the risk taken was, and whether there were ways of mitigating the risk that the defendant could but did not take.[107] While the court in *R v Brady* rejected the contention that a defendant must be *aware* of an 'obvious and significant' risk connected to the *actus reus*,[108] the court did not address the possibility that the risk itself (regardless of the defendant's subjective awareness) must actually be objectively significant in order for culpability to arise.[109]

Although it addressed the question in a different context, the appellate court in *R v Rowe*[110]–a case involving allegations of intentional (rather than reckless) transmission – addressed the likelihood of harm in its decision. In *Rowe*, a medical practitioner informed the defendant not only of his HIV status, but also of the types of sex acts which posed a greater risk of transmission, and further informed him of the means by which he could lower such risks.[111] Another medical practitioner likewise specifically informed him that his dual diagnosis of herpes and HIV rendered him at a greater risk of transmitting HIV,[112] and later told him that failing to take his medication daily might increase his viral load and could accordingly increase his infectiousness.[113] Since the case involved allegations of intentional and not reckless transmission, the court did not discuss the degree of the risk taken (and thus its justifiability) in detail. It did, however, note that 'the jury could properly infer from the evidence that the applicant fully understood the high risk of unprotected sex with the complainants. He could not have perceived the risk to be negligible…in light of the information and advice he received.'[114] This suggests that (a) a negligible risk may be able to be considered reasonable and thus justified, (b) assessing the level of that risk may be based

[105] Ryan 'Risk-Taking' (n 20) 225.
[106] Harm will be discussed in the subsequent chapter.
[107] Stark (n 10) 13.
[108] ibid citing [2006] EWCA Crim 2413 [14]–[16].
[109] ibid.
[110] (n 21).
[111] ibid [4].
[112] ibid.
[113] ibid [10].
[114] ibid [57].

on the medical advice given to a defendant, and (c) the subjective perspective of the defendant regarding the nature of the risk may be relevant to questions of culpability.

i. Negligibility of the Risk

Regarding the question of negligibility of a risk, an unreported hearing in *Dica* provided some guidance by indicating that wearing a condom, and thus having a 10%[115] chance of transmitting HIV in those circumstances, may be a risk level that is greater than negligible.[116] *Rowe* provides little guidance regarding what would amount to a negligible risk, though it did note that correct condom use renders the risk of transmission to be 'extremely low,'[117] and that an individual with an undetectable viral load would possess 'little risk of passing [HIV] on.'[118] Consequently, it is possible that condom use or an undetectable viral load may make a risk negligible, and increase the chance that the risk in question is considered justified.[119]

ii. Reliance on Medical Advice

The medical advice given to the defendant may likewise weigh heavily on the question of both justifiability and the defendant's subjective awareness. The defendants in cases such as *Konzani*,[120] *Golding,*[121] and *Marangwanda*[122] all admitted to recklessness, and consequently the opinions focused more on other aspects of the respective cases. While the

---

[115] Again, this number, while potentially believed to be accurate at the time, is not entirely accurate. Studies show that consistent condom use reduces the likelihood of HIV transmission by 80% during vaginal sex. Susan C Weller and Karen Davis-Beaty, 'Condom Effectiveness in Reducing Heterosexual HIV Transmission' (2002) Cochrane Database of Systematic Reviews. While this number sounds low, it should be noted that the aggregate study did not have information on whether the respondents were also using the condoms correctly. ibid. This should be further understood in conjunction with the fact that, as mentioned above, the per contact ratio for HIV transmission for vaginal sex (as in *Dica*) with a person with a detectable or unknown viral load is approximately .04%. Boily and others (n 73) 124. Additionally, the respondents in studies on prophylaxis often self-report and may overstate their condom usage, thus throwing off the results. William Pett, 'Do Condoms Work?' (*aidsmap.com*, February 2019) <www.aidsmap.com/about-hiv/do-condoms-work> accessed 13 April 2025. If condoms are used consistently and correctly, the risk of HIV transmission is estimated to be reduced by 98.5%. J Thomas Fitch and others, 'Condom Effectiveness: Factors That Influence Risk Reduction' (2002) 29 Sexually Transmitted Diseases 811 <https://pubmed.ncbi.nlm.nih.gov/12466725/> accessed 21 June 2024, 814.

[116] *Dica* Summing Up (n 70) 7-8. As addressed above, the judge informed the jury that, since the individual act where transmission occurred could not be identified, the jury would have to base their decision on whether or not Dica was 'reckless at the time of every act of sexual intercourse whether or not it was protected.' Consequently, the jury was informed that he could be found reckless if he wore a condom. ibid.

[117] *Rowe* (n 21) [25].

[118] ibid [26].

[119] While caselaw in England focuses more on negligibility as a potential defence in OAPA s. 20 cases for reckless transmission, Canadian caselaw requires a showing that the *actus reus* of the offense itself rose to the level of posing a 'significant risk.' *R v Cuerrier*, [1998] 2 S.C.R. 371. Consequently, assessing the risk level of the underlying act is already a part of Canadian law.

[120] (n 2) [4].

[121] (n 13) [7].

[122] [2009] EWCA Crim 60 [5].

question of recklessness arose in *Dica*, the court did not go into detail regarding the advice Dica received from medical practitioners, instead noting to the jury that they might 'think it to be certain' that he learned about dangerous sexual conduct at the same time that he learned of his HIV positive status in 1995.[123] While the English caselaw does not provide much information regarding whether or not medical advice can render a defendant's actions as justifiable, there is a hint of such in Scottish jurisprudence.

The 2007 case of *HMA v Giovanni Mola* involved a man accused of culpable and reckless conduct for transmitting HIV and Hepatitis C to a woman in 2003.[124] In that matter, the complainer allegedly asked the accused—who knew of his statuses and failed to disclose them—on multiple occasions to wear a condom.[125] While the prosecution claimed Mola had refused to wear condoms on most of the relevant sexual contacts, the defence disagreed and claimed that he had consistently used them.[126] Mola attempted to justify his behaviour by indicating that he received advice from a medical practitioner that he would not have to disclose his viral status if he took care to 'wear and use a condom properly.'[127] While the role of consent in cases of non-disclosure will be discussed further below, notable here is the judge's reaction to the medical advice given.

The trial judge, Lord Hodge accepted (to a degree) that the medical advice given may support an accused's assertion that they believed that their behaviour was not reckless. Lord Hodge specifically directed the jury that unless they found that the prosecution proved that Mola disregarded this medical advice and failed to consistently use a condom, they would have to acquit him.[128] Lord Hodge, in the sentencing statement, indicated that:

> You did not tell Miss X that you were infected with HIV and Hepatitis C. Standing the advice that you had received from medical practitioners that you did not have to disclose your viral status if you took care to wear and use a condom properly, *I do not consider that you can be judged to be criminally culpable and reckless on the ground only that you did not disclose your viral status. It is not for me to judge whether the medical advice which you received was appropriate*…As I say, it is not for me to judge the medical advice that you received. But you did not follow the explicit medical advice which you were given [regarding condom use].[129]

---

[123] *Dica* Summing Up (n 70) 22.
[124] *Mola* (n 21).
[125] Lord Hodge, Sentencing Statement, 5 April 2007 available at <http://news.bbc.co.uk/1/shared/bsp/hi/pdfs/05_04_07_mola.pdf> accessed 22 November 2024.
[126] James Chalmers, 'Getting mixed up in crime: doctors, disease transmission, confidentiality and the criminal process' in Danielle Griffiths and Andrew Sanders (eds), *Bioethics, Medicine and the Criminal Law; v. 2: Medicine, Crime and Society*. (Cambridge Cambridge Univ Press 2013).
[127] Lord Hodge (n 125).
[128] Chalmers (n 126) 76.
[129] Lord Hodge (n 125) (emphasis added).

While the role of disclosure remains unclear in Scottish law, Lord Hodge's statements indicate that following medical advice may be able to serve as a justification. Indeed, the statement lends heavy weight to the medical advice given, both accepting that—upon this advice being relayed to the accused—he could potentially justify not disclosing his status (allegedly in line with the medical advice), while being unable to justify failing to wear a condom (allegedly in opposition to the medical advice). Furthermore, Lord Hodge's statement suggests that the appropriateness (and presumably the fact-based accuracy) of the advice may be irrelevant to the question of recklessness. Had Mola received incorrect advice from a qualified medical practitioner that informed him that neither wearing a condom nor disclosure of his status were necessary, he would likely have had a strong defence that he was not aware of a risk and was thus not reckless. The sentencing statement in *Mola* does not deal with the question of the negligibility of the risk at all, suggesting that, in Scots law at least, justifiability may be shown if the defendant acted in accord with the medical advice given.

The context of both the comments of Lord Hodge and their sentencing statement is of particular import because in *Mola* it was not at-issue that the accused had, in fact, transmitted HIV and Hepatitis C to his sexual partner.[130] The strategy of the defence was clearly to emphasise that he had not been reckless in spite of transmitting two infections to the complainer. In order to demonstrate this, he had to emphasise that he acted justifiably by wearing condoms pursuant to his medical professional's advice—that transmission occurred anyway was owing to the fallibility of condoms.[131] The summing up in *Dica* left open the question of whether someone could be found reckless for transmitting HIV in spite of wearing a condom.[132] The summing up did not indicate how the jury was supposed to determine that Dica was reckless even when wearing a condom, implying that Dica could have been reckless by simply engaging in sex acts with the complainant regardless of the protections used. *Mola*, although likewise nonbinding and Scots law rather than English, adds a degree of clarification by simplifying recklessness in HIV transmission to whether or not the accused obeyed medical advice from a qualified medical practitioner. In the event that there was mixed condom use, as in *Dica*, the prosecution would likely have to argue that not

[130] Chalmers (n 126) 76.
[131] ibid.
[132] (n 70) 7-8.

obeying medical advice consistently imparted a reckless mindset regardless of whether condoms were used on the occasion where transmission occurred.

iii. Subjective Views on Negligibility

The above two sections address two aspects regarding justified risk taking: the objective negligibility of a given risk and the potential undercutting of subjective recklessness when the defendant acts in line with medical advice directly given to them. But what about a purely subjective perspective that the defendant's acts were not reckless? This issue was somewhat relevant in the intentional transmission case of *Rowe.* In that case, the defence argued that the Rowe believed he was treating his HIV with urine therapy[133] and foresaw only a 'negligible risk of infection.'[134] The court, however, was unimpressed with this contention and responded that:

> On the issue of intention the jury could properly infer from the evidence that the applicant fully understood the high risk of unprotected sex with the complainants. He could not have perceived the risk to be negligible. . .in the light of the information and advice he had received. Most importantly, the applicant's words and deeds indicated his clear intention.[135]

Since *Rowe* concerned intentional and not reckless transmission, the argument that the defendant did not appreciate the risk or harm of HIV was generally less relevant. The evidence adduced by the prosecution of Rowe's *mens rea* undercut the argument that he did not appreciate either the risk of transmission or the harm of HIV—particularly in light of the taunting texts he sent to some of the complainants after the fact[136] and the detailed discussion of risks provided by his medical practitioners.[137]

Could a similar argument be made under more relevant facts and in a case involving recklessness rather than intention? In other words, if someone is accused of recklessly transmitting HIV and argues that they did not believe they could transmit HIV because they practiced some sort of homeopathic treatment, would a court find they were behaving recklessly? Assuming that the prosecution could not adduce evidence to counter testimony that the defendant truly believed and followed a specific branch of homeopathy or alternative medicine, it seems possible. If the court embraces a more subjective assessment of risk and justification, then the objective level of a risk might not be particularly relevant. The *dicta* in

---

[133] *Rowe* (n 21) [29]
[134] ibid [39].
[135] ibid [57].
[136] ibid [13]-[18].
[137] ibid [4].

Rowe and the jury directions given by Lord Hodge appears to leave this possibility open, though again it would be unlikely to apply in cases of intentional transmission. This is an area where having both an objective and subjective assessment of risks would be illuminating. Even if the defendant engaged in a course of action which the prosecution proved as sufficiently objectively risky, the defendant would still have the opportunity to argue that they subjectively did not believe that the risk and the Crown would have to adduce evidence to the contrary.

3. Modern Science and Knowledge of Risks

Given everything listed above regarding risks, risk-taking, and justifiable risk-taking, is there a gap between the law and the science regarding recklessness? To a degree, there is, however mostly this is simply a question that has not been adequately assessed by courts. Aside from *Rowe*, which did not focus on recklessness, none of the courts fully engaged with the question of how different factors can affect how likely HIV is to be transmitted beyond some *dicta* impliedly referencing condom usage. Thus far, the question of justified risk taking in disease transmission cases has focused less on the objective level of risk of the act involved and more on the question of whether the defendant did something to reduce the risk. At the extreme end of this is *Marangwanda,* where—based on the allegations actually at-issue in the case—the risk of transmission was scientifically between zero and negligible. In the existing jurisprudence, defendants either did not adequately raise this as an issue, or the courts neglected to address the issue fully where the defence did raise it because of other factors that rendered the question fully or partially moot (such as a guilty plea). The end result of that omission is cases like *Marangwanda*, where something with an impossibly low risk can lead to a finding of recklessness. While *Marangwanda*, as previously addressed, involved an unusual set of circumstances, the door remains open to similar findings. The risk of transmitting HIV via oral sex is scientifically considered negligible though it remains possible, and there are no known cases of an individual contracting HIV through penetrative oral sex although that is likewise possible.[138] If transmission occurred during such an act, a court could rely on Spencer's arguments in the same way *Dica* had and find that the lack of condom use demonstrates recklessness regardless of how statistically unlikely such a transmission was.

---

[138] Keith Alcorn, 'Oral Sex and the Risk of HIV Transmission' (*Aidsmap*, 2 January 2021) <www.aidsmap.com/about-hiv/oral-sex-and-risk-hiv-transmission> accessed 31 May 2024.

What of the subjective aspects of recklessness? Will the individual in the above-referenced scenario be able to justify their actions by addressing what they subjectively believed to be the risk? Between *Rowe*, *Golding, Mola*, the answer seems to be that such beliefs are possibly relevant but the point remains unclear. *Rowe*, through *dicta*, possibly allows for a defendant's subjective assessment of risks to be relevant, though it remains unclear the extent to which that would apply since *Rowe* focused on intentional transmission and the prosecution's evidence undercut the defence's submission that he viewed the risk of transmission as negligible. Although Golding's plea led the judge on appeal to largely consider the question of risk as tertiary, they did briefly discuss it, stating:

> We conclude that there is nothing in the fresh evidence which would undermine the admission of recklessness. That was, in any event, a matter primarily for the appellant based on his own state of knowledge. There is nothing to detract from the effect of the appellant's admission by his plea that he knew that there was a risk and went ahead anyway.[139]

The reference to the fresh evidence potentially referred to either (or both) the expert opinions of Dr Mutton and Professor Kinghorn and the pre-sentence report. In relevant part, the experts discussed what advice Golding possibly received about his transmissibility since this was not available evidence.[140] While neither expert could be definitive in their guess, both estimated Golding's medical team would have informed him about the possibility of asymptomatic transfer.[141] The pre-sentence report, meanwhile, stated that he knew he was infectious during an outbreak and he experienced one shortly before initiating his sexual relationship with the complainant.[142] The language used by the appellate court appears to treat the question of recklessness as subjective, even though outside of the plea it was not clear whether Golding actually believed he could infect another person while asymptomatic. In the end, the existence of the plea minimised the issue.

Mola similarly framed recklessness in light of the medical advice received. This is problematic for several reasons. The first is that *Mola* 'effectively shifts moral responsibility from the accused to the doctor, and in different circumstances could lead to uncomfortably forensic examination of the content and appropriateness of medical advice offered to patients.'[143] While the facts of *Mola* were fairly straight-forward, the advice doctors give to

---

[139] *Golding* (n 13) [83].
[140] ibid [22]-[23].
[141] ibid.
[142] ibid [80].
[143] Chalmers (n 126) 78.

their patients may be tailored to the specific facts of their case, and the ruling in *Mola* may mean medical professionals have to navigate a legal complexity that would otherwise not be relevant to their advice.[144] Additionally, taken to its logical conclusion, a more widespread reliance on the *Mola* approach may mean patients are reticent to bring certain questions to their doctors, since the doctor's response may mean that the patient has additional legal burdens that they would otherwise not have.

Another issue is that there can potentially be a gap in an individual doctor's advice and scientifically grounded facts—in other words, doctors are humans and can give incorrect advice. Assume that a doctor misreads a patient's viral load and tells them they are undetectable when they are not, but also cautions them to use a condom to be safe. The patient is aware of the U=U campaign and engages in unprotected sex, and in doing so transmits HIV to another person. Were they reckless? On one hand, they disregarded medical advice. On the other hand, they believed credible information from another source that they could not transmit HIV. Would engaging in a treatment plan be enough of a modification as mentioned by Spencer? Would it matter if the patient did not rely on the U=U campaign, and instead believed that having certain crystals under his bed would prevent HIV transmission? There remains a large lack of clarity regarding the subjective aspect of recklessness as it relates to HIV transmission.

Instead of this current regime, which is unclear in many respects, it is submitted that courts should approach the question of risk as a two-pronged inquiry—one subjective and one objective. From a procedural standpoint, this clearly requires counsel for defendant's to be forward-thinking and avoid guilty pleas that acknowledge recklessness. It also requires defence counsel to specifically raise this issue before the court. If a court has the opportunity to fully address the question of recklessness, however, a subjective/objective analysis is the most complete way to ensure that recklessness is assessed fairly. The objective standpoint should be the first step, and cases where transmission occurred in spite of a sufficiently low risk should not rise to the level of recklessness. This is a matter of basic fairness—something should not be considered a risk to constitute recklessness where the odds of the harm occurring were negligible. If prosecution establishes this prong, however, the court should assess the defendant's subjective perspective. Did they believe they were engaging in some sort of mitigating behaviour? Did they subscribe to misinformation concerning their own HIV

[144] ibid.

status, or transmissibility more generally? What information did the defendant receive from a qualified medical provider? Under this approach, recklessness would not simply turn on the advice the defendant received from a medical professional and instead would assess both the likelihood of harm as well as the defendant's perspective. This would remove some of the burden from medical professionals who should not have to navigate this area of the criminal law, would encourage people living with HIV to speak more freely with their doctors or other medical personnel, would acknowledge different subjective circumstances, and would appreciate that numerous factors may impact the likelihood of transmission.

It is acknowledged that, under this proposed approach, many of the fact patterns which previously resulted in convictions may no longer meet the threshold of criminal liability. This is in large part due to the contention that most of the convictions in transmission cases involved objectively negligible risks. What then would potentially rise to the level of a significant objective or subjective risk? While stating an exact risk threshold as a percentage would be inappropriate and highly impractical, cases that involve egregious and compound risks may meet the threshold of significant. Two cases with fact patterns that meet such a criteria are *Rowe*[145] and *Pringle*.[146] If the evidence of intentional transmission were not present in *Rowe*, something which his taunting text messages and sabotaged condoms arguably indicated,[147] the other facts of his case demonstrate an example of an objectively non-negligible risk. He received medication which he did not take,[148] possessed an extremely high viral load and low CD4 count at the time of several of the encounters,[149] had a dual diagnosis with syphilis at one known point,[150] and engaged in unprotected[151] penetrative anal intercourse with several individuals.[152] Anal intercourse, when involving a PLWHA as the penetrative partner and a negative individual as the receptive one remains the most risky behaviour regardless of the sex of the receptive partner.[153] This risk increases when the viral load of the PLWHA is high,[154] and a syphilis infection can nearly triple the risk of HIV

[145] (n 21).
[146] (n 73).
[147] *Rowe* (n 21) [13]
[148] ibid [11].
[149] ibid [10]
[150] ibid.
[151] The unprotected nature of the sex acts was on several instances without the knowledge of the complainants. See, eg, ibid [18].
[152] Eg, ibid [5]-[16].
[153] See Vittinghoff and other (n 74); Boily and other (n 74).
[154] Boily and other (n 74) 123.

transmission.[155] As addressed above, had Rowe been tried for reckless rather intentional transmission the court may have found his subjective perspective more relevant when assessing whether he appreciated the risks he was taking in light of his homeopathic treatment plan.

Pringle likewise demonstrates a fact pattern that may be more in line with a significant risk. Like *Rowe*, he engaged in unprotected penetrative anal intercourse with the complainant in spite of the presence of blood.[156] His medical providers specifically informed him that this was the most risky form of intercourse[157] and he failed to take his medication for almost a year, consequently increasing his viral load during his sexual contacts with the complainant.[158] The combination of the means of sexual contact, the presence of blood, and the higher viral load which occurred as a result of a prolonged unmedicated period may arguably meet the threshold of a more objectively non-negligible risk. Additionally, the evidence that Pringle's doctors provided him with verbal and written information on how the behaviours he engaged in could increase the risk of transmission could meet the subjective threshold.[159]

The arguments for a higher threshold for reckless transmission cases are not in any way intended to condone a partner transmitting HIV without disclosing their status; rather, it is to highlight that there is a difference between actions which are morally condemnable and acts which are criminally liable. An initial objective assessment helps establish such a threshold by addressing whether the risks taken were objectively significant and thus unjustified, while a subjective assessment can allow for a more holistic approach to whether the defendant actually appreciated the nature and gravity of the underlying risk. What makes HIV different than other areas which deal with justified risk taking is two-fold. First, the 'betrayal of trust' narrative can heighten emotion and implicate the anecdotal bias, consequently causing objective statistical evidence to hold less sway than emotional testimony.[160] Secondly, people tend to vastly overestimate the risk of per-contact transmission. One South African study asked participants to estimate the per-contact risk of

---

[155] Meng Yin Wu and others, 'Effect of Syphilis Infection on HIV Acquisition: A Systematic Review and Meta-Analysis' (2020) 97 Sexually Transmitted Infections 531.
[156] *Pringle* (n 73) 26 November 2012 Proceedings 6.
[157] ibid 5.
[158] ibid 6.
[159] ibid.
[160] Traci H Freling and others, 'When Poignant Stories Outweigh Cold Hard Facts: A Meta-Analysis of the Anecdotal Bias' (2020) 160 Organizational Behavior and Human Decision Processes 51. Further discussion of the anecdotal bias can be found in Chapter 6.

HIV transmission for vaginal sex for both men and women[161] and the mean perceived risk was 35.2% for a man and 34.2% for women,[162] substantially higher than the actual risks of 0.04% [163] and 0.08%[164] respectively. Consequently, the unique circumstances in cases involving reckless sexual HIV transmission call for a more nuanced approach to the assessment of recklessness than may be found in other criminal settings.

IV. The Role of Consent

While consent is an answer to certain allegations of assault or battery,[165] *how* consent functions in such cases remains unclear.[166] There are two potential camps regarding how to view consent: consent as an element of the offence in its absence and consent as an affirmative defence.[167] While this distinction may appear nuanced, in certain cases it can be critical. If absence of consent is an element of the offence, then the burden is on the prosecution to adduce evidence of such; if it is an affirmative defence, the burden is on the defence.[168] Regardless of the evidentiary burden, an examination of the legal validity of consent usually requires a focus on three questions: (1) whether the consent was express or implied; (2) whether the complainant gave effective consent; and (3) whether the complainant gave legally valid consent in light of the context.[169] Within the context of disease transmission, it is predominantly the first two questions which are most relevant.

A. Consent to Harm and Sex - Background

The starting point for understanding the role of consenting to harm during otherwise private, consensual sex acts begins with *R v Brown.* The court in *Brown*[170] set the outer limits in determining if consent is a defence to an OAPA section 20 offence and found that a certain level of harm simply cannot be considered legal regardless of the consent of all parties.[171] In *Brown*, the defendant was involved in consensual sado-masochistic sex acts with several men

[161] Eva van Empel and others, 'Older Adults Vastly Overestimate Both HIV Acquisition Risk and HIV Prevalence in Rural South Africa' (2021) 50 Archives of Sexual Behavior 3257, 3258.
[162] ibid 3261.
[163] Boily and other (n 74) 118.
[164] ibid.
[165] Consent is not permissible in all circumstances. This will be discussed in further detail below.
[166] Ormond, Laird and Gibson (n 5) 716.
[167] ibid.
[168] ibid.
[169] ibid 717.
[170] (n 4).
[171] Dennis J Baker, 'The Moral Limits of Consent as a Defense in the Criminal Law' (2009) 12 New Criminal Law Review 93, 116.

which included severe acts of violence;[172] in that case, the 'gravity of the harm influenced the [court's] decision, as this was not merely a case of common assault.'[173] Where the harm is particularly grievous, as found by the court in *Brown*, consent may only be recognised if the underlying conduct relates to an exception recognized by the courts, and if it is of 'sufficient social utility.'[174] In *Brown*, the court enumerated numerous potential categories where consent may be found in spite of bodily harm, including: ritual circumcision, ear-piercing, certain lawful sports,[175] parental-based chastisement towards their child,[176] and reasonable surgery.[177] Lord Slynn highlighted how these categories—with the exception of tattooing and ear-piercing—were all 'subject to a reasonable degree of force being used.'[178] In the end, the court took the view that public considerations were relevant to the sanctions of the criminal law in *Brown*.[179]

As a point of comparison, two years later the Court of Appeal heard the case of *R v Wilson*.[180] In that case, a husband branded his initials on his wife and was subsequently charged with assault occasioning actual bodily harm.[181] The wife not only consented to the branding, she initiated the initial conversations about it.[182] Unlike *Brown,* the court found that there was not a public interest in the underlying behaviours and quashed the conviction. While both *Wilson* and *Brown* dealt with issues of consent distinct from *Dica* and the other relevant cases, they addressed some similar issues. More to the point, the comparison of these two cases highlight how sadomasochism in the context of a married couple was treated differently than sadomasochism in the context of group sex involving all men. The possibility of there being an implicit bias against sexual minorities, including people with STIs, is a theme revisited in this thesis.

---

[172] Including: 'nailing their prepuces and scrota to a board, inserting hot wax into their urethras, burning their penises with candles, and incising their scrota with scalpels'. ibid 116-7.
[173] ibid.
[174] Daniel Bansal, 'Bodily Modifications and the Criminal Law' (2018) 82 The Journal of Criminal Law 496, 496. The findings in Brown were upheld at the European Court of Human Rights in the case of *Laskey v United Kingdom* (1997) 24 E.H.R.R. 39. There, the court found that the convictions did not violate Article 8 of the European Convention of Human Rights.
[175] *Brown* (n 4) 231.
[176] This has largely been removed as a defence, particularly in Scotland and Wales. Children (Equal Protection from Assault) (Scotland) Act 2019 s 1; Children (Abolition of Defence of Reasonable Punishment) (Wales) Act 2020 s 1.
[177] *Brown* (n 4) 245.
[178] ibid 277. Lord Slynn did not include ritual circumcision in the specific list indicated.
[179] ibid.
[180] [1997] QB 47.
[181] ibid 48.
[182] ibid 50.

1. *Dica, Konzani*, and Consent

Dica,[183] which referenced *Brown*, distinguished itself from *Brown* by looking to the actions underlying the harm, rather than the harm itself. Specifically, the court noted that the aim of the sex acts in *Dica* was not to cause harm or spread a disease—it was sexual gratification. In *Dica* the court held that the defendants in such cases 'are simply prepared, knowingly, to run the risk — not the certainty — of infection.'[184] While *Dica* indicated that consent probably could not be a defence in cases of intentional transmission,[185] the fact that sexual contact always contains various risks allowed for consent to operate as a potential defence in situations where reckless harm is alleged to have occurred.[186] As a result, *Dica* held that, in reckless transmission cases, evidence that the complainant consented to the risk of transmission may operate as a defence.[187] When discussing consent, however, is the focus solely on the point of view of the complainant, or could a defendant argue that they reasonably believed the complainant consented to the risk of harm?

For consent to operate as a defence in reckless transmission cases, it must be 'informed consent.'[188] While neither *Konzani* nor *Dica* explicitly provided a definition of 'informed consent,' each discussed it in the context of the whether or not the defendant previously disclosed his HIV status. In *Konzani,* for instance, the court stated:

> 'When sexual intercourse occurred these complainants were ignorant of his condition. So although they consented to sexual intercourse, they did not consent to the transmission of the HIV virus…There is a critical distinction between taking a risk of the various, potentially adverse and possibly problematic consequences of sexual intercourse, and giving an informed consent to the risk of infection with a fatal disease.'[189]

Put another way, if a complainant was aware of a defendant's HIV status and chose to engage in sexual conduct regardless, consent is likely to be inferred. The critical point at issue in cases of reckless transmission is then how and when the complainant was informed.

---

[183] (n 48).
[184] ibid [47].
[185] Matthew Weait, 'Criminal Law and the Sexual Transmission of HIV: *R v Dica*' (2005) 68 Modern Law Review 121, 124. In addition to the difference between the risk and the certainty of infection, cases involving sadomasochism such as Brown had a much closer temporal and physical nexus between the act and the harm, leaving it less ambiguous (as it may by in transmission cases) about the actus reus which caused the harm in question. ibid 125-6.
[186] ibid 124.
[187] *Dica* (n 48) [59].
[188] See, eg, *Konzani* (n 2) [41].
[189] ibid.

The Law Commission first discussed the prospect of criminalising disease transmission in 1993 via its report *Legislating the Criminal Code: Offences against the Person and General Principles*.[190] There, the Law Commission considered disease transmission to be an offence against the person, and that culpability for such could apply to a defendant regardless of whether or not he acted recklessly or intentionally.[191] The Home Office—while generally agreeing with the Law Commission's report—did not originally support the criminalisation of non-intentional transmission cases.[192] After the decisions in *Dica* and *Konzani*,[193] however, the Law Commission put forth three potential approaches to the necessity of disclosure in a consultation paper:[194] 1. Disclosure is required only in situations where the risk was significant; 2. Disclosure is always required regardless of the risk; or 3. The necessity of disclosure is a question for the jury.[195] While no cases, to date, discuss the potential for disclosure to fall into category 1 or 3, it is possible that a future case may do so. In such cases, the perspective of the defendant may be enough for them to establish that they reasonably believed that the complainant consented, and non-explicit disclosure was thus justified.[196] The objective/subjective assessment proposed above would similarly be of assistance in resolving inquiries surrounding disclosure and consent as well. Where the risk is sufficiently objectively low, then it is submitted that recklessness may not be implicated and the question of disclosure and consent would thus be moot. Where risk is objectively significant, then subjective considerations become relevant. This includes evidence that the defendant believed the complainant knew of their HIV status or consented to the risk of harm.[197]

---

[190] Samantha Ryan '"Active Deception" v Non-Disclosure: HIV Transmission, Non-Fatal Offences and Criminal Responsibility' (2019) 1 Criminal Law Review 4 citing Law Commission, 'Reform of Offences against the Person: A Scoping Consultation Paper' Law (Comm No 217, 2014).
[191] Ryan, 'Disclosure and HIV Transmission' (n 9) 396.
[192] ibid 395-96.
[193] ibid 396.
[194] Law Commission, 'Reform of Offences against the Person' (n 190) para 6.30.
[195] ibid.
[196] While there may be situations of 'justified non-disclosure'—i.e. transmission occurs where the defendant simply neglected to inform the complainant of their status—it seems unlikely that there could be a similar parallel where the defendant overtly misled the complainant. One cannot imagine a defendant asserting a honest belief of the complainant's consent when the defendant themselves had been explicitly dishonest. The distinction between non-disclosure and active deception is discussed further in Ryan's '"Active Deception"' (n 190).
[197] The burden of proof would be on the prosecution to disprove this where the defence provided evidence for it.

2. Consent and the Knowledge of the Accused – Justified Non-Disclosure?

There are two potential situations where non-disclosure could be essentially justified in a reckless transmission case. The first, as addressed by the Law Commission,[198] involves a situation where the level of risk is insignificant. In such a case, the question would be less one of consent, and more one of justified risk taking, discussed above. If the risk is negligible and the defendant's actions reasonable, recklessness will not be established.

The other, which was discussed in *Konzani*, involves what may amount to an indirect disclosure. This situation, which *Konzani* stated would need to be assessed by a jury, could involve the consent being derived not from the explicit words of the defendant, but other scenarios whereby the complainant's knowledge of the defendant's HIV status could arise. The examples in *Konzani* involve a complainant who enters into a sexual relationship with an individual whom they knew to be undergoing medical treatment for their HIV, and where the defendant honestly believes that a third party previously informed the complainant about their HIV diagnosis.[199] If there is evidence of such an indirect disclosure, it would be a viable defence which the prosecution would have to disprove to achieve a guilty verdict.[200]

That said, the consent cannot be solely established based on the belief of the defendant where direct disclosure was not provided.[201] While the judgment indicated that a jury may find consent where the defendant honestly believed the complainant consented (despite not directly informing them), the subsequent paragraph immediately confined that, stating:

> [T]he defendant's honest belief must be concomitant with the consent which provides a defence… For it to do so here, what was required was some evidence of an honest belief that the complainants, or any one of them, were consenting to the risk that they might be infected with the HIV virus by him. There is not the slightest evidence, direct or indirect, from which a jury could begin to infer that the appellant honestly believed that any complainant consented to that specific risk.[202]

This suggests that a simple assertation on the part of the defendant of an honest belief may not be enough. At the date of writing, the question of *what* evidence is necessary to establish an honest belief remains unclear since this specific issue has not yet been a major point of

---

[198] Law Commission, 'Reform of Offences against the Person' (n 190) para 6.30.
[199] *Konzani* (n 2) [44].
[200] ibid.
[201] Perceived consent may, however, factor in when considering whether or not a defendant subjectively believed he was running a reasonable risk.
[202] *Konzani* (n 2) [45].

contention in any of the known cases, reported or unreported. This, combined with the court's repeated position that 'silence [regarding one's HIV status] is incongruous with honesty or with a genuine belief that there is an informed consent.'[203] leaves an extremely narrow opening for consent to apply in a case of nondisclosure.

Disclosing one's HIV status—something often met with anxiety—may thus be further compounded by the question of whether such disclosure is being done 'right.' For example, in a study which interviewed men living with HIV in England and Wales, one participant believed that having a biohazard symbol tattooed on him was sufficient to inform sexual partners of his HIV status.[204] The avenue needed to establish consent via indirect disclosure is so narrow that it may be a dead end in practice.

Could the defence of consent apply where the defendant honestly believes that the complainant consented to the risk of HIV broadly, regardless of not having any reason to honestly believe that the complainant knew of the defendant's specific HIV status? For example, could a defendant, who knew the complainant regularly took PrEP in the past—but was unsure if he remained on that regime—argue an honest belief that the complainant consented to the risk of HIV transmission?[205] Aside from the fact that the defendant could argue that he was not reckless since he did not believe he was taking an unreasonable risk, it could lead to an argument that the complaint was particularly aware of the means by which HIV may be contracted. In other words, could a defendant assert that a complainant had a high degree of understanding regarding the means of transmission, and thus impliedly consented to the risk of seroconversion by agreeing to engage in consensual sex acts? This potential is one not addressed in the current case law and involves medical advancements beyond what was available in the age of *Dica/Konzani*. Based purely on the language of *Konzani,* the answer is probably in the negative. Consent per *Konzani* requires showing that the complainant consented not just to the risk of acquiring HIV, 'but specifically were consenting to the risk that they might be infected with the HIV virus *by him.*'[206] Thus the consent must not be to the risk of HIV generally, and instead must be to the risk posed by the defendant specifically. Consequently, while a defence of consent might apply where the

---

[203] ibid [42].
[204] Catherine Dodds, Adam Bourne and Matthew Weait, 'Responses to Criminal Prosecutions for HIV Transmission among Gay Men with HIV in England and Wales' (2009) 17 Reproductive Health Matters 135, 139.
[205] This fact pattern would implicate both consent, as addressed here, as well as justified risk taking (addressed above).
[206] *Konzani* (n 2) [45].

defendant knew or honestly believed the complainant took PrEP or another HIV-specific preventative measure before engaging in sexual conduct with them, it would be unlikely to apply where it could only be shown that the defendant knew of the complainant's PrEP regimen generally.[207]

i. Inconsistent Consent?

It is notable that where sex and bodily harm intersect there is a great deal of inconsistency regarding both the role of consent and the threshold of harm that renders a sexual act criminal.[208] That consent was not allowed as a defence in *Brown*, involving sadomasochistic acts between men, and only allowed in a limited fashion in cases involving HIV causes some commentors to question whether the current caselaw is unjustified and further marginalizes already vulnerable communities.[209] Notably, where *Brown* found that consent could not operate as a defence in a case of sadomasochism, the court found in *R v Wilson* –- a case where a husband branded his initial's on his wife's rear end with a hot knife—that it could. That the judiciary deemed consent to a sadomasochistic act as a defence in a case with a married heterosexual couple and not in a group of same sex men has been criticised as showing 'moral popularism.'[210]

The court in *Wilson* distinguished *Brown* by highlighting that the certified question before the *Brown* court involved 'sado-masochism of the grossest kind, involving inter alia, physical torture' with risks of serious injury and infections; it equated the branding in *Wilson* to be being akin to a tattoo.[211] This, of course, ignores the fact that tattoos absolutely come with risks, including those which may cause serious injuries and infections.[212] Branding is distinct from tattooing and is extremely dangerous. One study examined four individuals in Pakistan who agreed to be branded for therapeutic purposes—all wound up receiving serious health issues requiring hospital admissions and two died.[213] Both *Brown* and *Wilson* involved

---

[207] While the defendant's belief that the complainant is on PrEP may not be relevant for consent, it still likely would be relevant in questioning whether or not the risk taken by the defendant was justified.
[208] Catherine Elliott and Claire de Than, 'The Case for a Rational Reconstruction of Consent in Criminal Law' (2007) 70 Modern Law Review 225, 248-9.
[209] ibid.
[210] Susan SM Edwards, 'Consent and the "Rough Sex" Defence in Rape, Murder, Manslaughter and Gross Negligence' (2020) 84 The Journal of Criminal Law 293, 298.
[211] *Wilson* (n 180) 50.
[212] Mayo Clinic, 'Thinking of Getting a Tattoo? Know What to Expect' (*Mayo Clinic*, 2024) <www.mayoclinic.org/healthy-lifestyle/adult-health/in-depth/tattoos-and-piercings/art-20045067#:~:text=An%20infection%20might%20be%20due> accessed 17 July 2024.
[213] Shahzad Raza and others, 'Adverse Clinical Sequelae after Skin Branding: A Case Series' (2009) 3 Journal of Medical Case Reports.

acts which could otherwise be considered tortured which entailed serious risks for the purpose of sexual pleasure. The court in *Wilson*, however, deemed it against public interest to deem the acts as criminal, noting: 'Consensual activity between husband and wife, in the privacy of the matrimonial home, is not, in our judgment, normally a proper matter for criminal investigation, let alone criminal prosecution.'[214] The court's distinguishment of *Brown* from *Wilson* makes little sense legally, and the language used suggests that the couple being heterosexual and married in *Wilson* was an influential factor.

Cases involving 'rough horseplay' follow a similar pattern of recognising consent despite serious harm; in such cases, the focus is on whether there was an intent to harm.[215] The courts in both *R v Jones*[216] and *R v Aitken*[217] permitted the defendants' appeal against an OAPA section 20 conviction on the grounds that the underlying conduct was lawful, the harm not intentional, and a jury could find that the complainants either consented or were believed by the defendants to have given such consent.[218]

In *Jones*, two boys were injured. The first boy described the act as one that began with 'play fighting,' and escalated to the point where the appellants threw him up in the air and he landed on his feet.[219] He protested and tried to escape, but the defendants repeatedly punched and kicked him before throwing him in the air twice more; on the last throw, he landed face down and ruptured his spleen, which doctors later removed.[220] The second boy was simply walking past the group of defendants when they tripped him and threw him in the air—the boy landed on his side and fractured his arm.[221] When interviewed, the defendants stated that the thought the episode was a joke and they had no intention of inflicting serious harm.[222] They further stated that they believed the complainants consented to the acts, and that any protestation on their part was an aspect of their normal play.[223] The defence, citing *Donovan,* argued that the conduct in question should be considered a 'rough and undisciplined sport or play,' which the court stated was an exception to the normal criminalisation of causing bodily harm on the grounds that such acts are 'manly diversions.'[224] The defence argued that where

---

[214] *Wilson* (n 180) 50.
[215] Gurnham (n 24) 88.
[216] [1986] 83 Cr App R 375.
[217] [1992] 1 WLR 1006.
[218] Gurnham (n 24) 89.
[219] *Jones* (n 216) 377.
[220] ibid
[221] ibid
[222] ibid
[223] ibid.
[224] [1934] 25 Cr.App.R. 1; [1934] 2 K.B. 498, 508.

there is 'rough and undisciplined play' that lacked an intent to cause injury, consent may be a defence.[225] Furthermore, reasonable belief that consent was given may also amount to a defence, regardless of whether or not it is reasonably held.[226] The court accepted this, stating that it was for the jury to consider whether or not that threshold was met.[227]

In *Aitken*, three Royal Air Force officers completed a course which ended their formal flying training and were celebrating its conclusion.[228] The three appellants drank heavily through the night, and the complainant—Gibson—along with the defendants and flight officers Huskisson and Thomas, moved to nearby quarters.[229] Soon after, Huskisson and Thomas fell asleep.[230] In the presence of Gibson, one of the defendants poured brandy onto the lower part of Huskisson's flight suit and set it on fire; the flame burned for a short period, and although the affected officer woke up, all considered it a joke and he went back to sleep.[231] The defendants performed a similar act, this time with a white spirit, on officer Thomas to a similar effect, albeit with larger flames.[232] The underlying act in the case occurred later, when the complainant was heavily intoxicated. The defendants grabbed him, ignored his resistance, and poured an unknown amount of white spirit on him and lit a match; 35% of the complainant's body wound up burned after the flames engulfed him.[233] While the court in *Aitken* refused to take the defendant's intoxication into account when assessing recklessness, the court relied upon *Jones* and stated that, based on the totality of the circumstance: 'In this event the judge advocate should have directed the court as to the necessity of considering whether Gibson gave his consent as a willing participant to the activities in question, or whether the appellants may have believed this, whether reasonably or not.'[234]

Thus, in *Jones* and *Aitken*, not only is consent allowed in cases of serious harm, actual consent to the risk is not needed as long as the defendant believes such consent existed. Horseplay, even violent horseplay, thus falls into the category of a recognised exception and is granted a degree of leniency not found in cases where the underlying background is sexual

---

[225] *Jones* (n 216) 378.
[226] ibid.
[227] ibid 379.
[228] (n 217).
[229] ibid.
[230] ibid 1008-9.
[231] ibid.
[232] ibid.
[233] ibid 1010.
[234] ibid 1020.

in nature.[235] The defence in *Konzani* cited *Jones* and *Aitken* in arguing for consent, but the judge dismissed these arguments, citing Lord Mustill's dissenting speech in *Brown* which stated that certain rough horseplay activities are allowed provided they do not go too far.[236] But why victims may implicitly consent (or have been believed to have consented) to an inherently risky activity—such as being lit on fire –in the case of horseplay, but not in the context of the transmission of HIV remains difficult to justify.[237] One answer is that HIV transmission involves more difficult questions regarding 'gender and justice that injury by horseplay does not.'[238] If the logic behind allowing a 'rough horseplay' exception is that horseplay is a natural part of life and entails certain risks of injuries---then why did that logic not translate more closely to the findings in *Konzani*? To rephrase, the case law concerning both horseplay and HIV involve consenting to the risk of injury; in horseplay cases the focus is on whether they consented generally, while cases involving HIV specifically focus on informed consent. If both categories involve underlying acts which are generally socially acceptable and entail assumed risks, why do cases involving HIV require the additional step of informed consent that is not required for horseplay cases? Returning to *Konzani*, the distinguishing factor appears to be a question of the level of harm. The court in *Konzani* was clearly influenced by the public interest in stopping 'the spread of catastrophic illness.'[239] While the court also discussed issues regarding autonomy, one could provide similar arguments to horseplay cases: one would be unlikely to agree to horseplay if one knew that a potential risk of that entailed being lit on fire. Just as horseplay may be spontaneous and not involve a discussion of the risks which it may entail before it, so too are sex acts on occasion. The difference between horseplay cases and HIV cases is that it involves more marginalised groups of people, in situations where British society may be uncomfortable as it involves sex acts, and involves the spread of a disease which the public still largely misunderstands.

---

[235] Gurnam (n 24) 93.
[236] *Konzani* (n 2) [36], citing *R v Jones* (n 216).
[237] Since the other officers did not receive burns from being set on fire, the logic for the consent in this case is: since Gibson 'consented to take part in rough and undisciplined mess games' involving fire and he consented to the risk of burned, not to being burned itself. *Aitken* (n 216) 1021. In this sense, the role of consent is similar to reckless transmission cases. Notably different, however, is the connection between the actus reus (setting someone on fire in one case and engaging in consensual sexual intercourse in the other) and the harm (burns and HIV transmission respectively).
[238] Gurnham (n 24) 98.
[239] *Konzani* (n 2) [42].

The court in *Dica'*s reference to *R v Clarence* – a case that had already been overruled in *R v R*[240]– suggests that there is something unique about risks in sexual relationships.[241] Indeed, while disease transmission was an issue in *Clarence*, much of the context for the court's decision centred on the fact that the complainant was the defendant's wife, and at the time certain sexual offences could not be established because she had 'no right or power to refuse her consent.'[242] In this sense, *Dica* was significantly distinguishable from *Clarence*. By drawing on *Clarence* as the lens to view reckless transmission, the narrative of all future transmission cases took on a decidedly different tone than the horseplay cases, categorising the relationship between the parties as a gendered-based power dynamic.[243] While the reliance on *Clarence* in *Dica* may have been intended to further distinguish the modern era from the past where women were essentially property of their husbands, the continued support for consent in rough horseplay cases supports a rhetoric steeped in centuries-old rights exclusive to men.[244] The exceptions for 'rough horseplay' are historically tied to (non-sexual) acts between men, and as such are a 'man's prerogative' and an area where criminal courts recognise that men have the right to implicitly consent to risky activities.[245] Neither *Brown* nor *Konzani* or *Dica* adequately explain why exactly it is that cases involving consent to OAPA offences in a sexual context are inherently different than other cases, such as *Jones* and *Aitken* which produced serious harms in a non-sexual context. That the cases where consent is denied (as in *Brown*) or extremely limited (as in *Dica/Konzani*) involve cases of already marginalised communities—men who have sex with men and people living with HIV—demonstrates how the caselaw's distinct treatment of matters involving sex can lead to disparate harm.

Consequently, modern jurisprudence generally downplays the knowledge of the accused in cases involving consent to reckless transmission, with the knowledge of the complainant serving as the more relevant live issue.

3. Consent, Non-Disclosure, Recklessness, and Responsibility

Since this thesis advocates for an objective/subjective analysis towards recklessness which entails a higher threshold than used in previous cases, it is acknowledged that

---

[240] [1992] 94 Cr App R 216.
[241] Gurnham (n 24) 98.
[242] *R v Clarence* (1888) 22 QBD 23, 63.
[243] Gurnham (n 24) 99.
[244] ibid.
[245] ibid.

assessments of consent may be less relevant under this rubric. That said, this chapter still aims to highlight the ways that medical advances may increasingly be useful in establishing defences based on perceived consent in light of innovations such as PrEP. The more general position asserted in this thesis is based on the starting point that the individuals involved in a consensual sex act have equal negotiating power as to whether a condom is used. In practice, imbalance can exist in condom negotiation, particularly in heterosexual relationships involving young women and in situations involving intimate partner violence.[246]

There are two potential forces at odds in such situations: the rights of a person who may not have full negotiating power to protect themselves against HIV and other STIs and the rights of people living with HIV and other STIs to not have the burden of safe sex practices fall solely upon their shoulders. There are three possible solutions to this quandary. The first is to require PLWHA to always receive informed consent regarding the risk of HIV transmission from a sexual partner prior to a sex act (which in practice, per *Konzani*, almost always requires disclosure of one's HIV status) if prophylaxis are not used in order to not implicate criminal liability. This position, which is closest to the current regime, makes preventing HIV the burden of the PLWHA and not the community and downplays an individual's own responsibility in protecting their sexual health.

Some argue that since this rubric places the onus of preventing transmission on the PLWHA, it can disincentivise people from learning of their HIV status (and thus trigger additional duties to disclose).[247] Additionally, this position ignores the relative position of power of each party and that both individuals may have chosen to engage in unprotected sex in spite of their knowledge of the risks of STIs when condoms are not used. This also means that if a PLWHA is in a situation where they are subject to intimate partner violence, they may have to choose between disclosing their status (which may expose them to violence) or placing themselves in a position that potentially exposes them to criminal liability.

The second solution is to do away with any laws criminalising reckless exposure. This may be more fair to PLWHA since it makes HIV prevention the responsibility of the

---

[246] See, eg, Kristin L Dunkle and Michele R Decker, 'Gender-Based Violence and HIV: Reviewing the Evidence for Links and Causal Pathways in the General Population and High-Risk Groups' (2012) 69 American Journal of Reproductive Immunology 20.; Leah East, Kath Peters and Debra Jackson, 'Violated and Vulnerable: Women's Experiences of Contracting a Sexually Transmitted Infection from a Male Partner' (2017) 26 Journal of Clinical Nursing 2342; Sandra L Martin and others, 'Domestic Violence and Sexually Transmitted Diseases: The Experience of Prenatal Care Parents' (1999) 114 Public Health Reports 262.
[247] See, eg, Scott Burris and Matthew Weait, 'Criminalisation and Moral Responsibility for the Sexual Transmission of HIV' (2013) Temple University Beasley Legal Studies Research Paper School of Law 2013-17 <https://papers.ssrn.com/sol3/papers.cfm?abstract_id=2126714> accessed 5 April 2025.

community rather than the individual and is more likely to reduce stigma. Unfortunately, it may mean that people who do not have full negotiating power regarding condom usage may have little recourse when infected with an STI that they had few safe avenues to prevent. It also means that there are no consequences for a person who lied about their HIV status, and in doing so diminished the autonomy of another individual to give informed consent.

The final possible solution is to draw a distinction between those who lie about their status and those who fail to disclosure their status. This thesis does not draw meaningful distinctions between 'active deception' and 'non-disclosure,'[248] however such a distinction does offer the ability to remedy the problems with the other two solutions. If an individual engages in risky behaviour, such as unprotected sex, and does not inquire into the STI status of their partner, then such behaviour could be considered consent to the risk of transmission.[249] This would not apply, however, if one partner misleads the other regarding their status, as this shows both greater culpability and more directly undermines the autonomy of the HIV-negative partner.[250] The main difficulty with this approach is defining what constitutes 'active deception' versus 'non-disclosure.'[251]

Currently, the law generally follows the first of the above solutions. The analysis advocated for in this section towards recklessness is a unilateral because under the caselaw the perspective of the complainant is largely irrelevant outside the question of whether they consented to the risk of HIV transmission in response to the defendant's explicit or implicit disclosure.[252] The defence in *Konzani* specifically argued that, by willingly engaging in unprotected sex acts, the complainants impliedly consented to the risk of HIV transmission;[253] the court disagreed. The testimony of the complainants that confirmed they knew unprotected sex carried a risk of HIV transmission[254] was largely irrelevant in the absence of disclosure.

This thesis does not aim to pronounce whether reckless HIV transmission should be criminalised, and questions regarding the negotiating power of the relevant parties as it relates to deception or non-disclosure is beyond the scope of this analysis. However, the 'betrayal of trust' narrative, which this thesis argues exists in many of the relevant of cases,

---

[248] Ryan, '"Active Deception"' (n 190).
[249] ibid.
[250] ibid 5.
[251] ibid 6-7.
[252] As detailed above, there are few limited situations where an honest belief of informed consent could apply per *Konzani*.
[253] *Konzani* (n 2) [5].
[254] see ibid [20]

can impact both questions of justifiability and confuse questions of consent. This narrative can cause relevant parties, including the court and jurors, to experience heightened emotions and skew their view of the risks, harm, and even the social value of sex when a person with HIV is involved.[255] Consequently, questions regarding the justifiability of the underlying risk may not be fairly viewed.[256]

V. Conclusion

A common thread between knowledge, recklessness, and consent is that their meanings belies the complexity of their legal definitions. While a single definition of 'recklessness' does not exist, the definitions that do often rely on the defendant's awareness of a risk and the reasonableness of his actions. Unfortunately, there is a lack of clarity regarding what it means to be 'aware' of a risk and how reasonability is determined in such circumstances. Where reckless HIV transmission is alleged to have occurred, there is a considerable gap in between the case law and the science considering how the defendant's knowledge interplays with recklessness, particularly in connection to the defendant's diagnosis, severity of HIV, and the risk of transmission. As such, defence counsel should be careful about preserving issues surrounding knowledge and consent, and courts should take a more comprehensive approach towards analysing recklessness when such questions arise before them in the future.

While unreported decisions infer that it is likely a medical diagnosis is sufficient to establish both the defendant's knowledge of their status and the harm posed by HIV,[257] it remains unclear how exactly the courts determine the severity of the risk and whether one can be said to engage in justified risk taking. The question of the severity of risk, how risky something needs to be in order to be 'reckless,' and whether a risk is justified are all interconnected topics that have thus far not been fully engaged with in a court addressing HIV transmission. Modern understandings of the actual risks of transmission have evolved significantly since the days of *Dica* and *Konzani* and the lack of caselaw that specifically addresses this issue exemplify one way there has been a disconnect between the law and science.

---

[255] Ryan, 'Disclosure and HIV Transmission' (n 9)
[256] It should be noted that the 'betrayal of trust' narrative even exists where there was non-disclosure as opposed to active deception. Cases such as *Mola*, although a Scottish case involving culpable and reckless conduct, involved this narrative in spite of there not being information that Mola directly lied to the complainer.
[257] See, eg, *Dica* Summing Up (n 70).

Knowledge and belief also connect deeply to the role of consent, a key point in both *Dica* and *Konzani*. Those two cases establish that consent can be a defence if it is informed and made with regards to the risk of HIV transmission.[258] *Konzani* leaves room for the defence to establish an honest belief of informed consent despite a lack of explicit disclosure of one's HIV status,[259] however in practice it will be difficult to establish this belief. Some argue that the court's approach to the role of consent contains inconsistencies which demonstrate a bias towards already marginalised communities,[260] and the case law indicates that courts are reluctant to include sex acts in the miscellaneous category of 'social benefit'[261] that categories such as extreme roughhousing may enjoy.[262] Beyond the likelihood of social biases coming into play when assessing consent to the risk of transmission, it is also notable that the court's assessment of a potential harm is highly relevant to the question of consenting to a risk of harm. While the court dealt with the question of consenting to harm rather than consenting to the risk of harm, the courts in *Brown* and *Wilson* highlight that the court's perception of the potential danger posed by an act is relevant to the question of consent. In the end, it is likely that part of the reason why *Konzani* specifically required the standard of informed consent to the risk of transmission is because of the perceived severity of HIV at that time. While the question of harm is discussed more thoroughly in the next chapter, this exemplifies yet another way that the archaic view of equating HIV with death can directly impact people. Requiring informed consent to the risk of transmission is a high standard that does not exist in other areas where there is a risk of substantial harm, such as rough horseplay.

It is submitted that a widening gap between the law and science where recklessness is concerned can have numerous harmful consequences that may only grow with time. Firstly, it may lead to situations where prosecutions occur in spite of the risk for transmission being objectively insignificant. Secondly, the current regime can place too much emphasis on a doctor's advice, which both drags medical professionals into the criminal realm in a way that is not fully appropriate and may chill communication between medical staff and their patients. Thirdly, there are many factors that can affect the likelihood of transmission, and means of mitigating or exacerbating transmissibility is understood to be more complex now

[258] See, eg, *Konzani* (n 2) [41].
[259] *Konzani* (n 2) [45].
[260] Gurnham (n 24) 99.
[261] *R v BM* [2018] EWCA Crim 560 [40].
[262] See, eg, *Aitken* (n 217).

than it was in *Dica*. As such, this chapter advocates for courts to use a two-pronged assessment of recklessness when relevant questions concerning risk and consent come before them in future HIV transmission cases. By first engaging in an objective assessment of recklessness and following with a subjective one, courts can approach the question of recklessness both holistically and with full appreciation of changing scientific understandings. Interconnected with this, as discussed above, is the court's perception of the level of harm posed by HIV. The next chapter will discuss the harm of HIV and assess whether it truly falls into the category of a grievous bodily harm.

Chapter 5. Harm and HIV: Why is HIV a Grievous Bodily Harm?

I. Introduction

Under the current law in England and Wales, the reckless or intentional transmission of transmissible diseases may be criminalised pursuant to the OAPA. The two relevant sections of the Act bar the intentional or reckless[1] infliction of 'grievous bodily harm.' While there is significant academic focus on the criminalised transmission of HIV, most of it focuses on the requisite *mens rea*, proof of causation, potential defences (such as consent), or broader public policy concerns. Of notable omission is the question of 'harm'—a curious omission not just in the case of communicable disease transmission, but within the criminal law as a whole.[2] This chapter seeks to highlight this issue in particular: Why is HIV considered a grievous bodily harm? What does it mean to be a harm at all, much less a grievous one? Key to all this is a question central to this thesis: have courts assessed modern medical and scientific evidence surrounding HIV when analysing the harm of HIV, assuming such a legal harm exist at all?

To begin, this chapter will discuss how one might define 'harm.' The first part of this section will address some of the works of Joel Feinberg and other legal philosophers. A cornerstone of the legal harm theory is Feinberg's harm principle.[3] While John Stuart Mill initially formulated the harm principle—a legal-philosophical theory that a state's power should be limited to preventing harm—in his 1859 book *On Liberty*, Feinberg's contemporary take on the topic in the four volume *The Moral Limits of the Criminal Law* is widely considered the most influential modern treatise on the topic.[4] In the first volume, *Harm to Others*, Feinberg broke down several categories by which one may assess harm.[5] For the purposes of the current discussion, it is the final two categories—harm as a violation of rights and harm as a setback of interests that are the most relevant. For the question of the setback of interests[6] in particular, whether HIV should be considered a harm is heavily dependent on how one defines the interests in question, since that relates to the core issue of

---

[1] The full text of OAPA section 20 uses the term 'maliciously' instead of 'recklessly'. The statutory formulation of 'maliciously' is satisfied by either intention or recklessness: *R v Cunningham* [1957] 2 QB 396, 399.
[2] Richard B Gibson, 'No Harm, No Foul? Body Integrity Identity Disorder and the Metaphysics of Grievous Bodily Harm' (2020) 20 Medical Law International 73, 74.
[3] Joel Feinberg, *The Moral Limits of the Criminal Law, vol 1: Harm to Others* (Oxford University Press 1984).
[4] Steven Debbaut, 'The Legitimacy of Criminalizing Drugs: Applying the "Harm Principle" of John Stuart Mill to Contemporary Decision-Making' (2021) 68 International Journal of Law, Crime and Justice 100508.
[5] Feinberg (n 3) 106-7.
[6] ibid 46.

how set back said interests are. An unfortunate limitation of Feinberg's harm principle is its lack of flexibility concerning the degrees of harm, and as such additional theories are helpful in assessing the nature and degree of the harm posed by HIV (if one assumes that there is a harm at all). To that end, this chapter will discuss three additional assessments of harm: the 'non-comparative account, the counter-temporal account, and the counterfactual account.'[7] These additional assessments present several possibilities for how HIV could be described—both as a harm or not—and highlight the importance of a consistent approach to defining harm.

While 'harm' plays a central role in much of the criminal law, there is no singular legal definition nor standard interpretation of the term.[8] That the breadth of caselaw and writings contain such a dearth of focus on the subject may suggest that many feel it is something so obvious and well-understood that a conclusive definition is not necessary. However, the harm principle is the backbone of liberal legal theory, and the uncertainty regarding the principle's scope may lead to confusion and injustice.[9] This is particularly true in the case of HIV transmission, where there has been a notable neglect in examining the classification of HIV as a 'grievous bodily harm.' This difference is not purely academic—the level of harm affects what offence may be charged. Depending on the specific offence, the maximum sentence in England and Wales can range from six months to life imprisonment.[10] What does it mean for something to be 'grievous bodily harm'? What is the difference between actions which rise to the level of 'grievous' and those that fall into the lower category of 'actual bodily harm,' prohibited pursuant to OAPA section 47? What even *is* harm, and why is it prohibited in the first place? This section seeks to explore these questions with the aim of answering a larger question: in light of modern medicine, should courts classify HIV as GBH?

The second part of this chapter will address the various definitions of the term 'harm' in English jurisprudence. While the notion of what 'harm' may embody has changed throughout the years, the definition remains vague, often implying that harm—and particularly GBH—is something that one simply intuitively recognises. Next, this chapter

---

[7] Gibson (n 2) 73.
[8] ibid 74.
[9] ibid.
[10] Sentencing Council, 'Assault – Sentencing' (*Sentencing Council*, 2022) <www.sentencingcouncil.org.uk/outlines/assault/> accessed 7 May 2025.

will address the differences between when a harm is categorized as GBH rather than ABH. Generally speaking, ABH—which is an element of a lower category of offences with attendant lesser punishments—is a catch-all for cases where the court does not consider the harm serious enough to reach GBH.[11] While prior jurisprudence defined some of the parameters for when a harm amounts to GBH instead of ABH, the lack of a clear definition for both the terms 'harm' and 'grievous' makes the determination of such unclear at best and subject to the biases of individual fact-finders at worst.

Next, this chapter will address the case law surrounding the definition of harm as it relates to the transmission of communicable diseases. The chapter will begin with addressing *Clarence*[12] and its discussion of gonorrhoea. While *Dica* later substantially overturned *Clarence, Clarence* remains a useful starting point for its discussion of ABH versus GBH. In spite of the detailed discussion of ABH and GBH in *Clarence*, no attention was given to the more basic question of *why* gonorrhoea was a harm—instead, this was taken as a given. This approach—or lack of approach--to the harm of STIs remains present in modern jurisprudence as well. Neither *Dica* nor *Konzani* addressed the question as to why HIV was a harm, much less a grievous one. *Marangwanda*,[13] a case involving gonorrhoea heard over a century after *Clarence*, likewise avoided the topic of harm altogether. *Golding*[14] addressed the topic to a degree, but largely avoided any legal pronouncements on the topic other than stating that the level of harm is a finding to be determined by the jury.[15]

There have thus far only been three reported cases[16] in England and Wales[17] regarding the criminal transmission of HIV—two involving reckless transmission and one involving intentional—and all three found the harm to be grievous. While on its face this would appear to show consistency, there are three significant issues: first, none of the relevant cases addressed *why* the court considered HIV to be GBH—this was simply taken as read. While the defence specifically raised this issue in *Rowe* as a ground of appeal, the court neglected to

---

[11] C Ashford, M Morris and A Powell, "Bareback Sex in the Age of Preventative Medication: Rethinking the 'Harms' of HIV Transmission" (2020) 84 Journal of Criminal Law 596, 608.
[12] *R v Clarence* (1888) 22 Q.B.D. 23.
[13] *R v Marangwanda* [2009] EWCA Crim 60.
[14] *R v Golding* [2014] EWCA Crim 889.
[15] ibid [77].
[16] The Court of Appeal also reported a second opinion regarding *Dica* in 2005 after the original appeal remanded the case for retrial. This second case asked that the original 2004 appeal to be reconsidered in the House of Lords and appealed the sentence. The appeal was not successful. [2005] EWCA Crim 2304. Since this second appellate decision did not significantly deal with the underlying substantive issues, it is rarely discussed.
[17] There are currently none from Scotland.

satisfactorily respond; instead, it relied on *Dica* in spite of the fact that that the court heard *Dica* almost a decade and a half prior and *Dica* itself never addressed why it considered HIV as a GBH.[18] In the end, *Rowe* did not discuss the harm of HIV. Instead, it noted only that: 'The transmission of HIV will have serious consequences for the infected person's health and the courts in England and Wales have recognised that transmission of HIV can amount to an offence under the Offences Against the Person Act 1861.'[19] The court went on to say: 'This was not an issue at trial and for good reason.'[20] This chapter argues that *Rowe* was remiss in its approach; instead, courts addressing this issue in the future should reassess the level of harm posed by HIV. It is submitted that while it is a harm, it is no longer at the level of GBH in most cases. There may be fact-specific circumstances where the level of harm caused by HIV is greater in one case than in another—such as a particularly traumatic seroconversion or a serious reaction to an HIV treatment regime—however courts should treat the harm of HIV as a live issue rather than a settled fact.

To date, few of the cases addressing transmission explore what it is specifically that makes a specific infection either a 'harm' or 'grievous,' and more recent case law neglected to re-assess the nature of HIV as GBH in light of newer medical and scientific advancements.[21] As with recklessness (addressed in the previous chapter) the question of the harm of HIV in some cases was either not raised or avoided by later courts because of the defendant's plea. Defence counsel should be careful to preserve this issue as it is one that could viably impact the defence. It is argued here that while HIV is still a harm, modern medical advancements have progressed to the point where HIV is no longer a harm serious enough to rise to the level of a grievous bodily harm in most cases.

II. Philosophy of Harm: How is HIV Conceptualised as a Harm?

John Stuart Mill originally introduced the harm principle in in 1859, stating: "The only purpose for which power can be rightfully exercised over any member of a civilized community, against his will, is to prevent harm to others."[22] Mill's philosophy highlighted the importance of individual liberty; he believed that the role of the state needed to be clearly delineated in order to justify legal interferences such as criminalisation.[23] Joel Feinberg later

[18] [2018] EWCA Crim 2688; [2019] 1 Cr App R (S) 38 [67].
[19] ibid.
[20] ibid.
[21] See *Rowe* (n 18).
[22] John Stuart Mill, *On Liberty* (Cambridge University Press 1859), 22.
[23] Debbaut (n 4) 1.

expounded further on this legal-philosophical question in the four volume *The Moral Limits of the Criminal Law* in the early 1980s and remains one of the most influential modern philosophers on the subject of criminal law.[24] In short, Feinberg prioritised individual liberties but agreed that criminalisation was morally justified in certain instances, such as the prevention of harm.[25]

To determine whether or not the prior jurisprudence properly categorized reckless HIV transmission as a grievous bodily harm, let us examine Feinberg and the definition of 'harm' more generally. Feinberg states that A harms B where there is (1) an act or series of acts or omission(s), (2) which A performed with an intentional, reckless, or negligent *mens rea*, (3) in an unjustifiable or inexcusable manner, (4) which causes a setback in B's interest, and (5) violates B's right.[26] The first prong—which, in the case of an alleged reckless HIV transmission generally refers to a sex act—is a question of fact, and has thus far not been a contested issue in the related jurisprudence. The second prong concerns the relevant *mens rea*, and was discussed in the previous chapter, while the third prong broadly relates to defences—such as consent—also discussed in Chapter 4. For the purposes here, let us instead focus on the final two prongs: the setback of interests and the violation of a complainant's rights.

The final prong—regarding the question of whether or not the accused violated the rights of the complainant—shall be discussed first, as it is in some ways the more straight-forward of Feinberg's two remaining prongs. One aspect of this prong is a clear legal one; while there is no specific statute which prohibits reckless HIV transmission on its face, several courts in England have found that recklessly transmitting HIV without consent constitutes a violation of OAPA section 20.[27] Rephrased, courts previously found a right of a seronegative person to not have another individual recklessly transmit HIV or other STIs to them. In that sense, a person who recklessly transmits HIV to another person without consent may have violated the rights of that person. This, of course, sidesteps the critical questions of (a) whether or not the court delineated such a right pursuant to the harm theory and (b) what other moral or implicit rights may be violated in an incident of HIV transmission. If one assumes that all individuals have a right of bodily autonomy, however, it is difficult to argue

[24] ibid.
[25] Feinberg (n 3) 12.
[26] ibid 105-6.
[27] See, eg, *Dica* [2004] EWCA Crim 1103; [2004] QB 1257 (CA (Crim Div)); *R v Konzani (Feston)* [2005] EWCA Crim 706; [2005] 2 Cr App R 14 (CA (Crim Div)) [2005] EWHC 1676 (Fam).

that recklessly transmitting a communicable disease to another without their knowledge or consent does not violate such a right. The right to bodily autonomy in its most absolute form means one should have as much control over their body as possible, including at the cellular level, regardless of whether or not any physical pain or illness accompanies the intrusion. In this sense, recklessly passing a common cold onto another person is a violation of another's right in the same sense that recklessly transmitting HIV is.[28] That said, few would argue that a person who recklessly transmits a cold should be charged with an offence. The primary difference, of course, is the potential degree of harm.

Feinberg described an individual's health and wellbeing as one of their core interests. Defining bodily health as a 'welfare interest,' Feinberg considered harm to the body as the most serious kind of harm that an individual can sustain.[29] He stated that harms to welfare interests such as bodily integrity can fall into one of three categories: a non-relativistic 'harmed condition', a relativistic 'harmed state,' or a 'doomed condition.'[30] For something to be a harmed condition, it must be at such a degree of deterioration that minor improvements will not significantly alter the condition.[31] The example Feinberg used was that of total starvation—while giving a crumb to a starving person may be a statistically significant improvement over them having nothing, the difference is still too minor to abate the broader harm.[32] Similarly, a doomed condition is one of foreordained defeat.[33] If one had asked Feinberg what type of harm he considered HIV to be in 1987 (the year he published Volume 1 of his work) he might very well have deemed it as a harmed or doomed condition. The risk of serious health issues in connection to HIV or AIDS, including death, was far more common in that era, and treatments were both expensive and limited in their utility. The courts in cases such as *Dica* and *Konzani* may likewise have taken a similar view, hence the lack of any meaningful discussion as to why and how HIV was considered a GBH. The historic harm of HIV aside, in its modern form with the treatments available, the court in *Rowe* was remiss to neglect to the question of whether or not HIV remains a grievous bodily harm.[34] Future decisions that involve transmission should visit this topic in light of medical

---

[28] Consenting to the risk of harm may change the nature of the harm—and thus the question of whether one violated the rights of another—in both these situations. See Feinberg (n 3) 115-117.
[29] ibid 37.
[30] ibid 53-4.
[31] ibid.
[32] ibid.
[33] ibid.
[34] There is, perhaps, a basis for arguing that intentional transmission imparts a greater degree of harm than reckless transmission because of the added humiliation and pain derived from knowing that a sexual partner

advancements. Here, it is argued that HIV is, in most cases, no longer at the level of seriousness to implicate GBH.

Feinberg describes relativistic harmed states in terms of a setback of interests.[35] 'To set back an interest is to reverse its course, turn it away, put it back toward the point from which it started. In terms of its associated goals, it is to reverse its progress, to put it in a worse condition than it was formerly in.'[36] Whether HIV should count as a harmed state in this context is a matter for debate. If a person initiates ART soon after they detect their HIV-positive status, they may reach a similar life span to a person without HIV.[37] While a person living with HIV may have a higher incident of certain co-morbidities, because PLWHA are more likely to have regular doctor visits and screenings, such conditions are more likely to be caught regardless of whether or not the comorbidity was due to the HIV infection.[38] Whether HIV is viewed as a significant setback of interests depends on how one defines the difference between the prior state and the harmed state. Assuming that the prior state is an individual's condition of health when HIV-negative, then is the 'harmed state' the difference between the prior state and (a) the state of having to treat HIV,[39] (b) the state of a person who chooses not to take any treatment, or (c) the state of health a person may have in the future with treatment? According to Feinberg's harmed state, the fact that there is any difference between two states may mean that there is a setback of interests and thus a harm. That said, there is a significant difference in the degree of harm depending on how the harmed state is defined. The law of England and Wales is not just concerned with the existence of a harm, since plenty of harms exist which do not amount to a criminal offence. Furthermore, harms which do amount to an offence may do so in several ways. This 'conceptual component' of varying degrees of harm is not present in Feinberg's harm theory in spite of its presence in English

---

intentionally aimed to harm you. Overall, questions regarding embarrassment should not generally factor into the question of harm as it is highly subjective.

[35] ibid 46.

[36] ibid.

[37] Marcus JL et al. Comparison of Overall and Comorbidity-Free Life Expectancy Between Insured Adults With and Without HIV Infection, 2000-2016. JAMA Network Open, 3: e207954, June 2020. While there is a statistically significant difference in the onset of co-morbidities, correlation is not causation and there may several reasons as to why such a correlation exists.

[38] ibid.

[39] The individual treatment plan a person living with HIV may take will vary, but can include: once daily pills, a combination of daily pills, monthly injections, or injections every other month. U.S. Centers for Disease Control and Prevention, 'HIV Treatment' (*CDC.gov*, 21 November 2023) <www.cdc.gov/hiv/basics/livingwithhiv/treatment.html> accessed 31 May 2024.

law; consequently, an alternate perspective may be useful in determining if HIV should be classified as GBH.[40]

Richard B. Gibson discussed an alternate framework for the metaphysics of GBH which may be instructive. The states of harms discussed by Gibson include the 'non-comparative account, the counter-temporal account, and the counterfactual account.'[41] The noncomparative account is similar to Feinberg's 'harmed condition' in that it involves a person being moved into a 'bad state,' or a state which is bad because it is bad in itself and not because it is bad compared to a former, better state.[42] The 'badness' is assessed by solely examining the present state. This involves an assessment of the new state against the normatively desired state and would be a question for a jury that would impart contemporary standards.[43] The problem with this assessment, and frankly any assessment that involves juries applying social norms, is that biases will come into play.[44] People without disabilities tend to assume that the quality of life for people with any health issue or disability is far worse than it is when self-reported by people with disabilities. This mismatch, known as the 'disability paradox,' means that a juror's assumption as to what is or is not a 'bad state' may be predicated on ill-informed and potentially problematic notions.[45] As such, this account may not be useful when assessing the state of any incurable health condition.

The second account, the counter-temporal assessment of harm, does not rely on normative assumptions of good and bad,[46] and instead compares an individual's state of well-being at two points in time; if the state improves there is a benefit, and if it worsens there is a harm.[47] This approach is more individualised, and requires an account of the person's life both before and after the *actus reus* in question.[48] For a prosecutor to show that one person caused another GBH, they would need to demonstrate that the accused's actions moved the complainant from their prior state into a present state which is altered in a manner that is

---

[40] Gibson (n 2) 83.
[41] ibid.
[42] ibid 85.
[43] ibid.
[44] ibid 86-7.
[45] ibid, citing G.L. Albrecht and P.J. Devlieger, 'The Disability Paradox: High Quality of Life Against All Odds', Social Science & Medicine 48(8) (1999), 977–88.
[46] ibid, 87-88, citing B. Foddy, 'In Defence of a Temporal Account of Harm and Benefit', American Philosophical Quarterly 51 (2014), 56.
[47] ibid.
[48] ibid 88.

significantly negative.[49] This account is in theory less prone to bias and should rely more on a research-based approach as to what life is like in that second state.[50]

Somewhat similar to the counter-temporal assessment is the third account, the counterfactual assessment of harm. While the counter-temporal assessment compares two points in time, the counterfactual assessment addresses the question of harm by looking to 'what would have occurred had the putatively harmful conduct not taken place. If a person's interests are worse off than they otherwise would have been then a person will be harmed.'[51] Rather than comparing a person at two separate points in time, the counterfactual assessment looks at the ramifications of the *actus reus* and compares the current state to the theoretical one that would exist had the act not happened.[52] To find GBH in a counterfactual assessment, a prosecutor needs to show that but for the act in question, the complainant's physical and/or mental well-being would be in a significantly better state.[53]

Applying these assessments to HIV transmission yields a potential array of results. A non-comparative account is likely to be tainted by the simple fact that many people still harbour outdated and stigmatised views of both the HIV infection itself and the person living with it. In 2021 the National AIDS Trust and Fast-Track Cities London performed a survey of approximately 3,000 people around the UK and asked them a variety of questions about their views, opinions, and understanding of HIV.[54] Most of the respondents' reference points for their knowledge of HIV were events and information from 1980s and 1990s.[55] Only 8% of the respondents were able to correctly list the modes of transmission with no incorrect answers.[56] Almost 30% either believed or were not sure that HIV always became AIDS,[57] and a similar percentage of the public either believed or were not sure that most PLWHA would die within five to ten years.[58] Only 30% of the respondents had unqualified sympathy for PLWHA, with the other 70% mostly qualifying their sympathy based on the means that seroconversion

---

[49] ibid.
[50] ibid.
[51] ibid, citing C. Purshouse, 'A Defence of the Counterfactual Account of Harm' (2016) 30 Bioethics pp. 251–259, 251.
[52] ibid 91-2.
[53] ibid 92.
[54] Fast-Track Cities London and National AIDS Trust, 'HIV: Public Knowledge and Attitudes' (*NAT*, July 2021) <www.nat.org.uk/sites/default/files/publications/HIV%20Public%20Knowledge%20and%20Attitudes.pdf> accessed 10 May 2024.
[55] ibid 9.
[56] ibid 21.
[57] ibid 25.
[58] ibid 27.

occurred.[59] In other words, most people saw two broad methods of acquiring HIV: 'faultless' meaning methods such as accidental contact with the blood of the infected person, and 'blameworthy' meaning methods such as unprotected sex or sharing needles for illegal drugs.[60] This sort of stigma and misinformation would almost certainly impact a jury's view of HIV in any basic non-comparative account. The latter two accounts would likely yield a more nuanced approach to the question of the level of harm a court may consider HIV. For the counter-temporal account of harm, the harm level of HIV is arguably just the difference between the state of health of the complainant before the *actus reus* and after; a difference which may be negligible outside of a daily medicine or monthly shot. The difference between these two temporal states is potentially relatively minor; a medical expert in a Canadian court described managing HIV with modern medicine as easier than similarly managing diabetes.[61] Similar arguments could be made in the counterfactual account of harm. An expert witness would likely need to impartially assess the complainant's state of health as it is and as it would have been without the seroconversion. The potential for future harm would likely remain a live issue, but arguments could be made for and against its severity; as noted above, in some cases PLWH can have a higher life expectancy than those who are negative due to the more frequent screenings provided by medical professionals.[62]

Rather than being a settled legal issue, the harm level of HIV should depend on the facts of the case and may be a minimal harm that no longer meets the criteria of GBH. The question of what harm is in English jurisprudence will be addressed next.

III. Harm – The Legal Definition

It is difficult to overstate the role of harm in liberal legal theory—the notion that the state's power over criminalisation should be constrained is a foundational aspect of modern political and legal dogma.[63] It is perhaps because of harm's central role in legal philosophy that it remains largely undefined by courts as a legal concept; it is so close to the heart of things, that many assume its definition is simply understood. While prior courts, as discussed

[59] ibid 51.
[60] ibid.
[61] Thomas Poberezny-Lynch, 'Criminalising Infection: Questioning the Assumption That Transmitting HIV Constitutes Grievous Bodily Harm' (2019) 44 Alternative Law Journal 138., 141, citing *R v Thompson* (2018) NSCA 13, [43].
[62] Françoise Barré-Sinoussi and others, 'Expert Consensus Statement on the Science of HIV in the Context of Criminal Law' (2018) 21 Journal of the International AIDS Society 7, citing Samji H and others, 'Closing the gap: increases in life expectancy among treated HIV-positive individuals in the United States and Canada' (2013) PLoS ONE. 2013;8(12).
[63] Gibson (n 2) 74.

below, attempted to define 'harm', no singular definition of harm exists in English case law.[64] Many courts treat it as intuitive, and as a result the 'harm' prong of an offence's *actus reus* may be subject to interpretational discretion and—consequently—applied inconsistently.[65] While this may be immaterial in some cases, in others the lack of a clear definition means that harm is assessed by what the fact-finder would consider to be a harm to them; as a result, its definition will be tied to individual perceptions which may be biased or incorrect. Courts often treat 'harm' as unquestioned, and instead focus of sorting harm by category,[66] although—as will be discussed further below—the jurisprudence is likewise vague in determining whether a harm is or is not grievous.

In many cases, there is no need for a court to question what amounts to a harm; few will dispute that a bullet or stab wound, for instance, is a harm. The problem with this is that while harm may often be self-evident, it is not always the case. This is particularly true in cases where the harm is not visible to the naked eye, as is the situation where HIV is concerned. The intuitive approach to harm does not work in all cases, and certainly not regarding HIV. Approaching the question of the harm of HIV from an intuitive standpoint will place a court or other fact finder at risk of relying on misguided and out-of-date notions of what it means to live with HIV. Instead, the question of the harm of HIV needs to be approached with evidence of what it means to live with now, based on modern evidence. What it means to live with HIV will change as modern medicine changes and cannot be approached as a static issue that is simply taken as read. This section will examine how courts previously approached the question of harm, and what it means for a harm to rise to the level of 'grievous.'

A. Jurisprudence

Although courts often do not attempt to define 'harm' with the same rigor as may be applied to other elements of an offence,[67] some courts have made attempts. One may find an early starting point in the 1858 case of *R v Ashman*.[68] In *Ashman*, the Crown charged the defendant with grievous bodily harm for shooting a reverend; while the gunshot did not result in a serious wound, he was harmed and understandably stunned.[69] Willes J instructed the jury

[64] ibid.
[65] ibid.
[66] ibid 76.
[67] ibid 74.
[68] (1858) 175 E.R. 638.
[69] ibid 638.

that grievous bodily harm did not need to be 'permanent or dangerous, if it be such as seriously to interfere with the comfort or health [of the victim].'[70] The 1934 case of *R v Donovan* expanded on this further.[71] The appellant, a man accused of beating a seventeen year-old girl with a cane, was charged with both indecent and common assault and argued that the girl had consented to the acts.[72] While the majority of the decision focused on the presence and role of consent, Swift J briefly addressed the meaning of the term 'bodily harm' on the basis that, if there was bodily harm, any consent would be of no effect[73] In context, Swift J discussed circumstances—such as rough play—where the intent to cause bodily harm may affect whether an act will rise to the level of assault.[74] He stated: 'For this purpose we think that "bodily harm" has its ordinary meaning and includes any hurt or injury calculated to interfere with the health or comfort of the prosecutor. Such hurt or injury need not be permanent, but must, no doubt, be more than merely transient and trifling.'[75] This definition, while providing some guidance, still leaves much to be desired. Aside from the limited context the definition applied to, the focus on intent still begged the question of what 'harm' was from an objective standpoint. That it must be more than 'transient or trifling' does little without additional guidance on the meaning of such terms. Consequently, the important takeaway from *Donovan* regarding the definition of harm is mainly Swift J's determination that a harm 'need not be permanent'—a requirement in line with that in *Ashman.*[76]

The case of *Director of Public Prosecutions v Smith* likewise set out to define harm in the context of GBH.[77] In *Smith*, the defendant killed a police constable who intended to question him about sacks in his car which contained stolen material by driving away while the constable clung to his car.[78] Central to the case was whether or not the defendant had intended to cause GBH.[79] In discussing the definition of GBH, Viscount Kilmuir stated that:

> It is true that in many of the cases the likelihood of death resulting has been incorporated into the definition of grievous bodily harm, but this was done, no doubt, merely to emphasise that the bodily harm must be really serious, and it is unnecessary,

[70] ibid 639.
[71] [1934] 2 K.B. 498.
[72] ibid 499.
[73] ibid 509.
[74] ibid 508-9.
[75] ibid 509.
[76] ibid.
[77] [1961] A.C. 290.
[78] ibid 292.
[79] *See,* ibid 319.

> and I would add inadvisable, to add anything to the expression "grievous bodily harm" in its ordinary and natural meaning.[80]

This definition, which expressly overruled the requirement in *Ashman* that GBH must 'seriously interfere with the victim's health or comfort,' premised its definition[81]—like the court in *Donovan*—on the assumption that fact finders simply knew what bodily harm and GBH was when confronted with it. In 1993 this definition, although already quite broad, was further expanded in *R v Chan-Fook.*[82] In *Chan-Fook,* the Crown accused the defendant of aggressively interrogating a man, locking him in a room, and hitting him; the man ultimately fractured his arm and dislocated his pelvis when trying to escape.[83] Although the complainant suffered physical injuries, the prosecution also alleged that the psychological harm suffered was additionally sufficient to rise to the level of harm for ABH.[84] The court found that while psychiatric injury could be ABH, it must go beyond 'mere emotions such as fear, distress or panic, nor does it include, as such, states of mind that are not themselves evidence of some identifiable clinical condition.'[85] This position—that psychiatric injuries could be enough to meet the standards needed for ABH—was affirmed in 1997 in *R v Ireland; R v Burstow.*[86] In *Burstow*, the defendant did not physically harm the complainants; instead, the prosecution alleged the defendant caused psychiatric harm after repeatedly making telephone calls while saying nothing.[87] The court considered whether ABH could include purely psychiatric harm; in doing so, the court found that 'bodily harm' could indeed include 'recognisable psychiatric illness' without the presence of physical harm.[88]

The case of *R v Janjua* provided further clarification regarding the definition of harm in 1998.[89] *Janjua* expanded on *Smith* and found that in some circumstances the judge could omit the word 'really' when discussing GBH in the summing-up, and could just refer to the harm as 'serious.'[90] *Janjua*, which involved a stabbing with a five-and-a-half inch knife, concluded that it may be up to the judge to describe the harm as either 'really serious' or

---

[80] ibid 335.
[81] ibid 333-4.
[82] [1994] 1 WLR 689.
[83] ibid.
[84] ibid 148.
[85] ibid 152. In this case, however, the prosecution did not adduce sufficient evidence to demonstrate the psychiatric injury. ibid 153.
[86] [1998] AC 147.
[87] ibid 154.
[88] ibid 159.
[89] [1999] 1 Cr App R 91.
[90] ibid 96-7.

'serious' in the summing-up depending on the facts of the case.[91] As a result, the definition of 'grievous bodily harm' in English law could be said to include any bodily harm that need not be permanent,[92] or of a nature that seriously interferes with health or comfort.[93] The judge may drop the word 'really' in 'really serious' in some cases.[94] The definition of 'harm' itself lacks clear guidelines, and is only meant to be read per its 'ordinary meaning' and be greater than that which is 'trifling.'[95] GBH is similarly meant to be read in its 'ordinary meaning' and only needs to be 'serious'[96] without the need for any further emphatics.[97] ABH need not include physical harm, and may be solely premised on psychiatric injuries[98] provided that these amount to a recognizable psychiatric injury and not just general emotions or panic.[99]

Only a few courts have expanded on the definition of harm further in the new millennium. In 2003, the case of *R v Bollom* addressed the nature of harm in response to allegations that the defendant injured a 17 month-old baby.[100] There, the court clarified that harm may be assessed in light of the specific circumstances of the victim, stating:

> To use this case as an example, these injuries on a 6 foot adult in the fullness of health would be less serious than on, for instance, an elderly or unwell person, on someone who was physically or psychiatrically vulnerable or, as here, on a very young child. In deciding whether injuries are grievous, an assessment has to be made of, amongst other things, the effect of the harm on the particular individual.[101]

The court went on to state that GBH is not limited to injuries with 'lasting consequences'[102] and that it was up to the jury to apply 'the standards of society as a whole in assessing…harm.'[103] *R v Golding*—discussed in further detail below—came to a similar conclusion in 2014 regarding the reckless transmission of herpes, stating: 'Ultimately, the assessment of harm done in an individual case in a contested trial will be a matter for the jury, applying contemporary social standards.'[104]

---

[91] ibid. The trial judge did use the term 'really serious' some of the time, just not every time. ibid 93-4.
[92] *Donovan* (n 71) 509.
[93] *Smith* (n 77) 333-4.
[94] *Janjua* (n 89) 96-7.
[95] *Donovan* (n 68) 508-9.
[96] *Smith* (n 77) 335.
[97] *Janjua* (n 89) 96-7.
[98] *Burstow* (n 86) 159.
[99] *Chan-Fook* (n 82) 152.
[100] [2004] 2 Cr App R 6, 51-2.
[101] ibid 60.
[102] ibid 61.
[103] ibid.
[104] (n 14) [64].

IV. Common Assault versus ABH Offences versus GBH Offences

When one person is accused of harming another, there are three main categories of assault offences in England and Wales that may be implicated: common assault (Criminal Justice Act 1998 section 39), assault occasioning ABH (OAPA section 47), and unlawfully causing GBH (OAPA sections 18 and 20, depending on whether or not the defendant intended to harm the complainant). Common assault, unlike ABH and GBH, is a summary offence and applies when one 'intentionally or recklessly causes another to suffer or apprehend immediate unlawful violence.'[105] The penalties for a common assault conviction are much lower than those for GBH or ABH offences; the offence carries a maximum penalty of a fine, imprisonment for six months, or both.[106] Both common assault and ABH have the same *mens rea* requirement, with the primary difference being the level of harm caused.[107] Common assault, ABH, and GBH exist on a spectrum with a degree of overlap, and an action which may qualify for an offence with a higher penalty (e.g. ABH) may also be sufficient for a lower category of offence (e.g. common assault).[108]

While there are some differences in terms of the language connected with each harm of the OAPA offences (section 47 prohibits 'assault occasioning actual bodily harm' while section 20 prohibits unlawfully and maliciously wounding or infliction any grievous bodily harm), in practice, prosecutors will frequently charge individuals with a section 47 offence if they judge that the underlying acts do not reach the threshold for GBH.[109] Other than the rule that ABH is criminal only in the context of an underlying assault or battery offence[110]—something not required for GBH—the predominant difference between the two terms is the level of harm involved, and it is up to the prosecutor to determine which charge is more appropriate.[111]

As with the definition of 'harm' more generally, there is significant ambiguity regarding the nature of harms that amount to GBH over ABH. In practice, since the level of harm for ABH can be quite low, that—plus the role of prosecutorial discretion—makes it less

---

[105] Crown Prosecution Service, 'Offences against the Person, Incorporating the Charging Standard' (*Cps.gov.uk*, 27 June 2022) <www.cps.gov.uk/legal-guidance/offences-against-person-incorporating-charging-standard> accessed 6 May 2025.
[106] Criminal Justice Act 1998 s 39.
[107] Andrew Ashworth, 'A Change of Normative Position: Determining the Contours of Culpability in Criminal Law' (2008) 11 New Criminal Law Review 232, 246.
[108] *Smith* (n 77) [10].
[109] Ashford and others (n11) 608.
[110] ibid FN 106.
[111] Crown Prosecution Service (n 105).

common for instances of ABH to result in successful criminal charges when compared to GBH.[112] Based on the case law then, what is ABH?

As discussed above regarding cases such as *Chan-Fook,* ABH does not require physical harm and can include recognised psychiatric injury.[113] The court in *Chan-Fook* confirmed that assault occasioning ABH could be committed in the absence of physical contact with the victim, and that 'bodily harm' referred to all parts of the bodily, including 'his organs, his nervous system, and his brain.'[114] In the 2006 case of *Director of Public Prosecutions v Smith*, the court noted that the term 'harm' could be interpreted liberally, and included terms such 'hurt' or 'damage' as well, and is not limited to 'injury.'[115] In *Smith,* the complainant's ex-partner used scissors to cut off the complainant's ponytail,[116] and argued that while the actions may have risen to the level of common assault, it was not bodily harm 'because there was no bruising, bleeding, or cutting of the skin. Cutting of the hair merely changed her appearance. There was no expert evidence regarding psychological or psychiatric harm…[distress] taken on its own…could not amount to actual bodily harm.'[117] On appeal the court disagreed, finding that 'hair is an attribute and part of the human body' because it is attached to the body, even if 'medically and scientifically speaking, the hair above the surface of the scalp is no more than dead tissue.'[118] As per the language in *Smith* then, 'harm' is any damage and 'bodily' is generally connected or concerned with the body.[119] The level of harm is encapsulated by the term 'actual,' which the court in *Smith* read as harm which is 'not so trivial or trifling as to be effectively without significance.'[120]

If *Smith* represents a delineation on what may amount to ABH, then when does harm cross the line into GBH? To date, little guidance exists on the difference between ABH and GBH in English jurisprudence. The Crown Prosecution Service's guidelines, while not law, provides some indication of how a prosecutor may distinguish the two charges. It indicates that conduct may be ABH rather than common assault where the injuries are serious (including 'damaged teeth or bones, extensive and severe bruising, cuts requiring suturing

---

[112] Ashford and others (n 11) 608. The reason for this is more generally owing to judicial economy and resources.
[113] *Chan-Fook* (n 82) 152.
[114] ibid.
[115] [2006] 2 Cr App R 1, 6. Note that while it shares the same name as the 1961 case, they are entirely distinct.
[116] ibid 3.
[117] ibid 4.
[118] ibid 6.
[119] ibid 5.
[120] ibid 5-6.

and those that result in lack of consciousness') and may require medical treatment.[121] For GBH, the CPS guidelines relies on the language in the case law which requires it to be 'really serious[122] but does provide further guidance. It states that:

> Life-changing injuries should be charged as GBH. Just as the need for medical treatment may indicate ABH injuries, significant or sustained medical treatment (for instance, intensive care or a blood transfusion) may indicate GBH injuries, even if a full or relatively full recovery follows.[123]

Where there is ambiguity in terms of the level of harm, the CPS guidance quotes *Golding* and confirms that the assessment is for a jury applying contemporary social standards.[124] That matter is solely for the jury, and evidence of expert opinions on whether the underlying harm amounts to GBH is not decisive.[125] Consequently, the case law allows for a flexible approach towards the level of harm that may depend on the facts of the case. How does all of this apply to HIV? The next section will apply the above analysis of harm to HIV and examine the HIV-specific caselaw. This will also include other sexually transmitted diseases as well.

V. Case law: Harm and Disease Transmission

Unlike cases where the physical harm is obvious, such as ones involving a broken limb or open wound, cases involving communicable diseases offer an additional level of complexity. The actual harm may be difficult to assess since the degree any disease impacts a person can vary depending on the strain of the virus and their individual health. Cases involving STIs likewise involve the additional difficulty of the infection being heavily stigmatised. The below section will discuss several different cases that dealt with STIs. The manner in which each court approached the question of harm will be assessed and placed in the context of the time it took place. The first case to be discussed is one of the oldest cases concerning disease transmission, *R v Clarence*.[126]

---

[121] Crown Prosecution Service (n 105).
[122] The guidelines rely on the definition in *Smith*. While *Janjua* allowed for some descriptions omitting the word 'really,' it was in the context of the summing-up and not the law itself. The Guidelines did not reference *Janjua*.
[123] ibid.
[124] ibid citing *Golding* (n 14) [64].
[125] *Golding* (n 14) [77].
[126] (n 12).

A. *R v Clarence*

R v Clarence is one of the earliest reported cases in English law concerning the reckless transmission of an STI. Decided in 1888, the case involved a husband who engaged in sexual activities with his wife while aware that he was suffering from gonorrhoea.[127] The wife contracted gonorrhoea as a result.[128] The husband was convicted of both unlawfully inflicting grievous bodily harm in addition to assault occasioning actual bodily harm against his wife.[129] While the details of the case regarding the other issues, such as consent, are discussed in different chapters of this thesis, here the focus will be on the framing of a STI as a harm. This aspect of the case received virtually no attention from any of the presiding judges; instead, they basically treated the harm of gonorrhoea as assumed. While several of the judges drew comparisons to communicable disease prevalent at the time, all of those mentioned were of a serious and potentially lethal nature, such small-pox, leprosy,[130] scarlet fever,[131] and diphtheria.[132] Although gonorrhoea can potentially be lethal due to sepsis if it remains untreated, it is rare for that to occur under a modern course of treatment.[133]

B. The Early HIV Transmission Cases: *R v Dica* and *R v Konzani*

The defendant-appellant in *Dica* learned of his positive HIV status in 1995,[134] and the court found that he transmitted HIV to two women: one in 1997[135] and one in 2001.[136] As mentioned previously, the court in *Dica* overturned the ruling in *Clarence* and preferred the minority opinion written by Hawkins, J.[137] Hawkins, J refuted the majority's approach which required an assault as a prerequisite to establishing GBH.[138] To further drive home the position that STIs may fall into the gambit of both ABH and GBH, *Dica* referenced *Chan-Fook*, noting that case had decided that 'bodily harm' included psychiatric injury and its effects, and that:

---

[127] ibid 27, Wills, J.
[128] ibid 23.
[129] ibid.
[130] ibid 30.
[131] ibid 35.
[132] ibid 52.
[133] NHS, 'Gonorrhoea - Complications' (*nhs.uk*, 6 July 2018) <www.nhs.uk/conditions/gonorrhoea/complications/#:~:text=In%20men%2C%20gonorrhoea%20can%20cause>. Treatment for gonorrhoea was available at the time of this case. Sabine Gorski, 'Gonorrhea History' (*News-Medical.net*, 4 November 2010) <www.news-medical.net/health/Gonorrhea-History.aspx#:~:text=The%20earliest%20treatment%20of%20gonorrhea>.
[134] (n 27) [4].
[135] ibid [5].
[136] ibid [8].
[137] ibid [26].
[138] *Clarence* (n 12) 49-50.

> … an injury can be caused to someone by injuring their health; an assault may have the consequence of infecting the victim with a disease or causing the victim to become ill. The injury may be internal and may not be accompanied by any external injury …[139]

While this definition, embraced by *Dica,* certainly may include communicable diseases, the court neglected to delve into the specifics of what it means for something to injure another's health or cause someone to become ill. To rephrase, the language from *Chan-Fook* used in *Dica* could encompass every contagious illness from a cold to the Ebola virus, and pays no heed to the curability, severity, or longevity of the underlying illness.

At no point in *Dica* does the court specify what factors about HIV in particular make it a grievous bodily harm; instead, this is simply assumed to be obvious. The court described the defendant-appellant as 'suffering from HIV'[140] and the complainants as individuals whom—upon infection—'suffered' similar symptoms.[141] The court repeatedly used the word "suffering" to describe both the underlying gonorrhoea at issue in *Clarence*[142] as well as the HIV underlying the facts of *Dica* in spite of the fact that gonorrhoea was potentially treatable at the time the court heard *Clarence* and is easily treatable today with modern medicine.[143]

It should of course be noted that it is difficult to know what treatments were affordable and easily available to the average person in the time of *Clarence* since, until the discovery of penicillin in the 1940s, an array of treatments may have been prescribed which likely came with an array of side effects and other health concerns.[144] Consequently, both the infection and the treatment may have caused significant harm. Unfortunately, since the court neglected to discuss the nature of gonorrhoea as a harm in terms of either ABH or GBH, both the majority and minority opinions in *Clarence* left little guidance for what diseases may rise to the level of a legal harm and what factors influence whether a court should view the spreading of that disease as an ABH offence, a GBH offence, or another offence altogether. The opinion in *Dica* must likewise be viewed in historical context. The first HIV treatment—AZT—came out in 1994, a decade prior to *Dica*. However, AZT was both notoriously

---

[139] *Dica* (n 27) [27], citing *Chan-Fook* (n 82) 151, Hobhouse LJ.
[140] See, eg, ibid [59].
[141] See, eg, ibid [8].
[142] See, eg, ibid [16]
[143] Gorski (n 133). Treatment options would likely have varied depending on the location and income level of the patient.
[144] ibid.

expensive[145] and came with numerous severe side effects.[146] Several new therapies emerged in the 1990s, however all of the treatments available during that era came with an array of side effects and it was often necessary to take numerous medications daily.[147] It was not until 2006 that treatment regimens which required only one pill a day—and consequently were easier, cheaper, and less harmful—became available.[148] Dica's original trial was in 2003 and the appeal took place in 2004; in 2002, AIDS was identified as the leading cause of death in various countries around the globe at that time.[149] Given the point of history that *Dica* took place in and the relevant treatments available at that time, it may be understandable that the court viewed HIV as a potential death sentence that had, at best, an onerous treatment regime. However, since the court did not engage with this issue at all and simply assumed HIV amounted to GBH, all of this only amounts to speculation.

Shortly after *Dica*, the Court of Appeal heard *R v Konzani* in 2005. Given the proximity of the cases, it is safe to assume that the prevailing attitudes and assumptions towards both HIV and its treatment were largely the same. Konzani first learned of his HIV positive status in 2000, and later admitted to transmitting HIV to three different sexual partners with whom he had unprotected vaginal intercourse.[150] At trial, Konzani did not give evidence and admitted that 'he infected them with the HIV virus, thus inflicting grievous bodily harm on them.'[151] Similar to the court in *Dica*, the court in *Konzani* paid little regard to the question of *why* HIV amounted to GBH. As in *Dica,* people living with HIV were described as 'suffering' from it.[152] Unlike *Dica*, the *Konzani* court specifically referenced the potential morbidity of HIV: 'We are concerned with the risk of and the actual transmission of a potentially fatal disease through or in the course of consensual sexual relations which did not in themselves involve unlawful violence of the kind prohibited in *Brown*.'[153] In the same paragraph, however, the wording surrounding the lethality of HIV switched from risking a

---

[145] An annual prescription cost approximately $16,500 in modern dollars. Stephanie Watson, 'The History of HIV Treatment: Antiretroviral Therapy and More' (*WebMD*, 9 June 2020) <www.webmd.com/hiv-aids/hiv-treatment-history>.
[146] ibid.
[147] ibid.
[148] U.S. Food and Drug Administration, 'The History of FDA's Role in Preventing the Spread of HIV/AIDS' (*FDA*, 2021) <www.fda.gov/about-fda/fda-history-exhibits/history-fdas-role-preventing-spread-hivaids> accessed 6 May 2025.
[149] 'Report on the Global HIV/AIDS Epidemic' (*UNAIDS* July 2002).
[150] *Konzani* (n 27) [3]-[4].
[151] ibid [4].
[152] ibid [41].
[153] ibid.

'potentially fatal disease' to risking an 'infection with a fatal disease.'[154] The switching of HIV's morbidity from 'potentially fatal' to 'fatal' may have been an unintentional slip on the part of the court, but it may also reflect general misunderstandings towards HIV that were prevalent at time. That said, if the court was more inclined to view HIV as fatal, the court's finding that HIV was a grievous bodily harm makes more sense. 'Potentially fatal' is vague, and virtually anything could be potentially fatal with the right circumstances and the wrong luck, but a definitely fatal or even a likely fatal infection is easy to justify as a grievous harm.

C. *R v Marangwanda* and *R v Golding*

Let us take a step back for a moment away from cases relating to HIV, and instead look once again towards cases alleging the transmission of STIs other than HIV. Like *Clarence, Marangwanda* also involved a defendant-appellant accused of transmitting gonorrhoea.[155] Unlike *Clarence*, the court did not state that Marangwanda transmitted the infection via sexual acts; instead, the prosecutors alleged that Marangwanda transmitted gonorrhoea through reckless means involving improper hygiene.[156] Additionally unlike any of the other cases mentioned, the victims were both young children,[157] and—as discussed in Chapter 2—the prosecutors may have chosen to pursue reckless transmission charges pursuant to OAPA section 20 because of complications with pursuing other charges. If one ignores the problematic issues regarding causation in *Marangwanda*, how then does the court—over a century after *Clarence*—justify classifying gonorrhoea as a GBH? As with many of the other cases, *Marangwanda* more or less side-stepped the issue.

Specifically, Marangwanda pled guilty to causing GBH[158] and on appeal did not focus on the severity of harm of gonorrhoea outside of arguing that the underlying conduct broadly at-issue was not criminal.[159] Since his appeal focused on the conduct he pled to and not the legal question of the degree of harm, the court did not discuss whether gonorrhoea amounted to GBH. The court's discussion of the nature of the harm Marangwanda caused was limited to the context of a related SOPO and required the court to determine if it was necessary to protect the public (or a member of the public) from a serious sexual harm.[160] On that front, the court stated as follows:

---

[154] ibid.
[155] (n 13) [3].
[156] ibid [5].
[157] ibid [3].
[158] ibid [5].
[159] ibid [7].
[160] ibid [16].

> The transmission of gonorrhoea is clearly *serious sexual harm* as defined in section 106(3) of the Act. In the judgment of this court, a Sexual Offences Prevention Order is appropriate in the case of a person who has the care of young children, who is prepared to act recklessly and so subject those children to the risk of the transmission of a sexual disease. It is also particularly important to bear in mind that the court making such an order is not only concerned with the facts of the offence which prompts the making of the order but also all matters of background concerning the appellant, which are relevant to assessment of the risk of further offending.[161]

The relevant section of the Sexual Offences Act 2003 does not shed any light on what conduct specifically is considered a 'serious sexual harm':

> Protecting the public or any particular members of the public from serious sexual harm from the defendant" means protecting the public in the United Kingdom or any particular members of that public from serious physical or psychological harm, caused by the defendant committing one or more offences listed in Schedule 3.[162]

While *Marangwanda* affirms that, as in *Clarence*, gonorrhoea may rise to the level of GBH, the somewhat artificial aspect of the charges in the case renders it difficult to determine why gonorrhoea, which is far more treatable now than it was during the *Clarence*-era, should be treated as a serious sexual harm. The strange circumstance of the case combined with the guilty plea and minor victims renders it unclear if GBH would apply in a future case where the facts were different.

More instructive on the question of harm is *R v Golding*, which focused on herpes. *Golding* involved a defendant-appellant who prosecutors alleged transmitted HSV-2 to his partner through consensual sex acts without first disclosing his HSV status to her.[163] Unlike Marangwanda, Golding did not specifically plea guilty to causing GBH; instead, the language he used applied to ABH, stating that he: 'behaved recklessly and as a result have assaulted her occasioning her actual bodily harm.'[164] Although he hoped to be able to plea to the OAPA section 47 ABH offence (as his plea obviously shows), he ultimately still pled to an OAPA section 20 GBH offence even though the language of the plea itself did not admit to causing GBH.[165] Additionally unlike *Marangwanda*, Golding specifically raised the issue of HSV's level of harm as a ground for appeal after the Crown commissioned a report from a virologist

[161] ibid (emphasis added).
[162] Sexual Offences Act 2003 s 106(3).
[163] *Golding* (n 14) [5].
[164] ibid [7].
[165] ibid [8].

which questioned such.[166] When discussing the impact of herpes, the court found the following:

> As to the impact of herpes, the evidence was that whilst it was not a life threatening condition, it is incurable. The initial infection is described as an unpleasant and painful acute illness with debilitating effects. On occasion admission to hospital may be required, (not in this case), and most affected people can return to work within a week or so. Episodes may recur throughout life. Generally when they do, they are milder and shorter in impact. Psychological disturbance is common in the immediate aftermath of the initial episode. HSV-2 has a higher recurrence rate than HSV-1.[167]

The court confirmed that the assessment of whether a harm rises to the level of GBH is one that must be performed on a case-by-case basis, and that the requirements for GBH are that it is 'really serious' but need not be permanent[168] nor require treatment nor be lasting.[169] Other than that, the level of harm is to be determined by the individual's circumstances and assessed by a jury.[170]

The complainant in *Golding* seemed to credibly experience severe pain, both physically and psychologically.

> She described her symptoms as initially soreness and pain on urination, but with the symptoms worsening and resulting in excruciating pain. Tablets and cream from a nurse had been of no effect and she had had to call out the emergency doctor. After that the symptoms continued to worsen. After diagnosis CS felt "absolutely disgusting and dirty" and "soul destroyed and inadequate". She had not slept well. She was in constant fear of a new outbreak, and her mental state fluctuated. It was implicit in what CS said that she had not had any relationship with another male at a relevant time.[171]

The problem with the court failing to further clarify what aspects of herpes cause it to amount to GBH rather than ABH is that is fails to provide later courts with an indication of what jury instructions a court should provide to ensure that an individual harm is being fairly assessed. While the complainant in *Golding* credibly testified to physical harm, the psychological harm that she attested to is in large part due to social norms which unfairly stigmatise people living with STIs. Transmission cases such as *Dica*, *Konzani,* and *Golding*, arguably contribute to that stigma based on the sheer among of publicity they draw and thus increase the psychological burden; in that sense, the justice system is adding to a problem with one hand

---

[166] ibid [9]. See also ibid [14].
[167] ibid [20].
[168] ibid [64], citing *R v Ashman* (n 68).
[169] ibid, citing *R v Bollom* (n 100).
[170] ibid [77].
[171] ibid [57].

that it is punishing with the other. Considering that approximately 70% of the UK population carry one of the types of HSV by age 25, whether genital or facial, the court in *Golding* potentially opened the door to a very wide-spread line of cases.[172] Just as there may be fact-specific reasons why HSV amounts to GBH, there may be fact-specific reasons why HIV does as well. A complainant may experience particularly serious seroconversion symptoms, or may have significantly negative reactions to ART, or the HIV may interact with an existing disability in a manner which compounds the harm. Courts should break down what factors impact whether a harm is grievous to a jury and should be assessing the harm of HIV as a live issue in each case. Some cases, such as *Rowe*, simply relied on the findings in *Dica* to neglect discussing the harm of HIV.

D. *R v Rowe*

R v Rowe, unlike all of the other cases discussed herein, involved a conviction of intentional infliction of GBH contrary to OAPA section 18.[173] The trial court convicted Rowe of five counts of intentional transmission and five of attempting to do so.[174] *Rowe* remains the most recent reported criminal case involving transmission of a disease, and involved detailed discussions of modern medical advancements as it relates to HIV.[175] Unfortunately counsel for the defendant-appellant did not advance arguments regarding the level of harm posed by HIV in a timely manner, and in fact conceded at the trial that HIV remained a serious harm.[176] The trial court turned to *R v Vickers* as a guideline for 'serious harm.'[177] *Vickers* stated: 'Grievous bodily harm need not be permanent, but it must be serious, and it is serious or grievous if it is such as seriously or grievously interferes with the health or comfort of the victim.'[178] Even so, the Court of Appeal—to a small extent—addressed the issue. The facts underlying *Rowe* are long, and a detailed discussion of the facts and other legal arguments pursued in the matter can be found in Chapter 2.

The defence in *Rowe* specifically argued on appeal that HIV transmission should not be considered a grievous harm.[179] While the court did not need to respond to the contention because of some of the technical issues with the claim, it did provide a two-paragraph section

---

[172] Herpes Virus Association, 'About Herpes Simplex Virus' (*Herpes Viruses Association*, 20 February 2025) <https://herpes.org.uk/frequently-asked-questions/herpes-simplex-virus/> accessed 6 May 2025.
[173] *Rowe* (n 18) [1].
[174] ibid.
[175] ibid [47].
[176] ibid.
[177] ibid.
[178] [1957] 41 Cr App 189, 196.
[179] See, eg, *Rowe* (n 18) [37].

devoted to the question. Unfortunately, the analysis there was somewhat lacking. The first of the two paragraphs details the court's response to the defence citing an Irish family law case, *The Child and Family Agency v AA & Anor*.[180] The main point the counsel for the defendant-appellant likely relied upon in that case was the Irish court's description of HIV, namely its pronouncement that: '…this Court concludes on the basis of the medical evidence that the contracting of HIV, although a significant condition, is no longer a terminal condition, but rather a lifelong condition that can be managed. Accordingly, it is not a 'very serious harm' to justify a breach of patient confidentiality.'[181]

The court in *Rowe* was not influenced by the Irish case, stating that they 'derive[d] no assistance from it at all.'[182] This is hardly surprising, given that the case was in a non-UK jurisdiction in a non-criminal court. Furthermore, the facts of the respective cases were simply too different. It is also worth noting that the fact that *Rowe* involved allegations of intentional rather than reckless transmission likely affected this analysis of harm. When discussing sentencing, the trial judge, Judge Henson, found that 'the intentional transmission of HIV was serious in the context of the offence and was a factor indicating greater harm.'[183] The Court of Appeal seemed to tacitly agree, stating that the contentions of the defence ignored 'the fact that the judge was not sentencing for one offence of causing grievous bodily harm with intent but for a campaign of causing grievous bodily harm directed at ten victims.'[184]

Even though the Irish court's lack of influence was not surprising, it is both disappointing and concerning that the court provided no additional dicta as to the level of harm of HIV. Instead, the court only stated:

> The transmission of HIV will have serious consequences for the infected person's health and the courts in England and Wales have recognised that transmission of HIV can amount to an offence under the Offences Against the Person Act 1861. (See, for example, *R v Dica* [2004] 2 Cr App R 28). This was not an issue at trial and for good reason.[185]

This language essentially upholds *Dica*'s finding that HIV constituted GBH, in spite of the fact the fact that *Dica* arrived at that conclusion 14 years prior and did so by simply assuming

[180] [2018] IEHC 112.
[181] ibid [6].
[182] *Rowe* (n 18) [67].
[183] ibid [77].
[184] ibid [84].
[185] ibid [67].

that HIV constituted GBH. The Court of Appeal in *Rowe* acknowledged expert testimony that 'antiretroviral medication is available and is effective at slowing down the virus and prolonging the life of the infected person.'[186] There was a significant difference regarding the life expectancy and the quality-of-life medicine could afford in between the time of *Dica* and the time of *Rowe*.[187] While the future of medicine cannot be predicted with any specific accuracy, the current trajectory makes it likely that the health differences between HIV-positive and HIV-negative individuals will be increasingly narrowed. Furthermore, re-affirming *Dica* as it relates to harm was not even particularly necessary. During sentencing, the trial judge found that 'the intentional transmission of HIV was serious in the context of the offence and was a factor indicating greater harm.'[188] It is unclear from the appellate judgment whether this referred to the harm as a whole in terms of sentencing or in regards to the specific level of harm. Even so, the Court of Appeal upheld the trial judge's sentencing decisions, and could have simply found in dicta that the intention to harm led to a greater degree of harm, particularly in light of the facts of this case which involved the defendant-appellant specifically taunting some of the complainants after having infected them.[189] Although the section relating to harm was a minor issue in *Rowe* and not part of a binding *ratio*, the Court's dicta still shows a reliance on *Dica* as it relates to harm in spite of there never being a clear discussion as to why HIV amounted to GBH in either *Dica* or *Rowe*.

VI. Conclusion

This chapter is not necessarily trying to suggest that transmitting HIV should never be a crime, nor that HIV is not a harm at all. As stated in *Golding*, it is within the power of the fact-finder to assess the situation of the complainant(s) and determine the level of harm.[190] That said, it is within the purview of the court to provide guidelines to a jury about what legally qualifies as GBH. However, none of the relevant cases fully addressed the legal question of *why* HIV remains a GBH in light of modern medical advancements. This remains the one aspect of cases involving the transmission of communicable diseases that has not been thoroughly addressed, and as such remains one of the most striking areas where there is a potential major gap between the state of the law and the state of the medical science.

---

[186] ibid [27].
[187] See Julia L Marcus and others, 'Comparison of Overall and Comorbidity-Free Life Expectancy between Insured Adults with and without HIV Infection, 2000-2016' (2020) 3 JAMA Network Open.
[188] *Rowe* (n 18) [77].
[189] ibid [57].
[190] *Golding* (n 14) [77].

The means by which a court assesses the harm of HIV has important ramifications for future cases. Non-relativistic means of assessment have the major drawback of both allowing for misconceptions and biases to influence the perception of the harm and potentially failing to adequately address the question of whether or not the HIV transmission would be more appropriately assessed as a different offence. The lack of a consistent definition of 'harm' in English case law means that there may be inconsistencies in the definitions embraced by different courts, which can both increase confusion and the possibility that the harm is viewed through a lens which may have pre-conceived notions and bias.[191] There is a significant amount of misunderstandings concerning HIV, and laws criminalising reckless HIV transmission arguably aggravate these misconceptions by implying the communication of HIV involves a 'good' person and a 'bad' person.

HIV remains incurable. That is an incontrovertible truth at the time of writing. It is likewise incontrovertible that there is a significant social stigma against people living with HIV. This stigma can make the already difficult process of finding a romantic partner even more challenging and can impact a person's life in a myriad of ways. There are also other non-medical means by which that HIV can serve as a setback of interests under Feinberg's rubric,[192] some of which are due to stigma and some of which are not.[193] There is a tension within the role of the court in HIV criminalisation broadly since the very imposition of criminalisation laws itself creates stigma. Cases involving HIV transmission tend to generate massive media interest, much of which sensationalise the subject and demonise the defendant in question.[194] If social stigma is considered part of the harm of HIV, then the court system is taxed with punishing a person for exposing another to a stigma that the court itself had a role in propagating.

Even beyond the related stigma, life with HIV entails additional challenges around sexual relationships and childbearing that may not exist otherwise and requires a regular treatment regimen. The harm of HIV could be said to encompass three parts: the physical

---

[191] Gibson (n 2) 74.
[192] Feinberg (n 3) 106-7.
[193] For instance, mothers living with HIV require extra steps to ensure the infant does not contract the virus. NHS England, 'HIV Prophylaxis in Women and New-Borns' (*NHS England*) <www.england.nhs.uk/patient-safety/patient-safety-insight/learning-from-patient-safety-events/how-we-acted-on-patient-safety-issues-you-recorded/hiv-prophylaxis-in-women-and-new-borns/> accessed 29 March 2025.
[194] See, eg, Edwin Bernard, 'The Return of the "HIV Monster"' (*POZ*, 27 July 2011) <www.poz.com/blog/hiv-monster> accessed 25 April 2025; Ben Fenton, 'Woman with HIV Who Deliberately Took a String of Lovers Is Jailed' (*The Telegraph*, 20 June 2006) <www.telegraph.co.uk/news/uknews/1521732/Woman-with-HIV-who-deliberately-took-a-string-of-lovers-is-jailed.html> accessed 8 April 2025.

harm, the social harm, and the emotional harm. The physical harm is addressed in detail in this chapter, and in most cases—under a properly supervised medical plan—is minimal. The social and emotional harms are highly subjective and based on the person in question. Assessing them requires two notable challenges: the first is showing that the social or emotional harm reaches the harm required by caselaw per *Ireland* and *Burstow*; the second is disentangling the harm of HIV from the harm of a heartbreak that may occur when a romantic or sexual partner was dishonest (either though a lie or an omission) regarding their HIV status. This thesis contends that the narrative used by the direct language of the relevant actors in these cases can conflate the harm of HIV with the harm of betrayal.[195] The exact extent to which the social and emotional harms impact a court's assessment of HIV as GBH remains unclear since most courts devoted little attention to the question of harm in general.

This chapter argues that virtually all the cases concerning HIV transmission have treated the question of the harm of HIV as a settled issue, however it is not and should not be considered as such. The defence in *Rowe* specifically raised the issue regarding the harm of HIV as a ground for appeal, and the court's response—which relied on *Dica* and declared it was not an issue to be addressed for 'good reason'[196]—was misguided. The court in *Dica* rendered its decision almost fifteen years prior to *Rowe* and the scientific community has made significant advancements in the treatment of HIV since then.

Courts should approach the harm of HIV as a live issue. There may be fact-specific circumstances which may exacerbate the level of harm, such as a particularly traumatic seroconversion or a negative reaction to treatment regimes. There also may be circumstances, such as in *Rowe*, where the court deems the malicious nature of the transmission and the taunting after the fact as aggravating factors which likewise increase the level of harm the court approaches HIV as in that specific situation. However, simply pointing to *Dica* and neglecting to reconsider the harm of HIV disregards the years of progress that scientists achieved. While there may be some circumstances, such as those listed above which exacerbate the harm level, it is submitted that the harm of HIV is no longer grievous in most situations and should not reach the threshold of GBH. The currently available treatment regimes assist people living with HIV in living a life of comparable quality and length to those living without HIV. While it may be too far, at least in the present, to say that HIV is not a harm at all—it still requires a person to take medication regularly—the harm of HIV

---

[195] See, eg, *R v Porter* [2006] Inner London Crown Court ,T20060260 (unreported), 19 June 2006 Sentence 3.
[196] *Rowe* (n 18) [67].

now is simply not the same as it was in 2004 when the court heard *Dica*. It is easy to have a fear-based response to the question of the harm of HIV—many grew up with ad campaigns which compared it to a death sentence—however this question is one that should be approached pragmatically. The 'setback of interests' of HIV is not the difference between a totally healthy person and one on their deathbed, it is the difference between a person at their usual health level and having to engage in a regular medication regime. While the interest is still setback, it is not as stark a setback as previously.

The above chapters discuss HIV in the context of English and Scottish criminal law. Is the approach taken the only one available, or do other courts frame questions about HIV transmission differently? Does the fact that the seroconversion occurred in a sexual relationship affect the outcome? Would a legislative approach aid in ensuring the laws concerning HIV transmission are compatible with modern science? To explore these questions, the next two chapters will each engage in a comparative analysis. Chapter 6 will look to English civil law cases and assess its approach towards HIV, while Chapter 7 will assess the laws of other common law jurisdictions.

Chapter 6. Civil Law and HIV Transmission

I. Introduction

In addition to criminal law, civil cases involving HIV likewise shed light on the means by which courts address new and changing evidence regarding transmission. While both the burden of proof and the nature of the claims are very different in civil courts as compared to criminal ones, civil judgments can show an alternate approach a court may take involving HIV transmissions (or risk thereof) outside of the existing confines of *R v Dica* and its progeny. This is particularly true in connection to questions regarding the acceptability of a risk of harm. This chapter aims to compare the criminal law to the civil law in regards to the treatment of scientific evidence related to HIV, and in doing so identify the areas that there is a divergence between the two areas of law. Comparing these divergences provides assistance for two reasons: the first is that it helps answer the question of why there is a gap between the law and science where HIV transmission and exposure is concerned, and the second is that highlights alternative ways for courts to approach questions regarding risk (and to a degree harm and causation) when relevant issues arise.

The first civil cases involving HIV predate the first criminal prosecutions for transmission in the United Kingdom,[1] and demonstrate alternative situations involving questions of risk and evidence of transmission. This chapter will primarily discuss four cases: *In Re C. (A Child) v (H.I.V. Testing),*[2] *London Borough of Brent v Mr & Mrs N*, *The Minor's Foster Carers, P, a minor (appearing by her Guardian),*[3] *High Quality Lifestyles Ltd v Mr Scott Watts*,[4] and *Alan Roger Plater v Sonatrach*.[5] These cases provide an interesting counterpoint to the existing criminal cases, in large part because the question of criminal culpability is not being determined; consequently, the question of transmissibility is treated in a way that seems more generally neutral. The first three cases discussed deal predominantly with the question of how HIV is transmitted and the likelihood of such transmission, while the fourth analyses evidence regarding the source of transmission.

---

[1] *R v Dica (Mohammed)* [2004] EWCA Crim 1103; [2004] QB 1257 (CA (Crim Div)). To clarify, this thesis focuses predominantly on cases where the exposure to or transmission of HIV is the crux of the matter. There are other cases where the presence of HIV factored in sentencing or other aspects of the case. *See, e.g.*, *Attorney-General's Reference No 51 of 2007* [2007] EWCA Crim 1752.
[2] [2000] 2 WLR 270.
[3] [2005] EWHC 1676 (Fam).
[4] [2004] WL 62159.
[5] [2004] EWHC 146 (QB).

In Re C is a 1999 case which examined whether or not a baby should be tested for HIV against the wishes of the mother who previously engaged in conduct which was, at the time, regarded as posing a high risk of transmission between herself and her daughter.[6] As a case which focused on mother-child transmission, *In Re C* demonstrated how different a court's approach towards risk may be when the element of sexual activity is removed. *Mr & Mrs N* likewise focused on the potential risk of transmission to a minor. In that matter, the question before the court concerned whether a foster parent could be forced to disclose his HIV status to the child's biological parent.[7] There, the court took a very statistics-based approach and determined that the risk posed was negligible and thus did not overcome Mr N's right to privacy concerning his serostatus.[8] Criminal courts in England have thus far not directly analysed a situation where disclosure was not required because the risk of transmission was low; *Mr & Mrs N* thus demonstrated one straightforward benchmark for considering a risk negligible.

This assessment—that a risk of transmission may be low enough to not overcome other rights—was similarly at issue in *Watts*. Although an employment law case rather than a family law one, the issue surrounded a caregiver with HIV and his management who terminated his employment on the grounds that any risk of HIV transmission to clients was unacceptable, no matter how unlikely the risk of transmission was.[9] The Employment Appeal Tribunal upheld the finding of employment-related discrimination, relying heavily on relevant employment guidelines which essentially detailed the entailed risks with Watts' position as negligible.[10] *Watts* thus showed another way of determining a benchmark where the risk of transmission was extremely low while also highlighting the importance of having a judicially recognised guidance which addressed relevant circumstances. The final case, *Plater v Sonatrach*, demonstrated a civil court's approach to determining the source of an individual's seroconversion. In *Sonatrach*, the question before the court concerned whether the plaintiff had enough evidence to show that he contracted HIV in a Sonatrach clinic in Algeria.[11] The court ultimately found that there was not enough evidence—between issues concerning the plaintiff's credibility, the plaintiff's specific sub-type of HIV, and the scientific and general likelihood of other sources of infection—to find the Sonatrach clinic

[6] *In Re C* (n 2) 50.
[7] *Mr & Mrs N* (n 3) [3].
[8] ibid [30].
[9] *Watts* (n 4) [29].
[10] ibid [18].
[11] ibid [1].

responsible for Plater's seroconversion.[12] The case highlighted the importance of using all available methods to determine whether transmission could have occurred through entities other than the one the plaintiff claims must have infected them.

Since *In Re C* and *Mr & Mrs N,* courts have heard two similar cases: *London Borough of Barking & Dagenham v R M L S the Children (through their Children's Guardian, Rosemary Boulton*[13] and *Kettering General Hospital NHS Foundation Trust v C, Northamptonshire Council*.[14] This chapter will likewise discuss these cases in detail. *Kettering General*, like *In Re C*, involved a court deciding whether or not to intervene in the health of an infant who may have HIV, unlike *In Re C*, the mother in *Kettering General* had not yet given birth.[15] Also like *In Re C*, the judge ultimately agreed with the application seeking medical intervention while stressing the exceptional circumstances of the case.[16] The court similarly took a very statistics-based view of the case and specifically addressed the question of the harm of HIV.[17] In *R M L S,*[18] the fact pattern was similar to *Mr & Mrs N*, and *Mr & Mrs N* was cited within the judgment. Unlike *Mr & Mrs N,* however, the court in *R M L S* ruled that disclosure of the parent's HIV status was necessary under the circumstances. Additionally unlike *Mr & Mrs N*, *R M L S* failed to discuss any scientific data regarding the risk of transmission and instead appeared to be influenced by the guardian's and local authority's assertions that the mother deceived them during their interactions and was repeatedly dishonest.[19]

By removing the criminal element, these cases evidence a striking alternative perspective regarding the evidence of transmission. This chapter sets out to compare modern civil and criminal jurisprudence for the goal of answering several questions. The first question is: What factors make courts more likely to engage objectively with scientific evidence? There are two primary factors: the non-existence of a 'betrayal of trust' narrative, and a situation where the risk of HIV is assessed from a pre-emptive standpoint rather than one that occurs after transmission took place. The second question to be asked by this chapter is: do these factors actually impact findings of culpability or liability? The answer to this also

[12] *Plater* (n 5) [98].
[13] [2023] EWHC 777 (Fam).
[14] [2023] EWHC 239 (Fam).
[15] ibid [2].
[16] ibid [29].
[17] ibid.
[18] (n 13).
[19] ibid [23].

appears to be yes. Although there is not enough information available related to every reported and unreported finding of a court related to HIV, the selection of cases discussed below focus more heavily on scientific and statistical evidence than their criminal counterparts and consequently did not find adequate evidence to support findings of liability regarding either causation or the risk of transmission.[20] Contrary to what one might assume, the assessment of causation and risk appears to be more stringent in civil cases than in the criminal ones, running counter to what should be the case in light of the differing standards of proof.[21]

The final question to be asked is this chapter is: in light of the above analysis, are there aspects of the civil law that the criminal law can draw assistance from in disease transmission cases in order to ensure that the criminal jurisprudence relies on up-to-date scientific evidence? The answer to this final question is also yes. As will be discussed further below, the civil cases approached the questions of risk, causation, and (to a limited degree) harm in a way that was largely reliant on modern statistical evidence. Although the fact patterns addressed in the non-criminal cases are obviously different than those in the criminal proceedings, the risk of a resulting loss of liberty through imprisonment should cause courts to assess risk and harm through a rubric that is at least as stringent as seen in the civil cases. The cases discussed below provide examples of non-criminal courts assessing the risk of transmission through a more direct and scientific-based model; this sort of model could apply to future criminal cases as well. Consequently, this comparative analysis serves to highlight some of the existing gaps that exist between the law and science in criminal English jurisprudence concerning HIV transmission and looks to the civil law for alternative approaches.

This chapter argues the civil law's approach towards HIV is most markedly different within the realm of risk. The most likely reason for this distinction is threefold: first because of procedural distinctions making the question of risk more likely to arise as an issue on appeal in civil courts, second because the criminal law in England only deals with matters involving transmission (as opposed to the civil law which deals heavily with the question of

---

[20] This is only partially true for *In Re C* and *R M L S,* as will be discussed below. It is additionally acknowledged that the family law cases are not concerned with liability as much as they are concerned with a balancing of interests. Even so, the point remains; the weight given to the risk of transmission were generally lower given the individual circumstances of the cases.

[21] It should of course be noted that while anyone (in theory) can bring a civil claim, a criminal prosecution would be vetted by a prosecutor would be more likely to bring charges in cases where there already appears to be evidence in support of prosecution.

risk) which can lead to an anecdotal bias and a hindsight bias, and third because the betrayal of trust narrative likewise leads to bias and a skewed perception of harm. These issues can be avoided in future cases, however courts will have to take care to focus on what conclusions they are reaching, why, and based on what evidence.

II. ***In Re C. (A Child) v (H.I.V. Testing)***

Heard in 1999, *In Re C* is an example of an early case involving HIV in a unique and surprising manner. The case involves a 32 year old woman diagnosed with HIV in 1990.[22] In 1991 she stopped regular blood tests, refused medication,[23] and instead adopted a critical view of the medical approach to HIV/AIDS.[24] Instead of science and medicine, she put her energy into fitness and healthy eating.[25] As of the date of the hearing, the woman had not yet experienced any symptoms of AIDS, and she expressed doubts both about her having the virus and the connection between HIV and AIDS.[26] In 1997 the mother met a man who adopted similar criticisms of the scientific community's approach towards HIV.[27] In 1997 the man tested negative for HIV, although it remains unclear if he took any further tests or if his serostatus ever changed.[28]

In 1998 the woman became pregnant.[29] Although aware that the medical recommendations for pregnant mothers with HIV included taking medication, undergoing a caesarean section rather than a vaginal birth, and refraining from breastfeeding, she disregarded all of this and instead underwent a home water-birth and breastfed the baby.[30] In 1999 the parents took the baby to a new doctor for a developmental examination; after the doctor read through the mother's files and discovered her HIV status, she contacted the parents and informed them that the mother should cease breastfeeding immediately and that the child should be tested for HIV.[31] A further meeting with a paediatrician reiterated the earlier advice, all of which the parents rejected.[32] In response, the local authorities initiated a proceeding for the court to direct the child to be tested for HIV.[33]

---

[22] *In Re C* (n 2) 50.
[23] ibid 51.
[24] ibid 50.
[25] ibid.
[26] ibid 51.
[27] ibid 50.
[28] ibid.
[29] ibid.
[30] ibid.
[31] ibid 51.
[32] ibid.
[33] ibid.

A. The Evidence

The evidence produced by the parents rested on the experience of the mother and the testimony of Professor de Harven. The mother insisted her expertise was based on her extensive reading on the subject, in addition to living with HIV for nine years and—as of the time of the hearing—failing to develop symptoms of AIDS.[34] She refused to believe in the accuracy of the tests[35] and felt that medical treatment for HIV at the time would 'do more harm than good.'[36] Professor de Harven was a retired pathology professor from the University of Ontario who, although not an expert in HIV/AIDS, analysed viruses under a microscope.[37] Based on his experience he denied the existence of HIV, its connection to AIDS, and the accuracy in the PCR testing—the HIV analysis at issue.[38]

The local authorities relied on the evidence produced by Doctors Novelli and Walters, both of whom worked in the field of paediatric infectious diseases.[39] Both doctors presented evidence that the baby was potentially already infected, citing research that the combination of refusing medication during pregnancy and the vaginal birth amounted to a 15% chance of infection.[40] While data regarding the transmission of HIV via breastfeeding in Europe was sparse at the time, the doctors stated that the risk of transmission from breastfeeding within the first five months was between 5-10%; consequently, the likelihood that the baby was already infected was approximately 20-25%.[41] The doctors further argued that continuing to breastfeed would increase the risk by approximately 3.2% each year, or 0.27% per month.[42] The doctors likewise stated that the PCR test was highly accurate and more likely to give a false negative than a false positive;[43] they noted, however, that the test would not 'reveal any infection communicated within the previous eight weeks,' and that a second test taken eight weeks after breastfeeding ceased should be performed.[44]

---

[34] ibid 50. The opinion notes that the timeline for HIV to manifest symptoms for age is generally 10 years, consequently it is not necessarily abnormal that she did not experience symptoms at that time. ibid 53
[35] Indeed, the mother was re-tested in the hopes of proving the inaccuracy of HIV testing; unfortunately—though unsurprisingly—she still tested positive. ibid 51
[36] ibid.
[37] ibid 55.
[38] ibid. Etienne De Harven, who died in 2019, remained an AIDS denialist throughout his career. In 2008 he published *Ten Lies About AIDS* which re-asserted his position—among others—denying that HIV existed, caused AIDS, and was alleviated by ART. Trafford Publishing, 2008.
[39] *In Re C* (n 2) 52.
[40] ibid 54.
[41] ibid.
[42] ibid.
[43] ibid.
[44] ibid 55.

In response to Professor de Harven's denial of HIV, its connection to AIDS, and the value of treatment, the court heard anecdotal evidence from the doctors:

> But more telling even than his theoretical refutation of the professor's argument are [Dr. Novelli's] and Dr. Walters's anecdotes about their lives as clinicians in two of the three H.I.V. paediatric units in London. At Great Ormond Street Dr. Novelli has been closing his wards; his patients are out-patients, taking antiretroviral treatment. Since 1997 his hospital has had one death in this sphere; before then, there were six each year. Dr. Walters's evidence is to the same effect: he has not attended a child's funeral for three years; before then, he had to attend them regularly.[45]

As to the necessity for medication, the doctors presented evidence that approximately 20% of infants living with HIV would develop AIDS-related illnesses within their first year without medication.[46] Two thirds of those, the doctors stated, would develop PCP, a highly dangerous illness that kills approximately 30% of infected infants.[47] The combination of this evidence indicated that the infant, if infected, faced a 4% chance of dying before she turned one without medication.[48]

The judge ultimately ruled for the local authority, finding that the 'case for testing is overwhelming.'[49] He specified, however, that the direction was only in relation to one HIV test, and did not include reference to further testing or treatment based on the result.[50]

B. The Treatment of the Evidence

The judge's response to this case and the evidence presented are extremely surprising. Given the relative novelty of HIV in 1999, in addition to the fact that the health of an infant was at issue, the writing of the opinion comes off as somewhat laissez-faire. Indeed, the discussions regarding the accuracy of testing take up approximately as much space as the legal analysis of the rights of the parents versus the rights of the child. While the court ultimately sided with the two doctors over Professor de Harven, the judge gave a considerable amount of weight to his testimony as to the very existence of HIV, noting: 'The professor, who was extremely charming, was the first to accept that his is a dissident view. It is none the worse for that. Orthodoxies are there to be challenged; and I would hope that there

---

[45] ibid.
[46] ibid 56.
[47] ibid.
[48] ibid. The parents indicated that even if the baby tested positive, they would be opposed to her taking medication (a drug named Septrim) because they did not believe in its benefits in light of the side effects, and doubted that it would even work. The parents likewise indicated that they would reject any combination therapy. ibid.
[49] ibid 61-2.
[50] ibid 58.

is no better place to do so than in a court of law.'[51] The court appeared to be heavily swayed towards the doctors over the professor based on the stories they told about the rate of children passing away due to AIDS-related illnesses.[52]

Considering the strong stance in criminal cases against taking risks where another person does not consent, in addition to the vulnerable health of infants, the court's approach to HIV seems radical compared to its criminal counterparts. The court noted:

> The local authority have made clear at the outset of the proceedings that their strong provisional view is that they would not want to ask the court to order the mother not to breastfeed the baby, however misguided her stance was. Should I, nevertheless, hang over the mother's head the possibility of a court prohibition against her breastfeeding the baby? My belief is that the law cannot come between the baby and the breast. Indeed, if she cannot be persuaded by rational argument that she must curb her instinct to feed, I doubt whether the mother would comply with a court order, which would be in effect impossible to enforce. The parents will respond better to this judgment if they realise that it has intellectual integrity and makes no idle threats.[53]

In a sense, the court sanctioned exposure to HIV between a mother and an infant. Undoubtedly breastfeeding is an inherent right and a matter that should be generally left to the parents, but is not consensual sex between adults not also a similar right? While the two situations may appear to be very different, they share significant similarities. Both belong to acts which the government is generally broadly reticent to interfere with—with infant rearing on one hand and sex on the other. Both situations involve exposing another individual to a risk of HIV transmission, with the risk actually being significantly higher in the civil case involving mother-child transmission. Finally, both cases involve an individual who is being exposed to the risk without being able to *consent* to it. An infant cannot know or consent to the exposure from their mother. In spite of this, the judge in *In Re C* was loathe to interfere more than ordering one HIV test. In criminal cases, however, judges have found defendants culpable for transmitting HIV (and exposing people without transmission to HIV in Scotland) and subject to lengthy sentences in addition to further limitations through the power of hybrid orders such as sexual harm prevention orders.[54]

---

[51] ibid 55.
[52] ibid.
[53] ibid 59.
[54] One SHPO required one HIV-positive man to not only inform the police of the contact details of a proposed sexual partner prior to sex, but also required him to wait for 'written approval before having intercourse wearing a condom.' Gareth Davies, 'Father who 'deliberately' withheld his HIV+ status and infected two women claims he was contaminated when a man sexually abused him' (*The Telegraph*, 30 October 2018) <www.telegraph.co.uk/news/2018/10/30/father-deliberately-infected-two-women-hiv-claims-contaminated/> accessed 11 October 2024.

In the end, *In Re C* may have simply been a product of its time and of a judge with more unorthodox views.[55] While it is unclear if the case would be treated differently if heard today, the general framing of the mother as a victim (the court referred to her infection as a 'tragic plight' from circumstances that can 'attract no moral blame'[56]) begs the question as to whether or not it is the element of sex and allegations of deception which cause transmission in criminal cases to be treated so differently.

C. What Can Criminal Courts Learn from *In Re C*?

Since *In Re C* is a very early case concerning HIV, it must be understood within the context of the time that it was heard in. While certain aspects of it remain strange, the judge in that case took a neutral view of the mother—neither condemning her as a victim nor framing her as a monster. Rather than focus on the perceived gravity of the harm, the case focused more on the statistical risks of both harm and death. The judge gave deference to the private sphere of birth and breastfeeding while also balancing the need for medical professionals to know the child's serostatus. While the case is in many ways an odd one, the broad approach and appreciation for up-to-date (at the time) statistical information when assessing risk, neutral approach towards the person living with HIV, and greater weight towards the private realm are factors which could transfer into criminal transmission cases.[57]

D. *Kettering General Hospital NHS Foundation Trust v C, Northamptonshire Council*[58] – Does *In Re C* Still Hold True?

In 2023 the Family Division of the High Court heard a more recent case with a fact pattern reminiscent of *In Re C*. *Kettering General Hospital NHS Foundation Trust v C, Northamptonshire General Council* involved 'C', a pregnant woman living with HIV who had an imminently planned caesarean section after refusing to take antiretroviral medication throughout her pregnancy.[59] The Kettering General Hospital NHS Foundation Trust submitted an application in order to ensure that the infant received ART for the first 28 days of their life.[60] As with the mother in *In Re C*, the mother in *Kettering General* ignored medical advice from her doctors and believed her HIV could be managed through diet and

[55] To reiterate, the lack of an order prohibiting breastfeeding was not simply the position of the judge; the local authority likewise indicated that provisionally they would not seek such an order. *In re C* (n 2) 60.
[56] ibid.
[57] No information could be found about the parties to this case after its resolution. It remains unknown if the infant was HIV-positive or if the mother ultimately received an AIDS diagnosis.
[58] (n 14).
[59] ibid [2].
[60] ibid.

vitamins.[61] The mother believed that her baby would be fine even without antiretrovirals and did not appear to be convinced about the risk of complications from AIDS-related illnesses.[62] C staunchly believed that antiretrovirals would not be healthy for herself or her baby.[63] Her partner likely possessed a similar anti-medical science perspective, as he and C had been engaging in unprotected sex acts for over twelve years and he refused to be tested.[64] Her anti-medical science stance is particularly perplexing as she claimed to have been a nurse in her home country of Romania.[65] Her doctor believed that the risk of the infant having HIV was very high, as was the possibility of the baby developing a life-threatening infection.[66] The court heard evidence that the mother-child risk of transmission was between 15-45% during the pregnancy, birth, and post-natal period, however that number could be reduced to as low as 0.1-0.2% with treatment.[67]

As with *In Re C*, *Kettering General Hospital* examined the available information regarding the risk of transmission, although it considered data not available at the time of *In Re C* concerning the role viral loads can play in transmission.[68] C evidently agreed to the treatment plan put in place by her medical team for her delivery, however both they and the court seemed pessimistic about whether or not she would stay committed to it given her history of previously agreeing to go on antiretrovirals during her pregnancy only to back out at the last moment.[69] The hospital's plan included PEP for the infant immediately after birth[70] and numerous tests to detect HIV after birth up until the child turned two.[71] Complicating the question before the court were rather suspect procedural steps taken on behalf of the hospital—the court heard the application only one day before C's scheduled caesarean section[72] and 'C had purposely not been informed of the hearing.'[73] Instead, the Official Solicitor acted as amicus.[74]

---

[61] ibid [3].
[62] ibid.
[63] ibid.
[64] ibid [5].
[65] ibid [11].
[66] ibid [5].
[67] ibid [6].
[68] ibid [7]-[9].
[69] ibid [11]. When asked why she would be okay with her infant being born with HIV, C responded: 'I have been ok and I would rather he had HIV than Downs and the test for Downs was wrong so this may be wrong.' ibid.
[70] ibid [14].
[71] ibid [15].
[72] ibid [2].
[73] ibid [18].
[74] ibid.

The court emphasised that there must be 'compelling reasons' for a public authority to submit an application that interferes with parental rights without the parent's notice or involvement.[75] While the court expressed sympathies to C—whose fear of medical procedures likely stemmed from the fact that she contracted HIV through a vaccination program that used contaminated needles[76]—the likelihood of C not complying with the recommended birth plan, her high viral load, and stated desire to have her infant moved to be seen at another hospital all influenced the court's decision to classify this as an exceptional circumstance for the application.[77] The official solicitor premised much of their submission on the level of harm posed by HIV, arguing that there was insufficient data on the long-term health impacts of HIV in children born with the infection.[78] In response to this, the court stated:

> HIV is, happily, not the death sentence it once was. But, the fact that people confront an HIV diagnosis with courage and phlegmatism does not, to my mind, detract from its life altering impact. It continues, as I was reminded, to carry very great stigma in all areas of the world. It requires lifelong medication. It has a real and enduring impact on the most intimate aspects of people's lives. It carries a psychological burden, which is not easy to bear. An infected child will come gradually to know of their infection but in early adolescence they will confront the stark realities of the virus at a time of their life when they will be ill-equipped.[79]

While *Kettering General* certainly did not overturn *In Re C*, it did show a greater willingness on the part of courts to interfere in parental rights where the risk of HIV was present. The difference in approach between *In Re C* and *Kettering General* seems to be based on three primary reasons: firstly, they were different circumstances. The mother already gave birth in *In Re C* and whatever harms stemmed from that already occurred, whereas *Kettering General* involved an emergency proceeding aimed at trying to prevent transmission before it took place. The second reason likely has to do with the passage of time and the greater data there is now than existed in 2000 during *In Re C*'s hearings. The statistical risks and role of medical interventions could be described far more accurately in *Kettering General* because of this. The third reasoning appears to be the judge's differing perspectives on the harm of HIV. The court in *In Re C* appeared more receptive to the mother's witnesses which downplayed both the severity of HIV and its connection to AIDS.

---

[75] ibid [20].
[76] ibid [24].
[77] ibid [27].
[78] ibid [29].
[79] ibid.

In *Kettering General*, the official solicitor's objection to the application predominately turned on the argument that HIV was not a significant enough harm to justify the exceptional circumstances needed for the declaration.[80] On that point the court expressly disagreed, noting that while HIV may not be as serious as it used to be, it still could have an impact on a child's life.[81] While the outcome was not as conservative as that in *In Re C*, *Kettering General* still came to a similar conclusion which relied significantly on scientific evidence.[82]

III. ***London Borough of Brent v Mr & Mrs N, The Minor's Foster Carers, P, a minor (appearing by her Guardian)***

Like *In Re C, Borough of Brent v Mr & Mrs N* was a family law case which concerned the risk of transmission. The case involved an application in 2005 concerning a two-year-old girl put into foster care in response to the lifestyle of her mother.[83] The local authority wanted to place P, the girl, with her father.[84] One of the foster parents, Mr N, was HIV-positive, and objected to his status being disclosed to P's father.[85] The case sought to determine whether or not the local authority could disclose Mr N's HIV status in spite of his refusal.

A. The Evidence

Unlike *In Re C*, the judgment devoted virtually no space to narratives or background. The primary evidence was the report of Dr Amanda Williams, a consultant paediatrician with a sub-specialty in infectious diseases.[86] Much of the opinion discussing the evidence cited to her report directly. The report indicated that HIV transmission was dependent on contact with certain bodily fluids, and that non-sexual households pose a negligible risk of transmission to a child.[87] The report noted the low risk of transmission from non-sexual contact (e.g. citing that needle stick from a HIV positive person carries a 0.3% risk of infection per instance),[88]

---

[80] ibid.
[81] ibid.
[82] The judgment includes the following postscript: 'In the paragraph above, I have referred to the baby by the male pronoun. As I was concluding this judgment, I was notified that the birth went well. C complied with the anti-retroviral medication immediately prior to the caesarean. Her baby boy is doing well. I have been told that both parents are expressing clear consent to the 28-day treatment regime. I hope that when they read this judgment, they will understand why the Court has taken the course it has. I should also like to extend my congratulations to them on the birth of their son.' ibid [31].
[83] *Mr & Mrs N* (n 3) [1].
[84] ibid [2].
[85] ibid [3].
[86] ibid [11].
[87] ibid [14].
[88] Modern reports place the number at 0.23%. Rebecca F Baggaley and others, 'Risk of HIV-1 Transmission for Parenteral Exposure and Blood Transfusion: A Systematic Review and Meta-Analysis' (2006) 20 AIDS 805.

and the role that a person's viral load may play.[89] The report further noted that HIV was not a notifiable disease, that screening based on HIV status was not required, and that the risks of discrimination from forced disclosure were high.[90] The court ultimately concluded that disclosure was not required.[91] It held that confidentiality may not be breached in the face of a negligible risk.[92] In the context of the underlying case, the court found the risk of HIV transmission was negligible in the circumstances, and thus found for Mr N.[93]

B. The Treatment of the Evidence

Unlike *In Re C*, this case put very little emphasis on narrative and focused almost solely on the scientific evidence. No information was provided about Mr N personally, including whether he was on a treatment regimen or if he had a low or undetectable viral load, indicating that this case was looking at non-sexual households with a person living with HIV more broadly. The court seemed significantly persuaded by the statistics and scientific evidence proffered.

This case serves as a direct counterpoint to *R v Peace Marangwanda*,[94] a case involving allegations that gonorrhoea was spread in a non-sexual manner, in spite of the evidence that such a transmission would be negligible at best.[95] The contrast between *London Borough of Brent v Mr & Mrs N* and *Marangwanda* highlight the possibility in *Marangwanda* that the plea and underlying allegations were mostly settled on as a way to ensure that the defendant was charged with *a* crime.

What *Mr & Mrs N* (and *Watts,* discussed below) indicate is that, in civil cases at least, there seems to be a general acceptance of the connection between low viral loads and a low risk of transmission. While relevant prosecutorial guidelines state that an individual on a regular medicine regime[96] may not be prosecuted for transmission or exposure, the guidelines are not law and it remains unclear what would happen in a relevant scenario. In this case, however, the court seemed inclined to take a straightforward view that medical evidence

---

[89] *Mr & Mrs N* (n 3) [14].
[90] ibid. The report discussed the impact of low viral loads but not undetectable viral load, which would be render transmission essentially impossible.
[91] ibid [32].
[92] ibid.
[93] ibid [31].
[94] [2009] EWCA Crim 60.
[95] ibid [15].
[96] Crown Prosecution Service, 'Intentional or Reckless Sexual Transmission of Infection' (*Cps.gov.uk*, 13 December 2019) <www.cps.gov.uk/legal-guidance/intentional-or-reckless-sexual-transmission-infection> accessed 6 May 2025.

suggested the risk of transmission in that case was low, and as such the law should not intervene.

C. What Can Criminal Courts Learn from *Borough of Brent v Mr & Mrs N?*

Similar to *In Re C*, this case highlights how a straightforward assessment of risk can occur. The individual circumstances did not matter outside of their impact of this risk. The approach also suggests that a 0.3% risk of transmission could be negligible and not enough to outweigh competing interests. Given the higher burden of proof and impact of a criminal conviction, a clearer delineation between negligible risks (not imparting a reckless *mens rea*) and a non-negligible risks (which do) should be a part of the criminal jurisprudence when such an issue arises before a respective court.

D. *London Borough of Barking & Dagenham v R M L S the Children (through their Children's Guardian, Rosemary Boulton)*[97] – Is *Mr & Mrs N* still applicable?

In the more recent case of *London Borough of Barking & Dagenham v R M L S the Children (through their Children's Guardian, Rosemary Boulton)*—another family law matter involving the balancing of a parent's right to privacy concerning their HIV status versus disclosure—the court directly referenced *Mr & Mrs N.* In that matter, local authorities intervened in the parental rights of a mother of a five-year-old and a two-and-half-year-old[98] after she drove recklessly while under the influence of alcohol with the older child in the car.[99] In addition to having a known history of struggling with alcohol,[100] the mother was born with HIV.[101] The mother treated her HIV with antiretrovirals and the children were all HIV-negative.[102] The parents were divorced, and there were allegations of domestic violence throughout their relationship.[103] After the local authorities became involved with the family, they came to an arrangement where the family (including the mother) lived with her sister under a plan monitored by the relevant authorities.[104]

---

[97] (n 13).
[98] ibid [2].
[99] ibid [3].
[100] ibid.
[101] ibid [6].
[102] ibid.
[103] ibid [5].
[104] ibid [4].

The primary question before the court in the case was whether the mother's HIV status should be disclosed to the father.[105] Even though the mother gave birth to two of the father's children, he evidently was unaware of her HIV status throughout the course of their relationship.[106] The only reason why this issue arose in the first place was because of a doctor who, without the mother's consent, informed the local authorities of her status owing to his concerns about the children not being brought in for recent testing that they believed necessary.[107] When discussing and distinguishing *Mr & Mrs N*, the court noted that *Mr & Mrs N* determined that the foster parent's HIV status was not at all relevant to underlying court process;[108] the question for this case was then whether the local authority could establish such relevance.

The local authority submitted that the father should be aware of the mother's HIV status for three reasons: first to monitor the health of the children, second to 'be aware of the mother's status and the need for her to look after her own health,'[109] and third so that he would learn of her HIV status in a controlled environment rather than through the children or someone else.[110] The third point is of particular relevance owing to the history of domestic violence in this case, and the language of the court indicated that the mother believed that his response to the revelation of her HIV status could be severe and impliedly dangerous.[111] As a consequence of this, the local authorities proposed that the father learn of the mother's status at an HIV clinic where his questions could be answered and he would be given advice not to spread information relating to the mother's HIV.[112] Furthermore, the local authority expressed concerns over the mother's honesty in addition to her ability to maintain her own treatment—they argued that a spike in her viral load could impact transmissibility and put her children at risk.[113] Counsel for the mother repeatedly questioned the relevance of the mother's HIV status in their submissions, pointing out that the children were currently well-attended[114] and that forcing the mother to disclose her HIV status would likely destabilise her co-parenting relationship with the father and harm the children's care plan.[115]

---

[105] ibid [7].
[106] ibid.
[107] ibid [8].
[108] ibid [19].
[109] ibid [20].
[110] ibid.
[111] ibid.
[112] ibid [22].
[113] ibid [23].
[114] ibid [28].
[115] ibid [34].

Contrary to *Mr & Mrs N*, the judge here sided with the local authority and ruled that disclosure was necessary upon balancing the respective interests. Although the ruling in the case was the opposite as in *Mr & Mrs N*, the court clearly distinguished the circumstances of the two cases.

E. *R M L S* and *Mr & Mrs N* – Why Was a Different Outcome Reached?

This thesis argues that in criminal cases involving HIV there is a gap between the law and science that exists for several reasons, including misunderstandings of the harm of HIV broadly and a fascination with a narrative involving a betrayal of trust which occurs when an individual's HIV-status is not disclosed to a sexual partner. This chapter in particular argues that the removal of the element of sexual relationships from the equation, and thus that sense of betrayal, influences non-criminal courts to have a higher threshold for what they consider an unacceptable risk of harm than their criminal counterparts. If all of this is correct, then what happened in *R M L S*?

It is submitted that the court incorrectly decided *R M L S* based on the evidence identified in the judgment. The local authority submitted two main reasons for the disclosure: the mother's health and the children's health; however, they additionally expressed concerns about controlling the environment in which the father learned of the mother's status.[116] Although the local authority alleged that the mother inconsistently engaged with her medical provider's for treatment,[117] it did not appear to be alleged that her HIV status or connected health concerns previously interfered with her ability to parent the children. To the extent that it might in the future, the court disregarded the fact that the mother did not parent alone when the children were in her custody—she lived with the children's aunt (whom the children regarded as a *de facto* mother) under a plan supervised by the local authority.[118] Even if the mother herself struggled with her health—something not alleged other than that which connected to her difficulties with alcohol—another relative lived in the house and assisted with child care. The concerns regarding the mother's health appear tenuous and not founded on specific evidence showing that she would be unable to care for the children in the future.

The concern about the mother's HIV appeared to be more relevant to the question of transmissibility to her children rather than her ability to care for them. The counsel for the guardian specifically highlighted that: '[the mother] not been consistent in engaging with her

[116] ibid [20].
[117] ibid [23].
[118] ibid [4].

own medical treatment, leaving her at risk and leading her own viral load to be detectable, therefore creating a risk to the children.'[119] The court also cited the possibility of the children 'turning out to be HIV positive' and requiring monitoring in the future.[120] All of this leads to the conclusion that the court believed that there was a realistic possibility of the children contracting HIV, whether owing to the mother's negligence in caring for her own treatment leading to her viral load becoming detectable or other factors.

This aspect of the case is the most baffling part in light of its earlier recognition of *Mr & Mrs N*. The court in *R M L S* distinguished *Mr & Mrs N* (as well as another case, *Re P*[121]) by stating that the presence of a person living with HIV 'was simply not relevant to the court process and that was the end of the matter.'[122] But part of why *Mr & Mrs N* found disclosure unnecessary was because it found the risk of transmission to be negligible.[123] Evidence submitted by an expert in *Mr & Mrs N* indicated that 'normal non-sexual household contact has a negligible risk of transmission of HIV.'[124] Regardless of the mother's viral load, the risk of infection in *R M L S* was likewise minimal. The court's assumption that a non-negligible risk of transmission exists in a normal parent-child relationship outside of birth and breastfeeding is outdated and incorrect. Unless the mother was still breastfeeding one or both of the children, something not addressed in the judgment, there should not have been a need at all to monitor the children's HIV status. The mother's HIV only became relevant because of a doctor's unilateral disclosure—a doctor who was evidently monitoring the HIV status of the children.[125] But why did the doctor deem it necessary to monitor the children's HIV status in the first place? There are two possibilities: the first is that the mother was breastfeeding[126] and this was not referenced in the judgement, the second is that the doctor themselves misunderstood the likelihood of HIV transmission via normal contact between parent and child. If the former, then that information was relevant to the proceedings and its omission

---

[119] ibid [23].
[120] ibid [29].
[121] *Re P (Non Disclosure of HIV Status*) [2006] 2 FLR. This was a short case that also involved an appeal by a mother to not have her positive HIV status revealed to the father. ibid [1]. The court ultimately decided against disclosure, in part because the underlying issue had been addressed by the solicitors. ibid [21]. The court found that disclosure would impact the mother's mental health and indirectly harm the children. ibid [31].
[122] *R M L S* (n 13) [19].
[123] (n 3) [31].
[124] ibid [14].
[125] *R M L S* (n 13) [8].
[126] Outside of breastfeeding, it is difficult to imagine any other way HIV could be transmitted between parent and child that would not implicate other greater concerns. Since the court did not address issues regarding potential needle-stick or sexual exposure, both of which would have been highly relevant for other reasons, it is safe to assume that they were not relevant.

strange, if the latter then the local authority's concern with ongoing monitoring of the children's HIV status was in itself based on a faulty misunderstanding regarding the risk of transmission. Curiously, the risks of transmission in a household setting were addressed in *Mr & Mrs N*—heard over 15 years earlier—and understood to be negligible.

The remaining reason for requiring disclosure was also strange. In short, the court determined that because the father's reaction may be 'highly negative,' that disclosing her HIV status in a controlled situation may reduce the fallout.[127] Although the court never explicitly stated that the father would react violently to the news, it appears possible given the history of domestic abuse in the relationship.[128] The court stated:

> The mother fears that when the father is told this information he may react in a very negative way. She fears that he will be upset with her, putting it in relatively neutral terms – this is a case with a substantial history of domestic abuse – but she also fears that he will talk about it around the town and spread the information generally in a way that would only be and could only be very adverse to her interests.[129]

In spite of these concerns for her reputation (as well as the other possible risks to both her physical safety and the relationship with her children), the local authority's solution aimed to disclose her status in a clinic and simply advise him to not spread the information concerning her status.[130] The local authority described the situation with the father as a 'ticking time bomb,'[131] and the court appeared to accept that the local authority's proposed approach would potentially reduce the father's negative reaction.[132]

The court's decision is strange because, unlike *Mr & Mrs N*, the balancing here was not just a matter of privacy. Given the history of domestic violence in their relationship and the father's ignorance towards her HIV status, the court's avoidance of discussing the potential risk of actual physical harm towards the mother is curious as it should be a highly relevant factor when balancing the competing interests. Even beyond that, it appears evident that the mother expressed significant concerns as to how it would affect their co-parenting relationship and her status in the community, both factors which can potentially negatively affect her children. The court's acceptance of the local authority's position that they would simply advise him not to tell anyone about her HIV status seems naïve given their

---

[127] ibid [36].
[128] ibid [5].
[129] ibid [21].
[130] ibid [22].
[131] ibid [21].
[132] ibid [36].

relationship history and the lack of any means of enforcing his silence. Contrary to *Mr & Mrs N*, there were more factors supporting her right to privacy. The risk contrary to it, namely the risk of transmission to the children or the risk of the parent's ability to care for the children in light of their status, remained similar. Why then did this case turn out so differently than *Mr & Mrs N*?

This thesis argues that many of the cases focusing on HIV transmission or exposure can be impacted by the underlying narrative focusing on the betrayal of trust. There are two factors that distinguish *R L M S* from *Mr & Mrs N* in this regard: the first is that there was a betrayal of trust in the course of a sexual relationship. Although not addressed in detail by the court, the fact that the mother was born with HIV[133] and had children with the father means she did not disclose her HIV status to him in the course of their relationship. The second factor is that the court appeared concerned with her honesty surrounding her HIV status more generally. The local guardian listed numerous ways she had not been truthful in a way they considered relevant, all mostly relating to testing for the children and treatment for herself.[134] The local authority likewise stated that she had not disclosed her HIV status to a psychologist or a social worker that assessed her as well.[135] Although the court addressed the importance of the guardians and local authorities being aware of the mother's health in order to assess the children's care plan, the purpose of this case was not regarding whether the local authority or the guardian were to be made aware of her HIV-status—they were clearly aware by that point—it was whether the father should be made aware. Even so, the court focused significantly on mother's lack of honesty—something the local authority and guardian referred to as a 'deception.'[136]

R L M S is a curious case, in large part because of the court's acceptance of the local authority's and guardian's contention that the mother's HIV status was relevant to her ability to care for her children in spite of no examples given as to how it would be so. The accepted medical evidence, including the evidence relied upon in *Mr & Mrs N*, firmly establish that the risk of children contracting HIV in normal household interactions is negligible, and there was not sufficient information that the mother's HIV status affected her ability to parent. The

---

[133] ibid [6].
[134] ibid [23]. One of the contentions was that 'she was dishonest in going against an indication given by the judge on a specific instruction by the local authority,' and it is unclear if the instruction was in regard to testing or treatment for herself or her children. ibid.
[135] ibid [24].
[136] ibid [26].

mother obviously struggled with alcohol-related issues, but her HIV was not relevant to her family coming to the attention of the local authority in the first place. Instead, much of the underlying narrative here is more in line with criminal cases in terms of its focus on deception and the betrayal of trust.

IV. ***High Quality Lifestyles Ltd v Mr Scott Watts***

Unlike the two cases discussed above, *Watts* was an employment law case. The claimant in *Watts* was a 30 year old man diagnosed with HIV in 2000.[137] While he was normally on an ART regimen, at the time of his job application he was on a planned break from his medicine on the advice of his medical consultant.[138] The company in question provided 'specialist services to people with learning disabilities, autistic spectrum disorders and those who sometimes present with severely challenging symptoms' and offered live-in aids to assist individuals with their daily activities.[139] The individuals who used the service could be unpredictable and occasionally could bite, scratch, or otherwise injure their caretakes.[140] The claimant began work in March 2004 and performed well enough to earn a promotion in July of that year.[141] Around that time, Watts decided to disclose his HIV status to his employer on account of an ex-partner threatening to reveal it for him and because he was on a new medication regimen.[142]

Watts permitted his employer to contact his treating consultant, who in turn confirmed that the risk of transmission in the workplace was very small.[143] In August 2004, two agents of the employer summoned Watts for a meeting and stated that they 'would not consider employing anyone who was HIV positive as a support worker,'[144] but agreed to carry out a risk assessment—albeit one that they indicated would likely assess Watts as a high risk who would need to leave the company.[145] Neither Watts nor his medical provider were part of the risk assessment, and the health and safety consultant concluded that the risks associated with broken and skin and biting made a person with HIV rated a '4/5 severity rating.'[146] The Tribunal noted that the risk assessment was made without specificity to Watts and did not

---

[137] *Watts* (n 4) [21](7).
[138] ibid.
[139] ibid [21](9).
[140] ibid.
[141] ibid [21](10).
[142] ibid [21](11).
[143] ibid [22].
[144] ibid [23](17).
[145] ibid [23](18).
[146] ibid [26].

reflect the relevant guidelines discussing HIV in healthcare workers.[147] In light of the risk assessment, and without reference to his doctor's letter, the company dismissed Watts in October.[148] Watts appealed the termination, however the managing director stood by the original findings, stating that although the risk of transmission was small, 'any risk at all was not acceptable.'[149]

In October 2005 an Employment Tribunal heard the case and focused predominantly on four issues: whether direct discrimination occurred, whether Watts' confidentiality was breached, whether disability-related discrimination occurred, and whether the employer met its duty to make reasonable adjustments for Watts.[150] The Tribunal found in favour of Watts, leading to the appeal.[151] The appellate body ultimately set aside the Tribunal's finding of direct discrimination and confidentiality, but upheld the findings on disability-related discrimination and the failure to make a reasonable adjustment.[152]

A. The Evidence

The appellate body focused (unsurprisingly) on the lower tribunal's legal justifications and accepted the underlying Tribunal's findings regarding the facts. The Tribunal itself appeared to be moved in large part due to the employer's failure to conduct the risk assessment in a way that reflected the relevant guidelines or considered Watts' specific set of circumstances.[153]

The guidelines in question indicated that a healthcare worker living with HIV should generally pose no risk of transmission to a patient, although certain invasive medical procedures—which were irrelevant to Watts' employment—would be an exception to this.[154] More relevant to Watts' claim were the sections devoted to biting. The guidelines indicated that, although no documented cases existed evidencing transmission from a seropositive healthcare worker to a biting patient, it was theoretically possible though negligible.[155] The guidance indicated that, because of the lack of evidence of seroconversion from a worker to a

---

[147] ibid [27]. The guidelines in question were issued by the Department of Health in 2005 entitled: HIV Infected Health Care Workers: guidance on management and patient notification; although not a statutory instrument, the court accepted it as influential. ibid [15].
[148] ibid [35]. The opinion is not clear on some on the dates of some of the hearings.
[149] ibid [29].
[150] See, eg, ibid [5]. There were also arguments about breaches of confidentiality that will not be discussed here.
[151] ibid [6].
[152] ibid [55]-[6].
[153] ibid [79].
[154] ibid [16].
[155] ibid [18].

biter, there was no reason to restrict people living with HIV from employment where they may be exposed to biting.[156]

B. The Treatment of the Evidence

As discussed above, the opinion of the appellate tribunal impliedly accepted the medical evidence relied upon at the lower level, and there is no indication that the employer contradicted it. Instead, the appeal focused on the standards for direct and disability-related discrimination from a legal standpoint.

That said, tacit in the opinion is an acceptance of the medical findings listed in the guidelines. The Employment Appeal Tribunal specifically noted that, although the guidance was not law, it was 'very important in this case.'[157] This demonstrates the means by which a detailed guidance can profoundly impact a case. While the prosecutorial guidelines in England and Scotland detail the general policies regarding whether someone will be likely to be prosecuted, *Watts* demonstrates how government-issued documents which cite information can be highly influential. Public Health England, for instance, released a 2018 report detailing some of the modern medical advancements, including the use of PrEP[158] and the transmissibility of HIV in light of an undetectable viral load.[159] In theory, the information contained therein could potentially influence cases regarding allegations of exposure or provide evidence of a person's knowledge about their own transmissibility.[160] Further guidelines detailing the risks of transmissibility may be highly influential in civil and criminal cases involving HIV. *Watts* thus provides an additional example of a straightforward, statistics-based risk assessment of the chances of HIV transmission in a case which does not focus on sexual transmission.

V. ***Alan Roger Plater v Sonatrach***

In 1995, Plater—who travelled frequently for work—went to Nigeria for approximately a month in December.[161] Approximately ten days after he returned from

---

[156] ibid.
[157] ibid [15].
[158] Public Health England, 'Progress towards Ending the HIV Epidemic in the United Kingdom 2018 Report − Summary, Key Messages and Recommendations' (*Public Health England*, 2018) <https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/759407/HIV_annual_report_2018_-_Summary_key_messages_and_recommendations.pdf> accessed 11 October 2024, 6.
[159] ibid 4.
[160] Meaning, someone who believes they are undetectable may not be convicted of GBH because he did not have the requisite knowledge required to be deemed reckless.
[161] *Plater* (n 5) [11].

Nigeria in January 1996 he became very ill and suffered from a range of symptoms including night sweat, aches, fever, diarrhoea, and chills.[162] His doctor excluded malaria as the cause, kept no blood samples, and dismissed him after four days when his symptoms abated.[163] Plater's doctor did not test him for HIV, although the symptoms presented are consistent with seroconversion.[164] In February 1996 Plater received a job offer that sent him to Algeria.[165] During his employment in July 1996 Plater suffered from diarrhoea and—unable to see a European doctor—went to a different camp with an Algerian clinic run by Sonatrach.[166] Dr Stalli treated Plater and, the following morning, Plater received an injection from a nurse.[167] Plater claimed that he had seen the nurse previously holding a loaded syringe, and claimed he was not informed about the nature of the injection.[168]

Plater received a positive HIV diagnosis in November 1996.[169] He contended that he could not identify any other potential source of the infection other than the injection in Algeria.[170] Plater denied any sexual encounters in Nigeria,[171] and claimed to have only three sexual partners in his life—all of whom were women, and none of whom tested positive for HIV.[172] Plater's subtype of HIV was consistent with a West African strain of the virus,[173] and he claimed that 'he vaguely recall[ed] seeing some black Africans [at the camp] though they could have been dark skinned Algerians.'[174] The doctors at the camp, however, denied the presence of any 'black Africans.'[175] Although Plater admitted that there was no direct evidence that the camp in Algeria was the origin of his HIV, he contended that the lack of other sources left the injection he received there as the only probable source.[176] The defendant contended that the injection given to Plater—a vitamin C injection—was done in accordance to proper protocols.[177] Sonatrach asserted that its clinic was properly run and denied having

[162] ibid.
[163] ibid.
[164] ibid.
[165] ibid [12].
[166] ibid [13].
[167] ibid.
[168] ibid.
[169] ibid [15].
[170] ibid.
[171] ibid [11].
[172] ibid [8].
[173] ibid [39].
[174] ibid [15].
[175] ibid.
[176] ibid [1].
[177] ibid [46]-[47].

ever re-used needles, stating that they had a sufficient stock of them.[178] Sonatrach asserted that there was no evidence of anyone else with HIV in the camp, and denied being the source of Plater's HIV.[179]

A. The Evidence

The court's assessment of Plater's credibility was a major part of the case. The court accepted that, although Plater was not homosexual, he was not credible regarding either his sexual history or his memory of prior injections.[180] The specific strain of Plater's HIV was highly relevant because, although he asserted that his seroconversion took place in Algeria, his subtype was consistent with those found in West African countries like Nigeria—a place he visited for a significant period of time.[181] Plater failed to disclose that he spent three months in Algeria instead of just one, and apparently did so because of his own belief that the 'incubation period was 3 months for HIV and that covered a longer period than the one month prior to December 1995.'[182] The court instead accepted that the incubation period for HIV is 'commonly 2-6 weeks but sometimes longer.'[183]

Plater's HIV sub type—sub type A/G—was prevalent in West Africa; little was known at the time about Algerian sub-types and the most common British sub type was type B.[184] The court noted, however, that the presence of people from Africa living with HIV in the UK may mean that subtype A/G existed in the UK at that time.[185] Algeria was known for having a low prevalence of HIV, and there was no other evidence of people living with HIV present at the camp at the time Plater was in Algeria.[186]

A significant amount of evidence in the case was notably missing, including any blood samples from Plater's admission to the hospital in January 1996.[187] The court accepted that, while there was no way to prove it without the blood sample, the symptoms presented at that time (six months before his trip to Algeria) were consistent with seroconversion.[188] The court ultimately found that while Plater's contentions were 'improbable but possible,' the

---

[178] ibid [71].
[179] ibid.
[180] ibid [76]-[77].
[181] ibid [9].
[182] ibid [39].
[183] ibid [61].
[184] ibid [62].
[185] ibid [93].
[186] ibid [62]-[63].
[187] ibid [94].
[188] ibid [86].

presence of other possible sources of infection meant that Plater failed to meet the requisite burden of proof.[189]

B. The Treatment of the Evidence

This case presents an interesting attempt at identifying the source of an HIV infection through circumstantial means. Many of the claims in this case rested on Plater being judged as credible, and this is ultimately where the case failed. Plater's strain of HIV, however, was highly relevant as well. The court was impliedly asked to determine if the source of Plater's HIV came from Nigeria (located in West Africa where the sub type A/G strain is prevalent), Algeria (where Plater asserted it came from in spite of little information about it existing there), the UK (where A/G is uncommon but can still exist), or elsewhere. When invoking the balance of probabilities test, it is unsurprising that the court was not convinced that there were no other possible origins of Plater's HIV outside of Algeria.

One aspect of the case not discussed, in contrast to *In Re C*, is the likelihood of needlestick transmission. Even assuming that the needle used on Plater had been contaminated, the risk of transmission from a single needlestick incident is still only 0.23%.[190] While this was not addressed in the court's opinion, it seems highly relevant in a case balancing the probabilities between several improbable situations. As with several of the other cases addressed above, *Plater v Sonatrach* exists as another example of a more forward approach towards scientific evidence when the element of sex is removed. The discussion of the phylogenetic analysis in the case is reminiscent of *Collins,* where both the complainant and the defendant had a relatively extensive sexual history and thus lacked the 'betrayal of trust' narrative present in several other cases.[191]

VI. Additional Cases[192]

While the above-listed cases represent the non-criminal cases which focus most heavily on the role of HIV and medical evidence, there are other cases where it took on a more ancillary role. Several of these cases will be briefly discussed below.

---

[189] ibid [98].
[190] Baggaley and others (n 88).
[191] *R v Collins* [2006] The Crown Court at Kingston Upon Thames, Case No T2040664 (unreported). A discussion of *Collins* is available in greater detail in Chapter 3.
[192] Not discussed in this chapter are the numerous asylum and immigration-based cases involving a person living with HIV. While HIV is certainly relevant in those cases, this thesis focuses predominantly on medical evidence in relation questions of causation, risk, and harm—issues which tend not to be as relevant in the immigration-based cases. There are also several other cases where HIV is tangential or otherwise not addressed in a manner which focuses on the issues of concern to this thesis.

A. *A mother v A father, A, B and C (the children) (by their Children's Guardian Hazel Borthwick)*[193]

This case involved a complicated dispute over custody between two parents. While there were numerous allegations in this case, the most pertinent ones surrounded the father's HIV-status. The father learned of his HIV-status in 2005, and claimed that in approximately 2008—before he met the mother in the case—his medical providers informed him that he would not be at risk of transmitting HIV as long as he maintained his medical regimen.[194] He did not tell the mother of his HIV status prior to initiating their sexual relationship,[195] and she only discovered his status in 2017 after finding some of his medication.[196] She herself tested negative for HIV.[197] The mother later took their children without their father's consent and argued that he had raped and abused her.[198] In her allegations against him, the mother specifically referenced him failing to inform her of his status.[199] A district judge initially ordered the mother to return the children, and on appeal the court conducted a fact-finding hearing.[200]

The mother essentially argued that the father concealing his HIV was evidence of his abuse in the wider sense of the term.[201] The court appeared to generally accept the argument that non-disclosure is abuse, although not to the level of warranting a restriction on his parental rights:

> I make clear that, abhorrent and abusive though it was in terms of emotional and psychological impact on the mother, the father's non-disclosure of his HIV+ status does not in itself create a risk to the children (or to the mother) and should not be seen as an impediment therefore to an ongoing and unrestricted relationship with the children through contact.[202]

Although the court used the language 'abusive' it is unclear if it actually meant it in terms of the legal definitions concerning domestic abuse. The court also inquired as to whether the father actually would have received information that he was untransmittable as long as his

[193] [2022] WL 00119519.
[194] ibid [15].
[195] ibid [16].
[196] ibid [19].
[197] ibid [21].
[198] ibid [4].
[199] ibid.
[200] ibid [1].
[201] ibid [159].
[202] ibid [189].

HIV was treated in 2008.[203] The court ultimately found that it was plausible that his doctors did state so at the time, but noted that 'the advice was unlikely to have been as clear cut then as the father suggests.'[204] But why was this inquiry relevant at all? The focus on the guidance given to the father suggests that had the father been told he could potentially transmit HIV to sexual partners, his non-disclosure could be tantamount to a more serious form of abuse in spite of the lack of transmission. In that sense, a family court could find a person who recklessly exposed another to HIV as abusive for custody purposes; though whether this would in itself be enough to actually impact parental rights remains unclear.[205]

B. *Re AB*[206]

In this case, heard before the Court of Protection in 2016, the court heard an application to approve a deceptive treatment[207] for a woman with a severe psychoaffective disorder in addition to HIV.[208] She suffered from significant delusions concerning her HIV status—she believed she did not have HIV, she was simply in a film about it—and her life more generally.[209] Because of this, the court agreed with the argument that if she learned that her care team was providing her with antiretrovirals, she would react very poorly.[210] The most relevant aspect of this case is the court's wholehearted acceptance of the importance of antiretrovirals and how revolutionary the role of undetectable viral loads can be. Through the judgement itself one can almost see the judge's worldview on HIV changing in real time. They stated at one point:

> The anti-retroviral drugs are so effective that, the doctor explained to me, it is possible for an infected person, after a certain period of treatment, perhaps to be measured in months or years, to live a normal life in almost all respects, including a normal sexual life, so that, extraordinary though it may sound, it is possible for someone who is in receipt of anti-retroviral treatment to have unprotected sex without risking infecting his or her partner. I would have thought that was almost impossible, but that is the evidence that I have received.[211]

---

[203] ibid [160]-[166].
[204] ibid [166].
[205] As noted in Chapter 3, women experiencing intimate partner violence or who are otherwise subordinate to a male partner in a relationship face a heightened risk of contracting STIs. See, eg, East L, Peters K and Jackson D, 'Violated and Vulnerable: Women's Experiences of Contracting a Sexually Transmitted Infection from a Male Partner' (2017) 26 Journal of Clinical Nursing 2342. While STI transmission may be indicative of violence or imbalance in a relationship, claiming that exposure itself is abusive is novel.
[206] [2016] EWCOP 66.
[207] ibid [3].
[208] ibid [14].
[209] ibid [16].
[210] ibid.
[211] ibid [9].

This revelation obviously had an impact on the judge. In 2021 the same judge heard *An NHS Trust v P (By Her Litigation Friend, the Official Solicitor)*[212] –another case concerning the capacity of a person with both HIV and mental health concerns[213]--and once again reiterated the power of modern medicine.[214]

C. *Darrell Stewart Jones v Ministry of Defence*[215]

This is a medical negligence case concerning the ten-month delay[216] in the diagnosis of a soldier in the British army.[217] The plaintiff alleged that the medical staff did not consider HIV as a cause of his health issues and neglected to test for such.[218] The defendant accepted liability for the ill-health suffered by the claimant during that ten-month period,[219] however they disputed the plaintiff's contention that the delay in treatment led to effects which affected him after treatment began and would continue to affect him throughout the course of his life (including an impact on his life expectancy).[220] While this case obviously focused heavily on HIV, it was not on the risk of transmission or the harm of HIV broadly; instead, it focused on the more specific issue concerning the effects of a delay in treatment.[221] Both sides presented experts which offered competing medical evidence supporting their assertations, however the court ultimately found that the delay did not lead to long-term adverse effects on his health.[222] While the questions and focus of the case are distinct, it does likewise demonstrate a case where the harm of HIV is assessed from a value-free perspective that focuses on medical data.

VII. Side-by-Side: The Differing Approaches of the Criminal and Civil Law

Obviously, criminal and civil justice systems deal with distinct standards, questions, and consequences. This comparative chapter, and this thesis more broadly, concerns itself with questions related to medical evidence and how it affects aspects of the case concerning

---

[212] [2021] EWCOP 27.
[213] ibid [2].
[214] 'Antiretroviral medication is little short of miraculous in the effect that it achieves. I discussed this at some length in my judgment of *Re AB* [2016] EWCOP 66. The difference between taking and not taking the medication is, usually, the difference between life and death. In this case the medical evidence is that there was a 50% probability that P would die within a year if she were to continue to refuse to take the medication; by contrast if she took the medication then she could expect to enjoy a normal life expectancy reduced by 5 to 8 years.' ibid [4].
[215] [2020] EWHC 1603 (QB).
[216] ibid [1].
[217] ibid [2].
[218] ibid.
[219] ibid [3].
[220] ibid [4].
[221] ibid [74].
[222] ibid [200].

causation, risk, and harm. Relying on the above-discussed cases, what are some of the specific differences between the approaches taken in civil matters as opposed to the criminal ones?

A. Causation

This thesis argues that issues concerning causation—in other words, proof that the defendant transmitted HIV to the complainant—generally rely on up-to-date scientific evidence and there appears to be less issues with courts accepting the validity of such findings. This is generally true for both criminal and civil cases. In *R v Rowe*,[223] the court's acceptance of phylogenetic analysis (as well as its caution regarding its limitations)[224] is similar to the approach taken in *Plater v Sonatrach*. Even more similar is the unreported case of *R v Collins*[225] discussed in Chapter 3, which likewise found that there was insufficient evidence to establish causation. For the purposes of establishing causation and directionality, both criminal and civil cases demonstrate a marked willingness to rely upon phylogenetic analysis and other forensic tools.

B. Risk

Unlike causation, this chapter argues that the question of risk (which connects to the more broad question of recklessness in criminal law) is approached very differently in the criminal versus the civil law. Most of the above mentioned non-criminal cases specifically address questions of risk, particularly *Mr & Mrs N*, and *High Quality Lifestyles v Watts*. Both assessed questions of risk with a focus on the statistical likelihood of transmission and both found that other concerns, such as privacy, outweighed the risk of transmission. Some concluded their balancing in a different way, such as *R M L S*, where the concerns were not solely privacy and where (notably) no statistical assessment of the risk of transmission occurred.[226] Two other cases, *In Re C* and *Kettering General* both likewise weighed the risk of transmission more heavily, however in both cases the judge took pains to limit the remedy sought in the circumstances; even so, the court approached the question of risk statistically. This sort of objective, statistics-based approach does not appear in any of the reported cases involving disease transmission with the limited exception of *Rowe*, which did address how

[223] [2018] EWCA Crim 2688; [2019] 1 Cr App R (S) 38.
[224] ibid [61].
[225] (n 191) 2-3.
[226] As stated above, it is unclear why the case appeared concerned with the risk of transmission to the children at all.

different factors can impact transmissibility.[227] *Rowe*, however, involved intentional and not reckless transmission so the analysis did not focus heavily on that issue.

In the transcripts of several unreported cases, however, one court did address this issue—albeit minimally. At one of the hearings in *Dica* the court indicated that a 10% risk of transmission—the risk level an expert stated existed when a condom was used[228]—could be sufficient to establish recklessness. Beyond the issues of the accuracy of that number given what is known today, none of the other cases indicated what factors establish an act as sufficiently risky to rise to the level of recklessness. Two unreported cases indicated vaguely that some acts can increase recklessness: *R v McClure* indicated the defendant engaging in sexual acts with the complainant on four occasions 'smacks of a greater degree of recklessness,'[229] while the court in *R v Pringle* found that the repeated exposures in addition to engaging in acts the defendant was specifically told were particularly risky were aggravating factors.[230]

Looking at the criminal and civil cases side-by-side, there is a notably greater reliance on medical and statistical evidence in the non-criminal cases. There is little discussion on why an act is or is not risky in the criminal cases in spite of the fact that the risks that can occur from needlestick injuries (addressed in *Mr & Mrs N*) and other non-sexual means are comparable to those that can occur from sex acts.[231]

Why is there this difference between the civil and criminal cases in terms of their respective approach to risk? There are three possible answers to this question. The first is the more basic procedural differences between criminal and civil law. Unlike civil law cases, which can (in theory) be brought by anyone, criminal cases can only be brought through a prosecutor; as such, there is a vetting step that does not exist in civil law that likely means cases with more solid evidence are the ones the prosecutor actually pursues. Pleas likewise factor in the caselaw in this area, as many of the relevant cases involved a defendant who specifically pled guilty to acting recklessly. Additionally, the appellate courts can only respond to the questions placed before them and the defence in many of the relevant cases

---

[227] *Rowe* (n 223) [4].
[228] *R v Dica* [2005] The Central Criminal Court, Case No T20047961, Summing-Up, 7-8.
[229] [2011] In the Crown Court at Teesside, Case No T20110659, 4 October 2011 Proceedings, 9.
[230] [2012] In the Crown Court at Newcastle Upon Tyne, Case No: T20120437, 26 November 2012 Proceedings, 8.
[231] Pragna Patel and others, 'Estimating Per-Act HIV Transmission Risk' (2014) 28 AIDS 1509 <www.ncbi.nlm.nih.gov/pmc/articles/PMC6195215/> accessed 31 May 2024.

simply did not raise this issue. Even so, there were opportunities in the some of the relevant judgements[232] as well as in several transcripts of hearings to discuss issues of risk.[233]

The second possible answer relates to the fact that all of the reported judgments concern English law, and under English law reckless transmission is potentially an offence but not reckless exposure. This means that in all of the relevant criminal cases, transmission *did* in fact occur; in the non-criminal cases addressed above, most of the cases involve situations where transmission *did not yet* occur. Beyond the fact that this makes the question of risk more at the forefront of many of the non-criminal cases, it also makes it easier to assess the question of risk objectively. In contrast, in all of the relevant criminal judgements the complainant is already infected. This in itself can lead to an anecdotal bias—or a preference for believing anecdotal data over statistical evidence.[234] Studies have found that when confronted with situations that involves a perceived life-threatening condition that implicates a person's health, people tend to have significant emotional responses and are more likely to be swayed by anecdotal information over statistical evidence.[235] This may cause both prosecutors and courts to ignore or sidestep questions addressing the risk level of the underlying acts because they are faced with a story of a person contracting HIV through sexual contact and the risk level may simply *feel* higher than it is. Because of this feeling, prosecutors, juries, and courts addressing criminal transmission may be more inclined to downplay statistical information. This anecdotal bias may likewise compound when considering the hindsight bias. The hindsight bias indicates that people are more prone to considering an outcome as likely when that outcome already occurred.[236] Because transmission already occurred, the hindsight bias and the anecdotal bias can cause people to ignore the objective risk assessments in favour of an instinctual sense that a given act amounted to an unjustified risk. Because many of the non-criminal cases do not involve transmission, these biases are not as much at play and risk can be assessed through statistics.

---

[232] This was raised as an issue in *R v Marangwanda* [2009] EWCA Crim 60 and *R v Golding* [2014] EWCA Crim 889. While neither case specifically dealt with HIV, they did both concern STIs. Since both cases involved underlying guilty pleas which admitted to recklessness, the issue was not a main focus of the court on appeal.

[233] A more in-depth discussion regarding recklessness can be found in Chapter 4 of this thesis.

[234] Traci H Freling and others, 'When Poignant Stories Outweigh Cold Hard Facts: A Meta-Analysis of the Anecdotal Bias' (2020) 160 Organizational Behavior and Human Decision Processes 51.

[235] ibid 60-1.

[236] Megan E Giroux and others, 'Hindsight Bias and Law' (2016) 224 Zeitschrift für Psychologie 190. See also Baruch Fischhoff, 'Hindsight Is Not Equal to Foresight: The Effect of Outcome Knowledge on Judgment under Uncertainty.' (1975) 1 Journal of Experimental Psychology: Human Perception and Performance 288.

The third possible answer concerns the narrative in the cases. As addressed in other chapters, nearly all of the matters involving criminal transmission[237] concerns a sex partner and allegations of deception. This, particularly when combined with the taboo and shame associated with STIs, can cause people to react with strong emotions which can likewise interfere with objectivity in a way similar to the anecdotal bias. In the end, prosecutors, judges, and juries are people, and the fear of being deceived by a romantic or sexual partner is common. Conversely, the non-criminal cases rarely involved allegations of deception; as consequence, HIV and the risks associated with it were easier to assess in a detached, objective manner. Interestingly, the non-criminal cases that did involve allegations of deception, such as *R M L S*[238] and *A Mother v A Father,*[239] specifically highlighted those issues. While it did not affect the outcome in the latter case, it did appear to affect the ruling in the former.

In this sense, then, the 'betrayal of trust' narrative can affect approaches to recklessness because of the combination of anecdotal and hindsight biases. The risk is downplayed both because of the harm already occurred (hindsight bias) and because the narrative can outweigh the statistical evidence put forth (anecdotal bias). For an example of this, let us examine once again the *Dica* transcripts. The 2005 summing up acknowledged that some of the sexual acts were protected and that some were not.[240] The court tasked the jury with assessing whether or not he was reckless in every sexual instance because it could not be determined definitively whether the transmission occurred during a protected or unprotected sex act.[241] The jury, however, had to make that assessment while already knowing that Dica transmitted HIV to the complainant. Furthermore, the jury's assessment required weighing the story of a complainant who stated in evidence: 'I trusted this man. I did not think he would give me AIDS. I loved him very much.'[242] The summing up described her as inexperienced in relationships[243] and reiterated her trust in him and love for him at several

[237] Technically, the judgment in *Marangwanda* did not allege sexual transmission, but there were irregularities in that case. See Chapter 2 for a discussion of this case.
[238] (n 13) [23].
[239] (n 193) a [189].
[240] (n 228) 7-8.
[241] ibid.
[242] ibid 23.
[243] ibid 20.

points.[244] The summing up included details that she gave up a prior relationship for him[245] and that she believed he wanted to marry her and have children with her[246] only for him to disappear when she began to show symptoms of seroconversion.[247] The story of the complainant in this instance was moving and many jurors could undoubtedly relate to falling for someone who seemed kind at first but later abandoned them. In light of the fact that she did contract HIV, this creates a situation where the anecdotal and hindsight bias could have a powerful sway over jurors deliberating whether the defendant was reckless even when using a condom. This, combined with latent fears regarding the harm of HIV, can impact how jurors weigh the narrative of a case against statistical information concerning the risks of transmission.

C. Harm

The main non-criminal cases which addressed harm[248] are *In Re C* and *Kettering General*. Both of those notably included an infant at risk of transmission, and the possibility of the baby developing complications unique to its age group.[249] *Kettering General* in particular specifically outlined *why* the judge considered HIV to be a significant enough harm to warrant the declaration in that case.[250]

As addressed in Chapter 5, the criminal cases involving HIV and other disease transmissions mostly sidestepped the issue of questioning what factors of an infection implicate grievous bodily harm. *Rowe* avoided the issue by ignoring the Irish family law case cited by the defence and simply relied on *Dica*—a case decided almost fifteen years prior.[251] *R v Golding*[252] provided some greater degree of clarification but ultimately left the decision of whether herpes amounted to GBH to the jury without clarification on what aspects of the infection were relevant to its classification as GBH as opposed to ABH.[253]

---

[244] See, eg, 'She said she just loved the defendant and she trusted him that is why when he said that he did not enjoy using condoms, she agreed that they should not.' ibid 22-3. 'She trusted him with all her heart, she said, and I use her words.' ibid 24.
[245] ibid.
[246] ibid.
[247] ibid 25.
[248] While *Jones v Ministry of Defence* discussed harm in depth, it was in the limited context of the degree of harm early versus later treatment afforded and is thus limited in its utility here.
[249] See *Kettering General* (n 14) [5].
[250] ibid [29].
[251] *Rowe* (n 223) [67]-[68]. *The Child and Family Agency v AA & Anor* [2018] IEHC 112 cited in *Rowe* was not discussed in this chapter as it pertains to Irish law rather than English or Scottish.
[252] [2014] EWCA Crim 889.
[253] ibid [77].

In the selection of transcripts addressed in Chapter 3, few cases addressed why HIV should be considered a serious harm; instead, the selection of transcripts frequently indicate that it was simply something implicitly understood. In *R v Kelly*,[254] for instance, the judge stated in his Charge to the Jury: '[While] it would be open to you to hold that [HIV] constituted permanent impairment, [t]he terms, to the danger of her health and to the danger of her life, I think are self-explanatory.'[255] The court in *Dica* took a similar approach during the summing up.[256]

Additionally, it is submitted that the narrative of the betrayal of trust may impact perceptions of harm. In some of the criminal cases, it is genuinely unclear whether the harm in question is the harm of HIV itself or the harm of romantic betrayal. In *Porter*,[257] for instance, which had a very strong narrative focus on the betrayal of trust, the actual harm of HIV played a very minimal role in the judge's sentencing statement. Although the sentencing judge referenced the complainant having to provide blood samples and that the complainant did not want to ask how long he had left to live,[258] there was nothing in the sentencing hearing indicating that his health was actually harmed or that HIV affected his longevity. A significant portion of the sentence, however, was devoted to his feelings of betrayal and the cruelty of the defendant.[259] This thesis argues that the 'betrayal of trust' narrative can affect a court's assessment as to why HIV is GBH. Once again, anecdotal bias, particularly with the underlying fear many have regarding HIV, can intertwine with the fear of betrayal and cause HIV's harm to be viewed in a manner that is skewed. It is not just the harm of HIV itself that is weighed, it is the harm of heartbreak, of deception, and of betrayal.

VIII. Conclusion

Why engage in this civil law comparison, and how is this relevant to the overarching question addressed by this thesis concerning the criminal courts' approach towards scientific evidence? There are several reasons to engage in this exercise. The first reason is that comparing the civil cases to the criminal ones highlight the factors which can influence whether questions in the case are approached objectively or not. The judgments in every single criminal case involving either transmission or exposure all involve this betrayal, thus

[254] [2001] ScotHC 7.
[255] ibid 23 Feb 2001 Long Charge to Jury, 39.
[256] *Dica* [2005] Summing Up (n 228) 5-6.
[257] [2006] Inner London Crown Court,T20060260, Sentence 19 June 2006 Sentence (unreported).
[258] ibid 3.
[259] See, eg, 'Of course, the remarks that J makes about your cruelty and dishonesty are, regrettably, feelings that the court and any member of the public must have as well.' ibid 5.

designating the defendant as a criminal who callously exposed or transmitted a disease to an innocent complainant who trusted the defendant with their body and their heart. While the question of whether the defendant informed the complainant about their serostatus can be relevant to questions of consent as set out by *Dica* and *Konzani* and discussed in Chapter 4), the betrayal of trust is sometimes explicitly addressed as an aggravating factor.[260] Outside of its relation to consent the betrayal of trust should not be a significant factor in these cases. The comparison to civil law is useful since it shows fact patterns where this betrayal is removed. Although the exposure to HIV in a non-romantic relationship such as those mentioned could still arguably have an aspect of betrayal within them, the removal of the romantic/sexual element appears to affect the manner in which the courts approach the case itself—emotion is more devoid from the judicial analysis and the focus is comparatively greater on the scientific evidence. This is additionally compounded by the likelihood of both anecdotal and hindsight biases. Since all of the relevant English criminal cases concern a situation where transmission already occurred, the judge, jury, and prosecutors are likely to have a skewed view on the transmissibility of HIV. Because of these biases, which are likely made worse by the increase in emotion derived from the perceived betrayal, there is an increased risk of the relevant individuals neglecting to address the actual likelihood of risk.

Although there are some differences in their approaches towards harm, the most notable difference between the relevant civil and criminal jurisprudence is this approach towards risk. Of the four main cases discussed above, three in particular deal with questions of risk and none concerned romantic or sexual relationships. In non-criminal cases assessed by reference to a lower standard of proof, it should in theory be easier to establish an unacceptable risk than in criminal law, but the opposite appears true in practice. Although the nature of civil cases may make these issues surrounding risk more likely to be relevant before a court, the criminal law's lack of discussion on this topic is notable. The above-analysis demonstrates that the civil courts approached the question of risk with a greater reliance on scientific and statistical data and were comparatively more shrewd when assessing risk when compared to the criminal courts. Because there is a risk of an individual losing their liberty in criminal matters, the evidential burden is higher in such cases and culpability is supposed to be more difficult to prove. Even so, none of the existing criminal reckless transmission cases

[260] See, eg, *HMA v Giovanni Mola* [2007] HCJ 02, Sentencing Statement: 'There is also the fact that your victim, as she told you, had no previous sexual experience and relied on your judgment as a sexually experienced person. You abused her trust.' ibid.

approached questions of risk and harm with as great of a reliance on modern (at the time) scientific and statistical data as the civil ones.

This flows to the third question regarding the purpose of a civil/criminal comparison: are there aspects of the judicial reasoning in the civil cases which could be beneficial in ensuring justice in criminal cases? The answer to this is likewise yes. Defence lawyers should be careful to ensure that issues surrounding risk factor into their defence both at the trial level and on appeal (should it reach that point). The defence should be careful to explain the risks of anecdotal biases to ensure that the fact finder is aware that transmission occurring in that case does not overcome the science which indicates that it occurs rarely. Courts should likewise be mindful of this bias and the risk that strong emotions associated with both the fear of betrayal and the fear of HIV can influence objectivity and fairness.[261]

[261] Countering latent biases is difficult, and studies have provided mixed results on what effectively counters them. Kim A Kamin and Jeffrey J Rachlinski, 'Ex Post ≠ Ex Ante: Determining Liability in Hindsight.' (1995) 19 Law and Human Behavior 89.

Chapter 7. HIV and the Criminal Law Outside the UK

I. Introduction

At least 72 nations around the globe have enacted laws criminalising HIV transmission or exposure.[1] Since addressing all of the relevant laws is well beyond the purview of this thesis, this chapter will examine the laws of three common law Western countries as a basis of comparison: the United States, Canada, and Australia. Since all three common law jurisdictions originate from English law, they provide a helpful counterpoint for identifying other ways that the law can evolve. In the course of this comparison, this chapter seeks to answer the following questions: what steps did other states take which successfully ensured criminal prosecutions of HIV transmission or exposure was in line with the best available science at the time? What steps made it worse? Additionally, this comparison will aid in pursing another question underpinning this thesis: *why* is there a resistance on the part of courts and lawmakers to embrace modern scientific evidence when prosecuting offences related to HIV transmission?

The countries examined here have states and territories which may vary in their approach towards prosecutions. Particularly in the case of the United States, these variations can be extreme. The United States has little in the way of federal laws criminalising HIV transmission, but previous legislation[2] required states to enact criminal laws for intentional transmission as a prerequisite to receiving federal aid. That, combined with a high-profile case involving HIV-transmission, led to a surge in state-based criminalisation laws—some of which remain in force. While the common law of some states evolved to acknowledge changing medical advancements, other states are restricted by extremely scientifically out-dated statutes. Although some states, such as California, have enacted statutes designed to ensure that prosecutions for HIV transmission must rely on up-to-date science, others are archaic in their approach.

Canada, on the other hand, does not possess laws which specifically criminalise transmission or exposure.[3] Instead, more akin to England and Scotland, courts have found HIV exposure and transmission to fall within existing offences. Unlike England and Scotland,

---

[1] D Carter, 'Transmission of HIV and the Criminal Law: Examining the Impact of Pre-Exposure Prophylaxis and Treatment-as Prevention' (2020) 43 Melbourne University Law Review 940.
[2] Ryan White Comprehensive AIDS Resources Emergency Act of 1990, Public Law ['CARE Act'] 101-381; 104 Stat. 576
[3] Sophie Patterson and others, 'Awareness and Understanding of HIV Non-Disclosure Case Law and the Role of Healthcare Providers in Discussions about the Criminalization of HIV Non-Disclosure among Women Living with HIV in Canada' (2019) 24 AIDS and Behavior 95, 96.

Canadian common law considers failing to disclose one's HIV status as vitiating consent. As such, it can result in prosecution for sexual assault (Canadian criminal law has no distinct offence of rape). Particularly after one high profile case in 2012, prosecutions for HIV exposure and transmission increased in frequency.[4] The jurisprudence in Canada has taken somewhat of a strange route—on one hand, the relevant cases have shown an embrace of modern science in terms of assessing the statistical likelihood of a risk; on the other hand, in spite of this, the caselaw has evolved to consider even negligible risks as sufficient to implicate a crime in this area. While there has been some slight improvement in recent cases,[5] and calls for change from government officials,[6] progress remains slow.

Australia, unlike England, Scotland, and Canada, has a history of statutory offences specifically concerning HIV transmission and exposure.[7] While the exact statutes depend on the state and some legislatures have repealed or amended them over time, there are several statutory offences remaining in force.[8] Contrary to the other listed common law countries, the main issue in many of the relevant cases turns on whether or not the risk of transmission was sufficient to warrant the defendant disclosing their status.[9] While there are some instances in Australian states of judges embracing more scientifically-oriented assessments of risks, there remain prosecutions for acts from which HIV could not have been transmitted.[10]

This chapter aims to determine what lessons can be drawn from other common law jurisdiction's approach towards criminalised HIV transmission and exposure. While Canadian law on the subject is very much established through developments in case law, Australian law is more legislative-based and the USA is very mixed depending on the state. While there are examples of good case law developing in certain areas as well as solid legislation that focuses on scientific evidence, there are some dangerously out-of-date examples that exist as well. Overall, this chapter argues that one of the risk factors impeding the law's embrace of updated scientific evidence concerning HIV are emotional outcries to

---

[4] Colin Hastings, Cécile Kazatchkine and Eric Mykhalovskiy, 'HIV Criminalization in Canada: Key Trends and Patterns' (*Canadian HIV/AIDS Legal Network*, 2017) <https://sagecollection.ca/wp-content/uploads/2018/07/hiv_stats_info_sheet-final-en.pdf> accessed 24 October 2024.
[5] *See, e.g., R v Murphy*, 2022 ONCA 615.
[6] Hon Jody Wilson-Raybould, 'Minister Wilson-Raybould Issues Statement on World AIDS Day – Canada.ca' (*Canada.ca*, 2016) <www.canada.ca/en/department-justice/news/2016/12/minister-wilson-raybould-issues-statement-world-aids.html> accessed 24 October 2024.
[7] Carter (n 1) 943.
[8] ibid.
[9] ibid 951.
[10] Mark Boyd and others, 'Sexual Transmission of HIV and the Law: An Australian Medical Consensus Statement' (2016) 205 Medical Journal of Australia 411.

highly publicised cases. For legislators, this reactionary approach may lead to legislation which prioritises immediate fears over evolving standards, and for case law establishes standards which later courts are reluctant to overturn.

II. United States

In 2008, Nick Rhoades of Iowa had a single sexual encounter involving protected anal sex and unprotected oral sex with a man with whom he did not disclose his HIV status; although he had an undetectable viral load and used a condom during one of the acts, the court sentenced him to 25 years in prison.[11] While the state ultimately released him after four months, Iowa law required him to register as a lifetime sex offender.[12] Even though years later the Iowa Supreme Court vacated the judgement of the Court of Appeals due to ineffective assistance of counsel, ultimately reversing the district court opinion and remanding the case back there for the sentence to be set aside,[13] the findings in the underlying case were neither surprising nor remarkable. With 50 states – each with its own separate laws – the US approach to HIV transmission criminalisation laws is extremely patchwork. Although some states enacted laws concerning the spread of HIV prior to the 1980s, HIV-specific laws became more common in the 1990s due to the Ryan White CARE Act[14] ['CARE Act'] enacted in 1990.[15] The CARE Act required states to enact laws prosecuting those who knowingly and intentionally spread HIV as a requirement to receive federal aid for HIV treatment programmes.[16] This led to an initial wave of laws criminalising reckless and intentional HIV exposure and transmission, in spite of the fact that the CARE Act itself only required criminal laws enabling prosecutions for knowing and intentional transmission.[17] In the later 1990s there was a second wave of new and updated criminal laws concerning HIV transmission and exposure in light of the high-profile case of Nushawn Williams[18]—a man who engaged in sex acts with dozens of women after being informed of his serostatus.[19]

---

[11] Saundra Young, 'Imprisoned over HIV: One Man's Story' (*CNN2*, August 2012) <https://edition.cnn.com/2012/08/02/health/criminalizing-hiv/index.html> accessed 24 October 2024.
[12] ibid.
[13] *Rhoades v. State*, 848 N.W.2d 22 (Iowa 2014), 33. Since the lifetime sex offender registration was a part of the original sentencing, that would have been set aside as well.
[14] CARE Act (n 2).
[15] Dini Harsono and others, 'Criminalization of HIV Exposure: A Review of Empirical Studies in the United States' (2016) 21 AIDS and Behavior 27 <www.ncbi.nlm.nih.gov/pmc/articles/PMC5218970/> accessed 6 May 2025.
[16] CARE Act § 2647.
[17] Courtney Cross, 'Sex, Crime, and Serostatus' (2021) 78 Wash. & Lee L. Rev 71, 102.
[18] ibid.
[19] Williams was estimated to have transmitted HIV to 13 women—seven before he was aware of his status and six after. Jennifer Frey, 'Jamestown and the Story of "Nushawn's Girls"' (*Washington Post*, 1 June 1999) <www.washingtonpost.com/wp-srv/style/features/jamestown0601.htm> accessed 24 October 2024.

Although the CARE Act's prosecution mandates were repealed in 2000,[20] few states repealed or amended their laws in response.[21] While some states have HIV or communicable disease-specific laws, other states may include HIV transmission or exposure under the rubric of another offence, including: murder or attempted murder, bioterrorism, assault with a deadly weapon, or aggravated assault.[22] Some states also use a defendant's HIV status to increase the punishments for other crimes, including those related to sex work.[23] Unsurprisingly, the approach of individual jurisdictions towards medical and scientific innovations regarding HIV is likewise mixed.

In 2011, congresswoman Barbara Lee proposed the Repeal Existing Policies that Encourage and Allow Legal Discrimination Act ['REPEAL Act'], which aimed to have multiple federal agencies review 'federal and state laws, policies, and regulations regarding people living with HIV/AIDS' to ensure that such laws could demonstrate – among other things—'a public health-oriented, evidence-based, medically accurate, and contemporary understanding of HIV transmission, health implications, [and] treatment.'[24] While the REPEAL Act received 41 cosponsors and referral to three subcommittees, the bill ultimately died without further action.[25] Congressman Lee tried introducing the bill several more times with little success.[26]

Recounting the history of HIV criminalisation at both the US federal and state level is beyond the scope of this thesis. Historically, however, some jurisdictions rendered decisions that displayed a profound misunderstanding of both the modes of HIV transmission as well as

---

While he was sentenced to 12 years' imprisonment for statutory rape and reckless endangerment charges, four days before his release date the New York Attorney General 'filed an application to have him indefinitely civilly committed as a dangerous sex offender and to continue his confinement until the application was resolved.' The Center for HIV Law and Policy, 'Essential Facts on the Nushawn Williams Case' (*The Center for HIV Law & Policy*) <www.hivlawandpolicy.org/sites/default/files/Essential%20Facts%20on%20the%20Nushawn%20Williams%20Case%2C%20CHLP%202021.pdf> accessed 24 October 2024. Although the confinement ostensibly did not have to do with his HIV status, the attorney general referenced HIV over 1,000 times in the application and proceedings and relied on inaccurate scientific evidence; the application was granted and Williams remains confined today. ibid.

[20] Pub. L. No. 106-345, § 301(a), 114 Stat. 1345 (2000).

[21] Cross (n 17) 103.

[22] ibid 104.

[23] ibid 104-5.

[24] H.R.3053— 112th Congress (2013-2014).

[25] Congress.Gov, 'All Actions except Amendments: H.R.3053 — 112th Congress (2011-2012)' (*Congress.Gov*) <www.congress.gov/bill/112th-congress/house-bill/3053/all-actions-without-amendments?q=hr3053> accessed 24 October 2024.

[26] Dan Roberts, 'New Bill Seeks to Repeal Outdated State HIV Discrimination Laws' (*The Guardian*, 10 December 2013) <www.theguardian.com/world/2013/dec/10/us-house-hiv-bill-discrimination>; H.R. 6111—117th Congress (2021-2022); H.R.1305—117th Congress (2021-2022).

the lethality of the infection. In a 2006 case, one court compared HIV transmission to first-degree robbery.[27] In that case, involving a man sentenced to 25 years in prison for the criminal transmission of HIV,[28] the defendant had unprotected sex with a woman on three occasions.[29] Although he did not use a condom, he was receiving medical treatment.[30] Justice Ternus wrote:

> The crime of criminal transmission of HIV is actually quite similar to the crime of first-degree robbery for purposes of proportionality analysis. First-degree robbery does not require an intent to inflict injury (only an intent to commit a theft), and it does not require that any actual injury result from the defendant's action… Thus, a defendant who intentionally exposes another to the virus is just like the first-degree robber who attempts to inflict serious injury on his victim. And, just like the robber carrying a gun or a knife, a defendant infected with HIV is armed with a dangerous virus capable of inflicting serious injury or death on the victim.[31]

While all of this paints a rather bleak picture of the treatment of people with HIV in the US, more recent cases show (to a varying degree) a greater willingness for judges to interact with medical and scientific personal in assessing the risk of transmission and the severity of the disease.

Let us return to the aforementioned Iowa case involving Rhoades. After his initial conviction, Rhoades sought postconviction relief attacking his guilty plea which was heard on appeal in 2014.[32] Claiming ineffective counsel and a lack of any factual basis for his plea,[33] the court compared the case of Rhoades to that of another HIV transmission case, *State v Keene*.[34] In the 2001 case of *Keene*, the court took judicial notice that HIV can be transmitted through bodily fluids exchanged during sexual contact, and used said judicial notice to '[fill] in the gaps in the factual basis for Keene's plea.'[35] In the 2014 *Rhoades* case, however, the court acknowledged the changing medical understanding of how viral load impact transmission and refused to take the same judicial notice as in *Keene*.[36] The court noted that although the notion that HIV is easily spread through sexual contact—regardless of viral

---

[27] *State v Musser*, 721 N.W.2d 734 (Iowa 2006).
[28] Although tried under a 'transmission' statute, the judgement is unclear if the complainant actually contracted HIV. The judgment indicates, however, that 'exposure' can fall into the language of the statute. ibid at 740.
[29] ibid.
[30] ibid.
[31] ibid at 749.
[32] *Rhoades* (n 13), 26.
[33] ibid 28.
[34] 629 N.W.2d 360, 365 (Iowa 2001).
[35] *Rhoades* (n 13) 32, *citing Keene* (n 35) 367.
[36] ibid.

load, protection, mode of sexual contact, etc.—'may have been a commonly held *belief*' in 2009, judicial notice is supposed to be taken towards *facts* that 'are not subject to reasonable dispute' and not *beliefs*.[37] Because of this, the court found:

> At the time of the plea, Rhoades's viral count was nondetectable, and there is a question of whether it was medically true a person with a nondetectable viral load could transmit HIV through contact with the person's blood, semen or vaginal fluid or whether transmission was merely theoretical. The judicial notice we took in previous cases is subject to reasonable dispute here; thus, it is improper for us to similarly take judicial notice in this case. With the advancements in medicine regarding HIV between 2003 and 2008, we are unable to take judicial notice of the fact that HIV may be transmitted through contact with an infected individual's blood, semen or vaginal fluid, and that sexual intercourse is one of the most common methods of passing the virus to fill in the gaps to find a factual basis for Rhoades's guilty plea.[38]

One unclear aspect of *Rhoades,* however, was the extent to which the court intended to limit the taking of judicial notice regarding the transmission of HIV. The language used indicated that judicial notice could not be taken irrespective of a defendant's viral load;[39] however, it is unclear if that was supposed to extend to other modes of transmission as well. In other words, while the judgement recognised that an undetectable viral load could render transmission near impossible, it did not draw any distinction between oral and anal sex, even though the two acts carry different risks of transmission.[40] Some argue that *Rhoades* only forbid a conviction by judicial notice for the underlying modes of transmission (including oral sex) and not any conviction without judicial notice.[41] However, since the holding in the judgment explicitly referenced Mr. Rhoades's viral load (which would, of course, also have impacted the risk of transmission via oral sex), this remains unclear.[42] While *Rhoades* shows

---

[37] ibid 32-3.

[38] ibid 33. In the same year, Iowa repealed the underlying statute and replaced it with a new statute which provided a more nuanced approach to transmission and exposure. *See* Contagious or Infectious Disease Transmission Act §709D.3. The new statute contains grades of offences depending on intent and whether transmission occurs while also allowing evidence that the defendant intended to prevent transmission as an affirmative defence. ibid. at §709D.3(7).

[39] 'Today we are unable to take judicial notice that an infected individual can transmit HIV when an infected person engages in protected anal sex with another person or unprotected oral sex, regardless of the infected person's viral load.' *Rhoades* (n 13) 32.

[40] See, eg, Pragna Patel and others, 'Estimating Per-Act HIV Transmission Risk' (2014) 28 AIDS 1509 <www.ncbi.nlm.nih.gov/pmc/articles/PMC6195215/> accessed 31 May 2024.

[41] See Brian Cox, 'Turning the Tide: The Future of HIV Criminalization after *Rhoades v. State* and Legislative Reform in Iowa' (2016) 11 Northwestern Journal of Law and Social Policy 28, 43.

[42] The potential for the court to clarify this arose in *Stevens v State* 924 N.W.2d 876 (2018), a case originally adjudicated in 2006 which took judicial notice that 'oral sex is a well-recognized means of transmission of HIV.' *State v Stevens* 719 N.W. 2d 547, 551. The 2018 matter ultimately failed on due process grounds (finding that the 2014 *Rhoades* case could not be applied retroactively) thus leaving the question of whether or not modes of transmission fall under the rubric of Rhoades in limbo. Stevens (2018) at 3.

a court acknowledging medical and scientific advancements and adjudicating accordingly, this spotlight highlights only one small area of the United States. How does the rest of the US treat HIV exposure or transmission? In short, it can vary extremely from one jurisdiction to the next. While recounting the laws of all US jurisdictions is well beyond the scope of this thesis, the sections below give a very general overview of how the law of the US (as it exists in its many jurisdictions) approaches scientific advancements related to HIV and the criminal law.

A. State Statutes at a Glance

Laws targeting the exposure and transmission of HIV are prevalent in the United States. As of 2022, 25 states have HIV-specific criminal laws focusing on exposure or transmission, nine impose sentencing enhancements on people with HIV for committing certain crimes, 25 have prosecuted people with HIV under general criminal laws that were not HIV-specific, and six may impose sex offender registration for individuals convicted under HIV-relevant laws.[43]

According to a 2014 analysis, many states criminalise behaviour whereby HIV transmission would be either extremely low risk or impossible.[44] While mostly in the context of prisons, 11 states criminalise behaviour such as 'biting, spitting, and throwing bodily fluids.'[45] HIV transmission via such behaviour, however, is either impossible or near-impossible.[46] Furthermore, 21 states similarly included oral sex in their transmission or exposure statutes, despite the risk of transmission from either receptive or insertive oral sex being considered statistically negligible.[47] As per the 2014 analysis, 18 states imposed sentences of up to 10 years, seven between 10 and 20 years, and five included sentences which may be greater than 20 years.[48] Most of the state laws reviewed in the analysis were

---

[43] The Center for HIV Law and Policy, 'HIV Criminalization in the United States' (*The Center for HIV Law and Policy* 2022) <www.hivlawandpolicy.org/sites/default/files/HIV%20Criminalization%20in%20the%20US%2C%20CHLP%20062822.pdf> accessed 24 October 2024.

[44] J Stan Lehman and others, 'Prevalence and Public Health Implications of State Laws That Criminalize Potential HIV Exposure in the United States' (2014) 18 AIDS and Behavior 997, 997.

[45] ibid at 1000.

[46] FV Cresswell and others, 'A Systematic Review of Risk of HIV Transmission through Biting or Spitting: Implications for Policy' (2018) 19 HIV Medicine 532. 'Of the 742 records reviewed, there were no published cases of HIV transmission attributable to spitting, which supports the conclusion that being spat on by an HIV-positive individual carries no possibility of transmitting HIV. Despite biting incidents being commonly reported occurrences, there were only a handful of case reports of HIV transmission secondary to a bite, suggesting that the overall risk of HIV transmission from being bitten by an HIV-positive person is negligible.' ibid at 538.

[47] See Patel (n 41).

[48] Lehman (n 45) 1001.

implemented before the year 2000—long before the advent of the medical advancements which make HIV the treatable illness it is today. As a likely result of all of this, the US 'has the highest rates of HIV exposure prosecutions and convictions per capita.'[49] Southern states, particularly Georgia, Florida, South Carolina and Tennessee,[50] account for the majority of convictions.

As for condom use, four states explicitly recognise it as an affirmative defence, while five states read it as an implied defence due to the reduced likelihood of transmission.[51] As of 2017, the statutes of 13 states were worded in such a way that make it impossible to assert the use of condoms as a defence, and prosecutors could enforce the law accordingly.[52] For a few states disclosure will likewise not act as a defence, essentially outlawing any sex acts of PLWHA.[53] Since 2013, seven states reformed or repealed their HIV criminal laws, often adding specific intent, a defence for complying with medical treatment, or reducing penalties.[54]

California is one of the most progressive states where HIV criminalisation is concerned—effective as of January 2018, California law only classifies HIV transmission as an offence if the following four prongs are met: (1) the defendant knew they (or a third party) had a communicable disease, (2) the defendant intended to transmit the disease, (3) the defendant acted in a way that posed 'a substantial risk of transmission' to the intended victim, and (4) transmission actually occurred.[55] If transmission does not occur, a defendant may be guilty of an offence if the other three prongs are met.[56] A transmission offence is a

---

[49] Cross (n 17) 107.
[50] ibid.
[51] Graham White, 'Pre-Exposure Prophylaxis (PrEP) and Criminal Liability under State HIV Laws' (2016) 126 Yale Law Journal Forum 77, 81 <www.yalelawjournal.org/forum/pre-exposure-prophylaxis-prep-and-criminal-liability-under-state-hiv-laws#:~:text=2016%2D2017-,Pre%2DExposure%20Prophylaxis%20(PrEP)%20and%20Criminal,Liability%20Under%20State%20HIV%20Laws&text=Every%20state%20imposes%20criminal%20penalties,aggravating%20factor%20for%20sentencing%20purposes.> accessed 24 October 2024.
[52] ibid 81-82. One Florida man was sentenced in spite of wearing a condom in 2014. The Center for HIV Law and Policy, 'Arrests and Prosecutions for HIV Exposure in the United States, 2008–2019' (*The Center for HIV Law and Policy*) <www.hivlawandpolicy.org/sites/default/files/Chart%20of%20U.S.%20Arrests%20and%20Prosecutions%20for%20HIV%20Exposure%20in%20the%20United%20States%20%28June%202019%29_0.pdf> accessed 24 October 2024.
[53] Deanna Cann, Sayward E Harrison and Shan Qiao, 'Historical and Current Trends in HIV Criminalization in South Carolina: Implications for the Southern HIV Epidemic' (2019) 23 AIDS and Behavior 233, 234 <www.ncbi.nlm.nih.gov/pmc/articles/PMC7182101/> accessed 25 March 2021.
[54] The Center for HIV Law and Policy, 'Timeline of State Reforms and Repeals of HIV Criminal Laws' (*The Center for HIV Law and Policy*, June 2022) <www.hivlawandpolicy.org/resources/timeline-state-reforms-and-repeals-hiv-criminal-laws-chlp-updated-2022> accessed 24 October 2024.
[55] Cal. Health & Safety Code § 120290(a)(1).
[56] Cal. Health & Safety Code § 120290(g)(2).

misdemeanour and punishable by a maximum of six months' imprisonment,[57] while exposure is a misdemeanour punishable by no more than 90 days' imprisonment.[58]

C. The Courts and HIV

Some states, in spite of the language of the underlying statutes being outdated medically, have seen a shift at the court level with the arguments being made. One study examined three states – Michigan, Tennessee, and Missouri—and compared the legal contentions made throughout the history of the HIV pandemic.[59] Pre 1996 and the advent of treatment, courts focused on whether or not exposure occurred; neither the court nor lawyers at the time argued about differentiating risks depending on behaviours.[60] Post-1996 however, lawyers increasingly engaged with witnesses to address biomedical issues and the nuances of risk.[61] While prosecutors could rely on the language of the statute to bypass the question of how great the risk involved was, this did not stop further arguments about the level of risk in cases as time and medical advancements moved forward.[62] Gradually, prosecutors would change their approach as well: in one 2004 Tennessee case, the prosecutor argued that a heightened risk of transmission served as an aggravating factor, while a 2014 Missouri case saw a prosecutor charging the defendant differently based on the level of risk involved in the underlying offence.[63] One writer argued that this shift shows that this demonstrated a court-level shift in the narrative surrounding HIV exposure and transmission—instead of being a purely ethical argument, medical advancements increasingly made it a biological and molecular one.[64]

How the virus itself is treated legally depends greatly on the jurisdiction. In New York, the Supreme Court found that, due to modern medical advancements which meant that HIV was no longer the deadly disease it used to be assumed to be, it was not a 'serious injury' and instead only constituted a 'physical injury.'[65] In Texas, however, engaging in an

---

[57] Cal. Health & Safety Code § 120290(g)(1).
[58] Cal. Health & Safety Code § 120290(g)(2).
[59] Rebeca Herrero Sáenz and Trevor Hoppe, 'Disease on Trial: Medical Risk and Molecular Responsibility in HIV Exposure and Disclosure Jury Trials (1994–2015)' (2018) 68 Current Sociology 97, 97.
[60] ibid 103.
[61] ibid.
[62] ibid 103-4.
[63] ibid 104.
[64] ibid 104-5. 'The trend towards medical detail also manifests in an increasing demand for quantification and calculability. Unthinkable in the early 1990s, today it is possible to quantitatively estimate the likelihood of transmission in a specific sexual act based on scientifically computed averages.' ibid 110.
[65] *People v Uver A*., 195 A.D.3d 61, 66 (New York 2021).

act which may cause HIV transmission may constitute assault with a deadly weapon.[66] In *Billingsly v Davis* the state charged the defendant with multiple offences for engaging in unprotected sexual intercourse while knowing he was HIV positive; in spite of the charges alleging that he knew or intended to cause harm, none of the facts presented demonstrated knowledge or intent; instead, they were more in line with reckless transmission.[67] The court literally referred to his 'bodily fluids containing the HIV virus' as the deadly weapon that the victim was assaulted with via unprotected protected sexual intercourse.[68] The United States District Court in Texas stated: '[T]he indictment also included a deadly weapon notice alleging that petitioner's HIV-infected bodily fluids and his penis were used in a manner capable of causing death or serious bodily injury.'[69]

In *State v Richardson*,[70] a man from Arkansas had a medium viral load count in February 2005 and an undetectable viral load in November 2005.[71] In October 2005, he had sexual encounters with two women, and was later charged with exposing them to HIV.[72] In his defence, he argued that HIV was not a life-threatening disease and he had not actually exposed--nor had the specific intent to expose --his partners to HIV.[73] The court disagreed with the state's argument that it was a general intent crime, since doing so could render a person with HIV as criminally liable even when using protection or acting with consent.[74] As such, the court stated that it is up to the prosecution to prove the elements of the specific intent (including whether a person with an undetectable viral load believed they could transmit HIV)[75] beyond a reasonable doubt. Regarding the question of 'life-threatening', the court side-stepped the issue, instead arguing that the term should be understood by a person of 'ordinary intelligence.'[76] The court wholly deflected that argument, and chose not to engage with any of the medical evidence available on that front.

---

[66] 2018 WL 2013046 (Texas 2018).
[67] ibid. Intent was clearly not proven, since there was no evidence in the judgment that he actually intended to cause harm. Knowledge is more complicated in any case involving HIV transmission, since it is impossible to 'know' that someone will contract HIV in response to an exposure.
[68] ibid.
[69] ibid.
[70] 289 Kan. 118 (Kansas 2009).
[71] ibid 119.
[72] ibid120.
[73] ibid.
[74] ibid 123.
[75] ibid.
[76] ibid 126.

Consequently, the laws in the USA concerning HIV transmission and exposure vary significantly. While there is evidence of some progressive statutes and case law, there are also laws and judgements based on highly outdated evidence.

III. Canada

Between 1989 and 2019 Canadian prosecutors prosecuted over 200 individuals for crimes related to HIV non-disclosure.[77] Although there is no national law explicitly criminalising exposure to or transmission of HIV or other STIs,[78] Canadian common law evolved in a manner that rendered non-disclosure a potentially very serious offence.

Under Canadian law, failing to discloses one's HIV status prior to engaging in a sexual act may negate any consent given—and thereby change the underlying act from a consensual sex act to criminal sexual assault—on the grounds that it represents fraud in violation of *Criminal Code* section 265(3)(c).[79] A Canadian court may further find that sexual intercourse in the absence of disclosure of one's HIV status amounts to aggravated sexual assault contrary to section 273(1) of the *Criminal Code* on the grounds that HIV 'endangers the life of the complainant'; such an offence entails a maximum sentence of life imprisonment.[80]

A. *Cuerrier* and *Mabior*

Just as *Dica* and *Konzani* were touchstone cases regarding HIV transmission in England, *R v Cuerrier*[81] and *R v Mabior*[82] defined the necessary elements the prosecution needed to prove in Canada. In 1998 *Cuerrier* established that disclosure of one's HIV status was necessary to assert a defence of consent to a charge of sexual assault.[83] However, the court further noted that careful condom use may render the risk of HIV transmission nonsignificant, and that 'there must be a significant risk of serious bodily harm before the

---

[77] Patterson (n 3) 96.
[78] ibid.
[79] *R v Cuerrier* [1998] 2 SCR 371 [127].
[80] *R v Mabior* [2012] 2 SCR 584 [8] citing Criminal Code s.273.
[81] (n 80).
[82] (n 81).
[83] 'Without disclosure of HIV status there cannot be a true consent. The consent cannot simply be to have sexual intercourse. Rather it must be consent to have intercourse with a partner who is HIV-positive. True consent cannot be given if there has not been a disclosure by the accused of his HIV-positive status. A consent that is not based upon knowledge of the significant relevant factors is not a valid consent. The extent of the duty to disclose will increase with the risks attendant upon the act of intercourse. To put it in the context of fraud the greater the risk of deprivation the higher the duty of disclosure. The failure to disclose HIV-positive status can lead to a devastating illness with fatal consequences. In those circumstances, there exists a positive duty to disclose. The nature and extent of the duty to disclose, if any, will always have to be considered in the context of the particular facts presented.' *Cuerrier* (n 80) [127].

section can be satisfied. In the absence of those criteria, the duty to disclose will not arise.'[84] Consequently, after *Cuerrier*, a person with HIV would potentially not have a duty to disclose their HIV status prior to sex if they used a condom during the sex act or there was otherwise something that made the risk insignificant.[85]

The 2012 case of *Mabior*,[86] however, significantly expanded the scope of people who could be charged with aggravated sexual assault for failing to disclose their HIV status. In *Mabior*, Chief Justice McLachlin modified *Cuerrier* and set out a new test for when non-disclosure negates consent and may lead to conviction:

> I conclude that a person may be found guilty of aggravated sexual assault under s. 273 of the Criminal Code if he fails to disclose HIV-positive status before intercourse and there is a realistic possibility that HIV will be transmitted. If the HIV-positive person has a low viral count as a result of treatment and there is condom protection, the threshold of a realistic possibility of transmission is not met, on the evidence before us.[87]

The decision in *Cuerrier* was controversial, and many argued that it left people living with HIV in a state of confusion and unfairly singled out HIV more generally.[88]

In *Mabior*, the nine women complainants testified that they had penetrative vaginal intercourse with the defendant and that he only wore condoms on some of the occasions.[89] Mabior did not disclose his status and none of the complainants contracted HIV.[90] At the trial court, the judge acquitted him of three of the counts where he wore a condom, finding that condom usage when combined with an undetectable viral load rendered the risk of sexual harm insignificant.[91] The Manitoba Court of Appeal disagreed, and instead held that '*either* low viral loads *or* condom use could negate significant risk'; thus, the question for the Supreme Court in subsequent appeal was whether both a condom and an undetectable viral load were necessary, or if the presence of only one of those factors could be enough to allow non-disclosure.[92] In the end, the court sided with the former and stated: 'Where there is a *realistic possibility of transmission of HIV*, a significant risk of serious bodily harm is

---

[84] ibid [129].
[85] ibid.
[86] (n 81).
[87] ibid [4].
[88] Kyle Kirkup, 'Law's Sexual Infections' (2023) 46 Dalhousie Law Journal 609, 623.
[89] *Mabior* (n 81) [6].
[90] ibid.
[91] ibid [8].
[92] ibid [9].

established, and the deprivation element of the *Cuerrier* test is met.'[93] The case further upheld that HIV was a serious enough harm to qualify for aggregated sexual assault under section 273 of the *Criminal Code*.[94]

The Court of Appeal heard expert testimony that the per act risk of transmission from penetrative vaginal intercourse ranged from 0.05% to 0.26%,[95] and that consistent condom use (due to human error and failure) lowered the risk of transmission by 80% (although it may be higher if the condoms are used correctly).[96] In spite of the fact that the testimony confirmed that condom use during vaginal sex rendered the risk of transmission to a number well under 1% per act, the Supreme Court rejected the Manitoba Court of Appeal's contention that condom use alone reduced the level of risk to an insignificant level because there was still 'a realistic possibility of transmission' owing to the risk of transmission still falling above the 'negligible' threshold.[97]

The Supreme Court further examined the evidence regarding viral loads. It noted a published study stating that the 'risk of HIV transmission is reduced by 89 to 96 percent when the HIV-positive partner is treated with antiretrovirals, irrespective of whether the viral load is low or undetectable.'[98] Since the court also noted a written report stating that the per act risk of transmission via penetrative vaginal sex was at most 0.26%, and that an undetectable or low viral load reduced that risk by at least 89%,[99] the per-contact risk of transmission with a person on ART was no greater than 0.0286% but probably significantly lower per the evidence before the court. Even so, the court still found this risk percentage to be high enough to meet the 'realistic possibility of transmission' standard; consequently, a person on ART with a low or undetectable viral load still needed to disclose their HIV status for a defence of consent to apply.[100] In the court's opinion, only condom use combined with ART rendered the risk of transmission to be low enough 'that the risk is reduced to a speculative possibility rather than a realistic possibility.'[101] The court specifically noted the distinction between low and undetectable viral loads, and noted that the expert witness 'did

---

[93] ibid [84].
[94] ibid [92].
[95] ibid [97].
[96] ibid [98]
[97] ibid [99].
[98] ibid [101], *citing* Myron S Cohen and others, 'Prevention of HIV-1 Infection with Early Antiretroviral Therapy' (2011) 365 The New England Journal of Medicine 493 <www.ncbi.nlm.nih.gov/pubmed/21767103> accessed 6 May 2025.
[99] ibid.
[100] ibid.
[101] ibid.

not accept, and presented as controversial, the 2008 announcement by the Swiss Federal Commission for HIV/AIDS that an HIV-positive person with an undetectable viral load is not sexually infectious.'[102] A companion case to *Mabior*, *R v DC*,[103] applied the principles of *Mabior* to a defendant with a confirmed undetectable viral load.[104] In that matter, however, the defendant was acquitted—not due to her undetectable viral load, but because the court concluded that the Crown failed to prove beyond a reasonable doubt that a condom was not used.[105]

B. Post-*Mabior* Canada

In 2016 the Honourable Jody Wilson-Raybould, the Minister of Justice and Attorney General of Canada, stated that there was an overcriminalisation of HIV exposure and transmission.[106] She noted that the criminal law was far behind the scientific evidence and that the policy of criminalising HIV non-disclosure could harm efforts to stymie the spread of and treatment for the disease. Following this, in November 2018 the Public Health Agency of Canada published a systematic review aiming to determine the risks of transmission posed in sexually active serodiscordant[107] partners.[108] Specifically, the study examined the risk posed when: the HIV-positive partner is taking ART with varying levels of viral loads, the HIV-positive partner is taking ART and has an undetectable viral load, the HIV-positive partner is taking ART (both with ranging and undetectable viral loads) and one of the partners uses a prophylaxis, and when prophylaxis is used without and corresponding ART.[109] The study concluded that there is only a 'negligible risk of sexually transmitting HIV when an HIV-positive sex partner adheres to antiretroviral therapy and maintains a suppressed viral load.'[110] The study further concluded that '[t]he risk of sexual HIV transmission is low when an HIV-positive sex partner is taking antiretroviral therapy without a suppressed viral load of less than 200 copies/mL, condoms are used or both.'[111]

---

[102] ibid [102].
[103] [2012] 2 SCR 626.
[104] ibid [29].
[105] ibid [30].
[106] (n 6).
[107] In other words, one person in the partnership is living with HIV and another is not.
[108] Jennifer LeMessurier and others, 'Risk of Sexual Transmission of Human Immunodeficiency Virus with Antiretroviral Therapy, Suppressed Viral Load and Condom Use: A Systematic Review' (2018) 190 Canadian Medical Association Journal 1350 <www.ncbi.nlm.nih.gov/pmc/articles/PMC6239917> accessed 16 May 2024.
[109] ibid 1351.
[110] ibid 1348.
[111] ibid.

Since the study's publication in 2018, little has changed in the law. *Mabior* shifted the threshold of required disclosure from situations which entails a 'significant risk' to situations where there could be anything above a negligible risk,[112] and there are indications that this caused a significant impact on prosecutions. One study analysed all known HIV non-disclosure cases both before and after *Mabior*.[113] Of the 200 cases involving 184 people since 1989, 35 occurred between *Mabior* and 2017.[114] Based on cases where the race of the defendant was known, the demographics of the defendants varies significantly pre- and post-*Mabior*.[115] Before 2012, 30% of the relevant defendants were black; after, the number is 48%.[116] While it must be acknowledged that correlation does not equal causation and that a third of cases have defendants whose race is unknown, the shift is potentially significant and may be indicative of other underlying biases in arrests.

The numbers similarly indicate an almost 10% increase in cases involving exposure (without the complainant contracting HIV) when compared to pre-2012 figures.[117] Outside of the effects of *Mabior*, the study similarly alleged that their data indicated that 70% of the cases resulted in a conviction, with 61% obtained through a guilty plea.[118] Although considered aggravated sexual assault, this conviction rate is extremely high compared to other sexual assaults, which tend to result in a conviction only 27% of the time.[119] The requirements of *Mabior* remain unknown for many people, and another (women-focused) study found that only 35% of the respondents reported both using a condom while maintaining an undetectable viral load -- the required standard set out in *Mabior* for non-disclosure to not negate consent.[120]

---

[112] *Mabior* (n 81) [99].
[113] Hastings et al (n 4). The study acknowledged that, since there was no known tracking method for such cases, their numbers were gathered from legal databases and the Canadian HIV/AIDS Legal Network. ibid 1-2
[114] ibid 2. Note that the HIV Justice Network calculated at least 234 cases on criminal HIV non-disclosure as of 2020. HIV Justice Network, 'Canada | HIV Justice Network' (*HIV Justice Network,* November 2023) <www.hivjustice.net/country/ca/> accessed 24 October 2024.
[115] Hastings et al (n 4) 4.
[116] ibid.
[117] ibid 7.
[118] ibid 6.
[119] ibid. The study notes: Making comparisons between the conviction rate in HIV non-disclosure cases in Canada and the conviction rate of other sexual assaults in Canada is challenging because estimates for conviction rates vary depending on how they are reported and the sources of statistical data.' ibid.
[120] Patterson (n 3) 100. The study notes: 'Legal scholars have cautioned that the revised legal test for Canadian HIV non-disclosure prosecutions may disproportionately impact women with HIV, due to gendered barriers to condom use negotiation and inequalities in health outcomes' ibid 96.

C. *R v Murphy*

Prosecutors in Ontario prosecuted Jennifer Murphy for three counts of aggravated sexual assault against three complainants: LM, IO, and JG.[121] The key issue of the case focused on the duty of Murphy to disclose her HIV status if she engaged in sexual activity with any of the respective defendants without also using a prophylaxis.[122] First diagnosed with HIV in 1994, she began ART in 2001 and was undetectable in at least 2005.[123] In September 2011 her viral load was detected but low at 39 on the 13th of the month and 40 on the 22nd.[124] The Crown contended that HIV remained a 'serious, life altering' infection and that even when the risk of transmission was 'slight,' the potential for 'serious bodily harm' required disclosure.[125]

LM, the first complainant, was a 62 year-old man who stated that he had two instances of sexual contact with Murphy; in each, he performed oral sex on her and did not engage in penile-vaginal intercourse.[126] He did not contract HIV.[127] IO, the second complainant, was a 56 year-old man who met Murphy at a store and engaged in unprotected vaginal intercourse.[128] While he could not recall who initiated the conversation, condoms were discussed although unused because neither possessed any on their person at the time.[129] IO likewise did not contract HIV.[130] The final complainant, JG, was 35 years-old.[131] They engaged in vaginal intercourse twice, the first time with a condom at her suggestion, and the second time without.[132] JG admitted that, prior to sex, he had used alcohol and marijuana[133] and that, although he was confident he did not use a condom during the second sex act, between the alcohol, marijuana, and prior head injuries, his memory and observational skills at the time may have been impaired.[134]

---

[121] *R v Murphy* 2013 CarswellOnt 11952 [1]. She was also charged—pled guilty to—an offence of obstructing a peace officer; she pled not guilty for the HIV-related offences. ibid.
[122] ibid [8].
[123] ibid [7].
[124] ibid.
[125] ibid [8].
[126] ibid [10].
[127] ibid [11].
[128] ibid [15].
[129] ibid.
[130] ibid [17].
[131] ibid [18].
[132] ibid [19].
[133] ibid [20].
[134] ibid. His HIV status was not disclosed in the judgment.

The expert called by the Crown, Dr Irving Salit, explained the basics of HIV[135] and stated that a viral load of less than 40 was considered undetectable.[136] He noted that six tests taken between September 2005 and July 2012 indicated that Murphy possessed undetectable viral loads.[137] The court acknowledged that Murphy's 'evidence indicate[d] that she had a low, in fact, undetectable viral load at the time in question.'[138] When asked what the risk of transmission was between a HIV-positive female with an undetectable viral load and a healthy male, Dr Salit answered: 'This risk is not defined in any studies but would seem to be much less likely than 1 chance in 25,000.'[139] He further estimated the risk between a sero-discordant heterosexual couple who engage in vaginal intercourse where one partner is undetectable: 'It is approximately 1 chance in 10,000-1:25,000 per sex act. However, some studies indicate that there may be no sexual transmission at all in the above circumstance.'[140] He also testified that, where a condom is used during sexual intercourse with a woman with an undetectable viral load '[t]he use of the condom to prevent HIV transmission in this setting adds so little that it is an un-measurable benefit.'[141] Although Dr Salit acknowledged that consistent ART use was as effective at preventing transmission as a condom, and that an undetectable load 'apparently' prevented transmission, he stated that 'there remains some concern because HIV can be found in genital secretions and can theoretically be passed on sexually.'[142] He acknowledged that he knew of no documented cases of transmission occurring through performing cunnilingus on a HIV-positive woman.[143]

The court, relying on *Mabior*, examined each of the relevant counts. For LM, the court determined that the expert evidence of the per-act risk of transmission via cunnilingus on a person with an undetectable viral load was so low that it did not meet the 'realistic possibility of transmission' standard. The court came to this conclusion by relying on Dr Salit's testimony which estimated that the risk was either 1:50,000 (0.002%) or 1:100,000 (0.001%).[144] For JG—the complainant who had a criminal history, memory issues from

---

[135] ibid [27]-[31].
[136] ibid [32].
[137] ibid [37].
[138] ibid [38].
[139] ibid.
[140] ibid.
[141] ibid. Immediately prior to this, he testified: 'The observed reduction in HIV transmission in a clinical trial setting demonstrates that successful ART use by the person who is HIV positive is as effective as consistent condom use in limiting viral transmission.' ibid.
[142] ibid [39].
[143] ibid [40].
[144] ibid [82]

concussions, and was on alcohol and marijuana[145]—the court determined that the Crown could not prove beyond a reasonable doubt that the second sexual intercourse did not involve condom usage.[146] Consequently, the court found her not guilty regarding the count concerning these two complainants.[147]

The claims concerning IO—the complainant who testified that he engaged in a single act of unprotected sexual intercourse with the defendant[148]—presented a more difficult situation.[149] In that case, although there was only one instance and IO did not contract HIV, the court found the Crown proved Murphy had committed an aggravated sexual assault against IO since the consent was negated due to fraud.[150] Thus, the court applied the principles in *Mabior*[151] and concluded that, since IO testified that he would not have engaged in intercourse with Murphy had he known of her HIV status, her failure to disclose her HIV status while not using a condom constituted fraud and vitiated 'an otherwise consensual activity.'[152] The court supported this conclusion by relying on Dr Salit's testimony that the per-act rate of transmission was between 1:10,000 (0.01%) to 1:25,000 (0.004%).[153] The court noted that: 'The clear message in *Mabior*, as further applied in *D.C.,* is that even an undetectable viral load raises the realistic possibility of transmission.'[154] Consequently, the court found Murphy guilty of aggravated sexual assault in relation to IO.[155]

Murphy appealed the conviction and the Ontario Court of Appeal recently issued its judgment.[156] On appeal, because of the evolution of the science related to HIV transmission,[157] Murphy:

> [Asked] this court to admit fresh expert evidence showing that the risk of HIV transmission is effectively zero when a person is on ART and their viral load is

---

[145] ibid [111].
[146] ibid [114].
[147] ibid.
[148] ibid [85].
[149] Curiously, the court emphasised that, while Murphy did not discuss money with IO prior to sex and only accepted money at his insistence, he 'did not think of her as a prostitute' and described her as 'tidy and clean looking.' ibid [86]. It is unclear what the relevance of this is, other than the possibility that he would not have engaged in unprotected sex with her if he knew she was a sex worker. If that was the case, then his insistence on offering her money remains odd.
[150] ibid [88].
[151] ibid [90]-[93].
[152] ibid [88].
[153] ibid [96].
[154] ibid [99].
[155] ibid [115].
[156] (n 5).
[157] ibid [4].

> undetectable, and thus that there was no realistic possibility of transmission of HIV from the appellant engaging in sexual intercourse with the complainant.[158]

She argued that since there was no realistic possibility of transmission, 'consent was not vitiated by non-disclosure of her HIV-positive status, and she should be acquitted.'[159] The Crown, as the respondent, consented to the admission of the fresh evidence and joined in agreeing that the appeal should be allowed, the conviction set aside, and an acquittal entered.[160] Even so, an issue remained on appeal:

> The appellant asks the court to go beyond the circumstances of her case, and to hold as a matter of development of the common law of the implementation of the "realistic possibility of transmission" test that a realistic possibility of transmission is negated when a person has a "suppressed" viral load and is on ART.[161]

The Crown disagreed that the Court of Appeal should issue such a statement, and argued that the court issue findings which went beyond the 'scientific and factual circumstances' of Murphy's case.[162]

Regarding the admission of fresh evidence, the Court of Appeal carefully noted that the decision in *Mabior* was 'based on the factual record before the court' and recognised that scientific evidence concerning transmission may evolve.[163] In relation to the underlying fact pattern involving a single act of unprotected penetrative vaginal intercourse with a woman possessing an undetectable viral load, the court accepted fresh expert evidence[164] which stated that there was zero risk of transmission in such a circumstance. [165] Consequently, the fresh evidence demonstrated that the test in *Mabior* was met, in spite of the absence of a condom, since there was 'no realistic possibility of transmission.'[166]

Since the parties agreed to the disposition of facts as they related to Murphy specifically, it is unsurprising that the court concluded as it did. More pressing was the contested request for a statement from the court since doing so would directly modify the standard set out in *Mabior*. If the court accepted Murphy's request, it would mean that a person with a supressed (not just undetectable) viral load—defined as under 200 copies of

---

[158] ibid [5].
[159] ibid.
[160] ibid [6].
[161] ibid [27].
[162] ibid [8].
[163] ibid [14].
[164] ibid [20]-[26].
[165] ibid [19].
[166] ibid [26].

HIV per mL of blood'[167]—would not be committing an offence if they engaged in sexual intercourse without disclosing their HIV status. This would expand *Mabior* and apply to situations distinct from *Murphy*; in other words, where there were multiple instances of sexual contact, where defendant's viral load could not show that it was stably suppressed for a period of time, and that the viral load was supressed rather than undetectable the defence may apply.[168]

The appellate court declined to make a broader holding, citing institutional reservations and concerns about the facts as it related to the fresh evidence.[169] Regarding institutional concerns, the court found that fresh evidence 'should not be admitted as a matter of course'[170] and that a 'trial court is better placed than this court sitting on appeal to develop and assess a factual record necessary to decide the application of the realistic possibility of transmission standard to circumstances different than those in the appellant's case.'[171] Regarding the evidence, the Court of Appeal found that the expert testimony may not apply to circumstances beyond a single sexual contact.[172] The court stated that the question of 'cumulative risk' was not addressed by the fresh evidence.[173] Additionally, the expert testimony was in connection to an undetectable viral load which was stable for at least six months.[174] While the court specifically declined to issue a more broad statement, it did highlight that its decision should not be read as indicating that only situations involving a stable undetectable viral load and a single unprotected sex act should meet the standard in *Mabior*.[175] The court emphasised that the *Mabior* judgment could adapt to changing medical and scientific advancements.[176]

The Court of Appeal's reluctance to issue a statement that would set a new legal standard was disappointing but not surprising—many common law courts are hesitant to take such a step beyond the facts presented to them, since doing so may be viewed as usurping legislative power. At the same time, it was certainly a missed opportunity given the

---

[167] ibid [28].
[168] ibid.
[169] ibid [31].
[170] ibid [33].
[171] ibid [34].
[172] ibid [37].
[173] ibid.
[174] ibid [38].
[175] ibid [40].
[176] ibid. '*Mabio*r is clear that the implementation of the realistic possibility of transmission threshold can adapt to advances in scientific knowledge about HIV transmission and treatment and to risk factors other than those considered in *Mabior*. On a proper evidentiary record, it would be open to a trial court to find other circumstances in which there is no realistic possibility of transmission even in the absence of condom use.'

significant jump between *Mabior* and *Cuerrier* relating to when non-disclosure does not negate consent. The appellate court's concerns regarding the amount of time a person living with HIV with a viral load less than 200 copies per mL of blood was well-founded in light of the expert testimony presented to them, which repeatedly referenced an undetectable viral load maintained for a period of six months or more.[177] It is submitted, however, that the court's discussion concerning the difference between a single incident versus multiple incidences[178] was flawed. The expert—Dr Philippe El-Helou—testified that there was 'zero risk [the appellant], who was being treated by ART and had an undetectable viral load at the time, would transmit HIV through a single act of condomless vaginal intercourse.'[179] Dr El-Helou did not describe the risk of transmission as 'low', 'insignificant', or even 'negligible'—he described the risk as 'zero.'[180] Logically, if the risk of transmission in a single instance is zero, then—assuming the viral status of the individual remains the same—the risk should likewise be zero regardless of how many instances of contact there were. Zero multiplied by any other number always remains zero. Institutional concerns aside, a statement affirming that a stable (for at least six months) undetectable viral load posed zero transmission risk per sexual contact would have been in line with the expert evidence.

Regardless, Canadian criminal law's approach to HIV-related offences remains strange. Under English law, the question of the likelihood of the risk of transmission is relevant since it directly ties to whether or not the defendant acted recklessly and the common law defence of consent; in Canadian criminal law, the connection between the risk of transmission and culpability seems tenuous at best. In *Cuerrier*, the court looked at numerous cases—including *R v Clarence* – which concerned the validity of consent in light of undisclosed STIs; however all of the referenced cases involved actual transmission (and not just exposure).[181] From there, the court extrapolated that fraud possessed two requirements: dishonesty and deprivation. Regarding dishonesty, section 265 of the Canadian Criminal Code required that the 'dishonest action or behaviour must be related to the obtaining of consent to engage in sexual intercourse, in this case unprotected intercourse.'[182] The court decided that nondisclosure would always amount to fraud in this manner since '[t]rue consent

[177] ibid [38]. The appellate court did not highlight the difference between a supressed and undetectable viral load in its consideration of the fresh evidence.
[178] ibid [37].
[179] ibid [19].
[180] ibid.
[181] *Cuerrier* (n 80) [118]-[124].
[182] ibid [126].

cannot be given if there has not been a disclosure by the accused of his HIV-positive status.'[183]

The court continued to describe the second requirement of fraud: deprivation, defined as a non-trivial harm or risk of harm.[184] The connection between fraud and harm was sound given the case law cited by the court—all of those cases involved actual transmission.[185] The court did not, however, cite to any cases where the risk of harm negated consent when there was no actual transmission. While the court cited an American case from 1984 which stated that 'consent to sexual intercourse vitiated by one partner's fraudulent concealment of the risk of infection with venereal disease,'[186] at issue there was not just the 'risk of infection,' it was actual infection.[187] The paragraph immediately after the one cited by the court in *Cuerrier* stated that the issue was not that the complainant was no longer virtuous as a result of the deception, but that she actually was harmed by the respondent's misrepresentation of his herpes status.[188] Thus, the *Cuerrier* court opened the door to exposure-only cases without stating supporting case law, and from there turned the focus to the degree of risk. While the court's acknowledgement that condom usage may reduce the risk of transmission to insignificant is commendable, the entire line of reasoning behind the focus on the risk of transmission appears artificial.

Based on *Cuerrier, Mabior* expanded the focus on the risk of transmission. The 'realistic possibility of transmission' standard, as applied by *Mabior*, meant that even if the risk of transmission was under 0.3% a person must disclose their HIV status prior to sex or potentially face a charge of aggravated sexual assault.[189] By finding that only the combination of ART and condom usage together produced a risk that was 'extremely low,' the court was implicitly saying that a risk of 0.26% (the highest testified estimated per-contact risk of HIV transmission for penetrative vaginal sex) was not a number which qualified as 'extremely

---

[183] ibid [127].
[184] ibid [128].
[185] ibid [119] – [122]. While the court discusses two American cases-— *State v. Lankford*, 102 A. 63 (U.S. Del., 1917) and *Kathleen K. v. Robert B*., 198 Cal. Rptr. 273 (U.S. Cal. Ct. App. 2 Dist., 1984)—it neglects to mention that both of those cases involved actual transmission.
[186] ibid.
[187] *Robert B* (n 186) 274.
[188] ibid 277. 'Appellant is not complaining that respondent induced her to "step aside from the paths of virtue," and in fact she willingly engaged in sexual intercourse with him. This is an action for damages based upon severe injury to appellant's body, which allegedly occurred because of respondent's misrepresentation that he was disease-free.' ibid.
[189] *Cuerrier* (n 80) [97].

low.'[190] Given the serious nature of the offence, the current focus on whether the risk of harm is 0.01% or 0.0001% is absurd.

Consequently, the Canadian criminal law's treatment of HIV exposure/transmission shows, on one hand, a willingness to engage with modern medical and scientific advancements. On the other hand, the common law created a situation where people have been and will continue to be prosecuted for aggravated sexual assault for scenarios that (a) did not involve HIV transmission, (b) scientifically could not have resulted in HIV transmission, and (c) involved fact patterns where the risk of transmission was negligible.

IV. Australia

Like Canada, Australia remains a fellow Commonwealth nation that has much of its jurisprudence influenced by English law. While the impact of *R v Clarence*[191] and its progeny remain, in Australia it is more in the form of legislation rather than common law jurisprudence.[192] Depending on the jurisdiction, HIV-related offences tend to fall into one of three categories: assault criminal offences, endangerment criminal offences, and public health-based statutory offences.[193] Unlike English or Scottish law, many of the relevant criminal statutes reference HIV specifically.[194] The assault-based offences referred to HIV as either a 'very serious' or 'grievous' disease and a conviction of malicious or intentional transmission could carry a maximum penalty of 25 years' imprisonment.[195] Over time, pushes for legal reform led to states removing the HIV-specific offences, with the most recent repeal occurring in Victoria in 2015.[196] Although many of the jurisdictions removed the offences identifying HIV by name, criminal penalties could still apply in cases of HIV transmission under assault or endangerment offences.[197] Similar to how *Dica* overturned *Clarence* in the English common law, the Australian cases of *Aubrey v The Queen*[198] and *Zaburoni v The Queen*[199] —two cases involving HIV transmission—re-defined the terms 'inflict' and

[190] ibid.
[191] (1888) 22 QBD 23.
[192] Carter (n 1) 943.
[193] ibid.
[194] ibid 944.
[195] ibid.
[196] ibid.
[197] ibid 945.
[198] (2017) 260 CLR 305.
[199] (2016) 256 CLR 482

'infliction' in assault offences to include 'the nonviolent and non-immediate infliction of a disease.'[200]

Exposure without transmission may also be a criminal offence in certain Australian jurisdictions under endangerment offences. As with English law GBH offences, Australian jurisprudence established that informed consent may act as a defence to endangerment offences.[201] Unlike English or Scottish Law, several Australian jurisdictions established an affirmative duty for people living with HIV or other STIs to disclose their status to potential sexual partners under public health laws.[202] This is an area under reform, and some jurisdictions have modified the requirements.[203] New South Wales, for instance, changed the disclosure requirement to one mandating that an affected individual take reasonable precautions to prevent spreading a disease.[204] Although these mandates are under the rubric of public health rather than criminal law (with an attendant lower penalty) the laws still do in many ways mirror the endangerment laws—similarly punishing those who expose another to HIV without actual transmission.[205] While modifying the disclosure laws into 'reasonable precaution' laws may seem like a positive change on its face, in practice it is essentially another offence criminalising exposure; instead of the controversial rubric of endangerment offences, it is a public health offence that acts like a criminal offence with strict liability.[206] Curiously, while endangerment offences are the target of frequent controversy, these public health offences have flown largely under the radar.[207] Regardless of whether the law requires disclosure or 'reasonable precautions,' the legal burden to prevent the spread of HIV falls on the person living with the infection rather than both partners.[208]

Although public health laws have not drawn the same degree of attention as criminal laws, one notable case concerning them likely acted as an impetus for the current HIV disclosure regime present around Australia.[209] In 1989 Sharleen Spiteri, a sex worker, appeared on *60 Minutes*.[210] In the interview, Spiteri—who was HIV-positive—admitted that

---

[200] Carter (n 1) 946.
[201] ibid citing *Neal v The Queen* (2011) 32 VR 454.
[202] ibid 949.
[203] ibid.
[204] ibid.
[205] ibid 950.
[206] ibid.
[207] ibid.
[208] ibid 951.
[209] ibid 939 fn 2.
[210] Tom Morton, '"Dirty Little Secret": Journalism, Privacy and the Case of Sharleen Spiteri' (2012) 18 Pacific Journalism Review 46, 48.

she did not tell her clients about her HIV status. She informed the interviewer that she did not do so because she feared that honesty on that subject could lead to her murder; instead, she stated that she made all of her clients use a condom.[211] The interviewer later described her as 'more dangerous than a serial killer.'[212] The interview drew a massive amount of attention, and the following day police detained Spiteri.[213] The state held Spiteri in numerous forms of public health detention from 1989 to her death in 2005; some argue that at least 12 years of that detention were without legal sanction.[214]

Questions regarding scientific advancements concerning HIV treatments, specifically those regarding viral loads, have been—to an extent at least—addressed in Australian law. In 2011 the Court of Appeal of the Supreme Court of Victoria heard *Neal v The Queen*.[215] The Crown accused Neal of a host of offences, including several offences concerning attempting to infect another person with HIV.[216] On appeal, the defendant-applicant argued that the trial court erred in directing the jury that, in order to convict the him for the charge of attempted infection, they had to find that he believed that 'he *may* be infectious.'[217] The defendant-applicant's counsel submitted that the judge should have instead instructed the jury that they needed to be satisfied that he believed he '*was* infectious' in order to convict on those counts.[218] This was relevant to several of the counts because, at the time of some the underlying acts, the defendant had a low or undetectable viral load; consequently, the defence argued that the Crown could not establish that Neal believed he was infectious during those times.[219] The appellate court agreed with the Neal.[220] Although the charges in *Neal* were not specifically reckless transmission, the court's approach highlights how viral loads may impact transmission and exposure cases. If a defendant knew or believed that they had an undetectable viral load and thus could not transmit HIV, the requisite *mens rea* for

---

[211] ibid.
[212] David J Carter, 'The Use of Coercive Public Health and Human Biosecurity Law in Australia: An Empirical Analysis' (2020) 43 University of New South Wales Law Journal *citing* 'Shutting Down Sharleen', Hindsight (*ABC Radio National*, 21 March 2010) <http://www.abc.net.au/m/hindsight/stories/2010/2848373.htm>.
[213] ibid.
[214] ibid 118-19.
[215] (n 201).
[216] ibid [3].
[217] ibid [40].
[218] ibid.
[219] ibid [46].
[220] ibid. The court still upheld with several of the charges which alleged that he intended to transmit HIV. ibid. Neal faced numerous of varying natures and ultimately the court sentenced him to 12 years' imprisonment, although this was a reduction from the 19 years' imprisonment the trial court initially sentenced him with. ibid [111].

recklessness would be undercut. This more firmly establishes the *mens rea* in similar transmission cases as being subjective in Victoria. This approach appears likely to be followed in other Australian jurisdictions in reckless transmission or exposure cases. A New South Wales case, *R v Navarro*,[221] appears to support the contention that an undetectable viral load undercuts recklessness. In that case, which involved accusations of reckless transmission, the court specifically noted that Navarro had been aware that treatment could have lowered his viral load and reduced the risk of transmission but still chose not to receive treatment during his relationship with the victim. [222] This suggests that the court may not have found him reckless had he undergone treatment.

Depending on the jurisdiction, however, Australian courts may not always rule that way. The High Court of Australia in the NSW case *Aubrey* affirmed that the subjective assessment of risk in a matter involving GBH was one of the risk possibly materialising (as opposed to the higher standard used in homicide cases which required the probability of the risk actuating).[223] The Australian Medical Consensus Statement on HIV repeatedly described undetectable viral loads as having a 'negligible possibility' of transmission rather than no possibility.[224] Consequently, a court approaching a reckless transmission or exposure case with a defendant with an undetectable viral load may deem a negligible possibility a sufficient one per *Aubrey.*[225]

Unfortunately, regardless of some of the positive developments listed above prosecution of HIV-related offences in Australia remains problematic. This is largely because several modern Australian cases have involved prosecutions for biting or spitting,[226] acts which contain no risk of transmission.[227]

V. Conclusion

Although the above is only a general sampling of both the legislation and case law established in other common law countries concerning HIV transmission and exposure, it

---

[221] [2019] WL 4926839.
[222] ibid [12].
[223] Carter (n 1) 964 *citing Aubrey* (n 199). *Aubrey* additionally rejected English caselaw which addressed the reasonability of the risk taken. ibid [49].
[224] Boyd (n 10) 409.
[225] Carter (n 1) 965 *citing* Boyd (n 10). In a reckless transmission case, if the defendant had an undetectable viral load transmission should not have been able to occur at all. If transmission did occur, it would likely mean that the complaint's HIV originated from a different source or that there was a mistake in the defendant's treatment.
[226] ibid 973.
[227] Boyd (n 10) 411.

documents alternative approaches taken towards HIV from those seen in England and Scotland. While certain areas have legislation and progressive jurisprudence which reflects changing scientific knowledge, other areas have stubbornly resisted any change. Particularly as seen in Australia and parts of the United States, lawmakers need to be very careful when drafting legislation to ensure that the relevant laws are not so restrictive as to constrain judges when faced with changing medical understandings. Similar issues can arise in the development of common law jurisprudence. As the narrow Canadian approach towards risk demonstrates, acknowledging medical advancements while keeping a narrow test for permissible risks can lead to prosecutions for exposure offences for negligible risks of transmission.

It is notable that in all of the jurisdictions discussed much of the current legal regime developed in response to notable early cases that drew a significant degree of public attention and outcry. Cases such as those involving Williams in the USA, Cuerrier in Canada, and Spiteri in Australia attracted media attention that inevitably affected the development of the legislation and jurisprudence that exists today. The fear of both a widely misunderstood infection as well as the fear of betrayal that such cases represented likely contributed to the laws developing the way they did.

What conclusions can be drawn from this comparative analysis? The first is that the 'betrayal of trust' narrative present in many English and Scottish cases is not unique. Rather than being borne out of a desire to protect the public health, fear of both HIV and betrayal appears to be the catalyst for the development of many regimes which criminalise exposure or transmission. This fear underlies transmission cases around the world, and feeds into the heightened emotions which make it more likely for the anecdotal bias to be at play. The second is that, while establishing legislation governing this area may be a solution to ensuring that up-to-date evidence is relied upon, caution must be taken in drafting. While California's laws are designed to adapt with the medical knowledge available at the time, other states' laws are impossibly restrictive. Finally, because this is an area where the scientific understanding may change relatively rapidly, judges may need to be more openminded towards overturning precedent than they may be in other areas. In *Murphy*, for instance, while the appellate judge's reticence in making a broader pronouncement on the case was certainly predictable, it would have been a relatively minor expansion of the law that would decriminalise negligible risks. Overall, the struggle with adapting the law to evolving medical scientific standards is one not unique to England or Scotland.

Chapter 8. Conclusion

What is HIV, and what does it mean for the people who live with it? That question, the question this thesis began with, underlies the analysis taken through the above chapters. Talking about HIV requires acknowledging the complex role it plays as an infection which disproportionately affects marginalised communities. Talking about HIV means realising that people even now significantly misunderstand HIV,[1] both in in terms of how it is transmitted and what living with HIV is like. Talking about HIV means realising these misunderstandings lead to bias, and this sort of bias can lead to discrimination and harm. Talking about HIV means addressing how amazing modern medical efforts are, and how HIV as it is now is extremely different to how it existed even a decade prior.

This thesis aimed to answer one deceptively simple question: has the law kept pace with the science of HIV? This question requires addressing several underlying inquiries. In particular: what is the science, what is the relevant law, and why such a gap may exist in the first place. Chapters two and three are backwards looking chapters that identify the relevant law and science in connection with HIV transmission and exposure in England and Scotland. "The law", of course, is a broad term. To that end, this thesis breaks down the laws criminalising HIV transmission and exposure into three broad prongs: causation, recklessness, and harm.

Here lies the crux of this thesis's argument: while the current jurisprudence largely does not have a law/science gap where causation is concerned, it does in regards to recklessness and harm. Issues regarding recklessness, knowledge, and consent tie together and are discussed in-depth in Chapter 4. There is a lack of clarity in the jurisprudence as to whether recklessness is assessed objectively or subjectively, and to what extent a risk may be justified. In relation to HIV transmission and exposure, this lack of clarity is problematic because modern scientific discoveries indicate that the per-contact risk of HIV is actually extremely low, and even then the risk level can vary significantly depending on other factors.[2] To date, none of the relevant decisions fully addressed the question of how risky is risky enough to implicate recklessness. This potentially opens the door to convictions for acts

[1] See, eg, Fast-Track Cities London and National AIDS Trust, 'HIV: Public Knowledge and Attitudes' (*NAT,* July 2021) <www.nat.org.uk/sites/default/files/publications/HIV%20Public%20Knowledge%20and%20Attitudes.pdf> accessed 10 May 2024.

[2] Pragna Patel and others, 'Estimating Per-Act HIV Transmission Risk' (2014) 28 AIDS 1509 <www.ncbi.nlm.nih.gov/pmc/articles/PMC6195215/> accessed 31 May 2024, table 1

which contained a risk that is negligible to impossible—something that technically already occurred in *R v Marangwanda*.[3] Additionally, the lack of any up-to-date discussion on risk and recklessness means that the jurisprudence continually relies on *Dica*[4] and *Konzani*[5] in spite of the fact that courts issued those judgments approximately twenty years ago and there has been significant changes in the scientific community's understanding of HIV since then. This is particularly true where harm is concerned.

Like recklessness, this thesis argues that there is a significant gap between the law and science regarding the question of harm. Very few courts discussed what factors they viewed as relevant to assessing a harm as grievous as opposed to an actual bodily harm offence or another assault offence, and this absence is particularly notable in the cases concerning HIV. Going back to *R v Clarence*,[6] sexually transmitted infections are simply assumed to be grievous without further discussion. The most recent case concerning HIV, *R v Rowe*,[7] likewise avoided this topic—instead, the court cited *Dica*'s findings and neglected further discussion.[8] There have been significant leaps forward in the treatment of HIV since *Dica*, and the caselaw has yet to properly re-assess the harm of HIV in the criminal law. The question of the harm of HIV needs to be treated as a living one that may continually shift throughout time as further scientists discover additional treatments. As it stands, the current case law's approach to the harm level of HIV is stuck in the year 2004—a time when having HIV meant something very different than it does today.

This thesis additionally performed several comparative analyses. These comparisons serve three purposes: the first is to see if the English and Scottish criminal law's approach towards HIV transmission and exposure is unique; the second is to identify what factors lead to a greater reliance on up-to-date medical evidence; and third is to assess why the gap between the legal and scientific realms exist regarding recklessness and harm. To that end, this thesis examined English civil law cases that concerned HIV as well as the approach of other common law jurisdictions. While the civil law comparison did not show notable differences concerning harm or causation, it did regarding the approach towards risk. This juxtaposition highlighted three possible causes for *why* there is a gap between the law and

---

[3] [2009] EWCA Crim 60.
[4] *R v Dica (Mohammed)* [2004] EWCA Crim 1103.
[5] *R v Konzani (Feston)* [2005] EWCA Crim 706; [2005] 2 Cr App R 14 (CA (Crim Div)) [2005] EWHC 1676 (Fam).
[6] (1888) 22 QBD 23.
[7] [2018] EWCA Crim 2688; [2019] 1 Cr App R (S) 38.
[8] ibid [67].

science regarding recklessness and harm. The first is procedural, the vetting process performed by prosecutors, the pleas which often remove the question of harm or risk from the purview of the appellate court, and the defence which, for varying reasons, did not put such questions before the court. Consequently, the questions are not raised as issues for the reviewing court to adjudicate. While this addresses issues in several of the cases, it is not applicable for all of them. The second reason risk is approached differently in the criminal sphere versus the civil one possibly relates to the role of anecdotal and hindsight biases.[9] In the same way that one may conclude Russian roulette is not dangerous if they only speak to survivors,[10] courts and juries may conclude a risk is greater than it is because they are dealing with a situation where one party did, in fact, transmit HIV to another. This is likewise true because of the third reason this thesis argues that there is a gap between the law and science: the anecdotal bias is likely greater because many of the cases focus on a narrative that highlights a sexual betrayal. This plays into a core fear that many people have of being lied to and of being betrayed, and this fear is further exacerbated by misunderstandings surrounding HIV. Particularly considering so many grew up with the 'Don't Die of Ignorance' campaign which equated HIV to death,[11] HIV can still inspire a great amount of fear. That fear, combined with the fear of betrayal, likely heightens emotions which can increase the anecdotal bias and cause judges, juries, and prosecutors to unconsciously downplay scientific evidence in favour of a compelling narrative.[12] It also raises the possibility that what is really being punished is not the transmission or exposure of HIV, but betrayal. The fact that, particularly in the United States and Australia, the respective governments saw a surge in transmission and exposure laws after a highly publicised case demonstrates how common it is to have a fear-based response to the thought of being 'tricked' by a person with HIV.

In a broader sense, the 'betrayal of trust' narrative is not just about the emotional betrayal caused by a lie or an omission in a relationship, it is about the hidden fear society as a whole has regarding both sexual disease transmission and communities that have historically been looked down upon. It is an 'othering' force that draws a line between 'us'—

---

[9] See Traci H Freling and others, 'When Poignant Stories Outweigh Cold Hard Facts: A Meta-Analysis of the Anecdotal Bias' (2020) 160 Organizational Behavior and Human Decision Processes 51.
[10] This is actually the survivorship bias and not the anecdotal bias, but the point remains.
[11] See Hannah Kershaw, 'Remembering the "Don't Die of Ignorance" Campaign' (*London School of Hygiene & Tropical Medicine: Placing the Public in Public Health: Public Health in Britain, 1948-2010*, 20 May 2018) <https://placingthepublic.lshtm.ac.uk/2018/05/20/remembering-the-dont-die-of-ignorance-campaign/> accessed 13 May 2024.
[12] Freling and others (n 9).

the good, honest citizens—and 'them.' 'They' should stay on their side of the line. 'They' should be solely responsible for safe sex practices, because when such a burden falls only on their shoulders it is easier for the entire community to avert their collective eyes from HIV. When transmission occurs, it means one of 'us' turned into one of 'them'; the fear that such a transformation could happen to anyone is likely part of the reason why cases involving HIV evoke such emotional responses.

In light of the above, what is the solution? How does one close the gap between the law and science, particularly in connection to recklessness and harm? Firstly, counsel for defendants in relevant cases need to be sure to preserve such issues for appeal. Defendants need to be careful to what they plea to, since this can hamper later efforts. Additionally, defence counsel needs to ensure that they address the implication of changing scientific standards on appeal. Secondly, where there have been significant scientific changes, courts should perform an analysis that goes beyond simply relying on *Dica* as the court did in *Rowe*. Issues connecting to risk and harm in particular are alive and need to reassessed according to contemporary knowledge and new treatments such as PrEP. Regarding recklessness, this thesis argues that a more holistic approach which considers both objective and subjective evidence is the most appropriate way to ensure that scientific advancements are considered along with the individual circumstances of the defendant. Thirdly, judges, juries, and prosecutors need to be cognitive of the potential role of anecdotal bias. Finally, a legislative approach may solve the issue of the science/law gap more directly, but lawmakers need to be cautious in the language used. While some jurisdictions, such as California, have laws which specifically reference the need for risks to be assessed with modern knowledge,[13] other areas jurisdictions codified laws which treat acts which cannot transmit HIV (such as spitting) as potentially an exposure offence.[14]

Evolving scientific advancements regarding HIV may entirely change the landscape of the criminal law regarding transmission and exposure. This is good. Change is good. A world where transmissions increasingly dwindle, a world where people living with HIV have a lifespan of equal length and quality as those without, these are things which we as a society should embrace and strive for. The legal world needs to similarly embrace all these changes. The gap between the law and science is not one borne out of malice; instead, it is likely borne

[13] Cal. Health & Safety Code § 120290
[14] J Stan Lehman and others, 'Prevalence and Public Health Implications of State Laws That Criminalize Potential HIV Exposure in the United States' (2014) 18 AIDS and Behavior 997, 1000.

out of fear. Fear of betrayal, and fear of an infection that many grew up hearing was a death sentence. But things change. That scientists made such great leaps since the era of *Dica* is a fact to be celebrated. In light of this, courts need to be prepared to interact with situations that the court in *Dica* did not contemplate. The risk of transmission can now be assessed much more accurately statistically, and risks that are at a certain level of objectively low should not rise to the level of recklessness. Subjective assessments of recklessness can certainly still be relevant, and as such courts should use both when assessing risk and recklessness. Similarly, changes in treatment mean that HIV no longer needs to be considered a grievous bodily harm in all circumstances. The harm of HIV should be approached as a living issue with a case-by-case assessment. This does not mean that the court decided *Dica* incorrectly at the time, but it does mean that the world now is different than the world then. And for people living with HIV, that is a change to be embraced.

Bibliography

Books, Journals, News Articles, and Websites

Abecasis AB, Pingarilho M and Vandamme A, 'Phylogenetic Analysis as a Forensic Tool in HIV Transmission Investigations' (2018) 32 AIDS 543

Aidsmap, 'No Decline in HIV Testing in Scotland Following Stephen Kelly Case' (*aidsmap.com*, 10 July 2002) <www.aidsmap.com/news/jul-2002/no-decline-hiv-testing-scotland-following-stephen-kelly-case> accessed 13 November 2024

Alcorn K, 'Oral Sex and the Risk of HIV Transmission' (*aidsmap.com*, 2 January 2021) <www.aidsmap.com/about-hiv/oral-sex-and-risk-hiv-transmission> accessed 31 May 2024

Alexander TS, 'Human Immunodeficiency Virus Diagnostic Testing: 30 Years of Evolution' (2016) 23 Clinical and Vaccine Immunology 249 <https://cvi.asm.org/content/23/4/249> accessed 6 May 2025

Amel Alghrani, Bennett R and Ost S, *Bioethics, Medicine, and the Criminal Law. Volume I, the Criminal Law and Bioethical Conflict: Walking the Tightrope* (Cambridge University Press 2013)

Ashford C, Morris M and Powell A, 'Bareback Sex in the Age of Preventative Medication: Rethinking the "Harms" of HIV Transmission' (2020) 84 The Journal of Criminal Law 596

Ashworth A, 'A Change of Normative Position: Determining the Contours of Culpability in Criminal Law' (2008) 11 New Criminal Law Review 232

Baggaley RF and others, 'Risk of HIV-1 Transmission for Parenteral Exposure and Blood Transfusion: A Systematic Review and Meta-Analysis' (2006) 20 AIDS 805

Baker DJ, 'The Moral Limits of Consent as a Defense in the Criminal Law' (2009) 12 New Criminal Law Review 93

Bansal D, 'Bodily Modifications and the Criminal Law' (2018) 82 The Journal of Criminal Law 496

Barré-Sinoussi F and others, 'Expert Consensus Statement on the Science of HIV in the Context of Criminal Law' (2018) 21 Journal of the International AIDS Society <www.ncbi.nlm.nih.gov/pmc/articles/PMC6058263/> accessed 6 May 2025

BBC, 'Daryll Rowe Admitted Infecting Men with HIV in Edinburgh' (*BBC News*, 4 May 2018) <www.bbc.co.uk/news/uk-scotland-edinburgh-east-fife-44003613#:~:text=An%20Edinburgh%20hairdresser%20has%20been> accessed 31 May 2024

BBC, 'Man Jailed after Passing on HIV' (*BBC News,* 5 April 2007) <http://news.bbc.co.uk/1/hi/scotland/edinburgh_and_east/6528885.stm> accessed 16 September 2024

BBC, 'Woman Jailed for Giving Lover HIV' (*BBC News*, 19 June 2006) <http://news.bbc.co.uk/1/hi/5094708.stm> accessed 16 September 2024

Bernard E, 'Scottish Sexual HIV/HCV Transmission Trial Ends with Guilty Verdict' (*aidsmap.com*, 7 February 2007) <www.aidsmap.com/news/feb-2007/scottish-sexual-hivhcv-transmission-trial-ends-guilty-verdict> accessed 16 September 2024

Bernard E, 'The Return of the "HIV Monster"' (*POZ*, 27 July 2011) <https://www.poz.com/blog/hiv-monster> accessed 25 April 2025

Bird S and Leigh Brown A, 'Criminalisation of HIV Transmission: Implications for Public Health in Scotland' (2001) 323 BMJ 1174

Boily M-C and others, 'Heterosexual Risk of HIV-1 Infection per Sexual Act: Systematic Review and Meta-Analysis of Observational Studies' (2009) 9 The Lancet Infectious Diseases 118

Boyd M and others, 'Sexual Transmission of HIV and the Law: An Australian Medical Consensus Statement' (2016) 205 Medical Journal of Australia 409

Burris S and Weait M, 'Criminalisation and Moral Responsibility for the Sexual Transmission of HIV' (2013) Temple University Beasley Legal Studies Research Paper School of Law 2013-17 <https://papers.ssrn.com/sol3/papers.cfm?abstract_id=2126714> accessed 5 April 2025

Cann D, Harrison SE and Qiao S, 'Historical and Current Trends in HIV Criminalization in South Carolina: Implications for the Southern HIV Epidemic' (2019) 23 AIDS and Behavior 233 <www.ncbi.nlm.nih.gov/pmc/articles/PMC7182101/> accessed 25 March 2021

Carter DJ, 'Transmission of HIV and the Criminal Law: Examining the Impact of Pre-Exposure Prophylaxis and Treatment-as Prevention' (2020) 43 Melbourne University Law Review 940

Carter DJ, 'HIV Transmission, Public Health Detention and the Recalcitrant Subject of Discipline: Kuoth, Lam v Rand the Co-Constitution of Public Health and Criminal Law' (2016) 25 Griffith Law Review 172

Carter DJ, 'The Use of Coercive Public Health and Human Biosecurity Law in Australia: An Empirical Analysis' (2020) 43 University of New South Wales Law Journal

Carter M, '40 Month Sentence in First Gay Case of Reckless HIV Transmission in England' (*aidsmap.com*, 4 August 2006) <www.aidsmap.com/news/aug-2006/40-month-sentence-first-gay-case-reckless-hiv-transmission-england> accessed 16 September 2024

Chalmers J, 'The Criminalisation of HIV Transmission' (2002) 28 Journal of Medical Ethics 160

Clinicalinfo.HIV.gov, 'Acquired Immunodeficiency Syndrome (AIDS)' (*clinicalinfo.hiv.gov*) <https://clinicalinfo.hiv.gov/en/glossary/acquired-immunodeficiency-syndrome-aids> accessed 12 November 2024

Cohen J, 'HIV Treatment as Prevention' (2011) 334 Science 1628 <https://science.sciencemag.org/content/sci/334/6063/1628.full.pdf> accessed 6 May 2025

Cohen MS and others, 'Prevention of HIV-1 Infection with Early Antiretroviral Therapy' (2011) 365 The New England Journal of Medicine 493 <www.ncbi.nlm.nih.gov/pubmed/21767103> accessed 6 May 2025

Congress.Gov, 'All Actions except Amendments: H.R.3053 — 112th Congress (2011-2012)' (*Congress.Gov*) <www.congress.gov/bill/112th-congress/house-bill/3053/all-actions-without-amendments?q=hr3053> accessed 24 October 2024

Connor S, '"Anonymous" Research Data Used in Prosecution' (*Independent*, 25 August 2003) <www.independent.co.uk/news/uk/crime/anonymous-research-data-used-in-prosecution-101735.html> accessed 16 September 2024

Cox B, 'Turning the Tide: The Future of HIV Criminalization after Rhoades v. State and Legislative Reform in Iowa' (2016) 11 Northwestern Journal of Law and Social Policy 28

Cresswell F and others, 'A Systematic Review of Risk of HIV Transmission through Biting or Spitting: Implications for Policy' (2018) 19 HIV Medicine 532

Cross C, 'Sex, Crime, and Serostatus' (2021) 78 Wash. & Lee L. Rev 71

Crown Office and Procurator Fiscal Service, 'Prosecution Policy on the Sexual Transmission of Infection' (*Copfs.gov.uk*, 1 July 2014) <www.copfs.gov.uk/publications/prosecution-policy-on-the-sexual-transmission-of-infection/html/> accessed 6 May 2025

Crown Prosecution Service, 'Intentional or Reckless Sexual Transmission of Infection' (*Cps.gov.uk*, 13 December 2019) <www.cps.gov.uk/legal-guidance/intentional-or-reckless-sexual-transmission-infection> accessed 6 May 2025

Crown Prosecution Service, 'Offences against the Person, Incorporating the Charging Standard' (*Cps.gov.uk*, 27 June 2022) <www.cps.gov.uk/legal-guidance/offences-against-person-incorporating-charging-standard> accessed 6 May 2025

Crown Prosecution Service, 'Sentencing – Overview, General Principles and Mandatory Custodial Sentences' (*Cps.gov.uk*, 14 June 2023) <www.cps.gov.uk/legal-guidance/sentencing-overview-general-principles-and-mandatory-custodial-sentences> accessed 6 May 2025

Davies G, 'Father Who "Deliberately" Withheld His HIV+ Status and Infected Two Women Claims He Was Contaminated When a Man Sexually Abused Him' (*The Telegraph*, 30 October 2018) <www.telegraph.co.uk/news/2018/10/30/father-deliberately-infected-two-women-hiv-claims-contaminated/> accessed 11 October 2024

Day H, 'Why Did Daryll Rowe Use HIV as a Weapon?' (*BBC News*, 15 March 2019) <www.bbc.co.uk/news/resources/idt-sh/Why_Did_Daryll_Rowe_Use_HIV_As_A_Weapon> accessed 2 August 2022

Debbaut S, ‘The Legitimacy of Criminalizing Drugs: Applying the “Harm Principle” of John Stuart Mill to Contemporary Decision-Making’ (2021) 68 International Journal of Law, Crime and Justice 100508

Dodds C, Bourne A and Weait M, ‘Responses to Criminal Prosecutions for HIV Transmission among Gay Men with HIV in England and Wales’ (2009) 17 Reproductive Health Matters 135

Dunkle KL and Decker MR, ‘Gender-Based Violence and HIV: Reviewing the Evidence for Links and Causal Pathways in the General Population and High-Risk Groups’ (2012) 69 American Journal of Reproductive Immunology 20

Dyer C, ‘Use of Confidential HIV Data Helps Convict Former Prisoner’ (2001) 322 BMJ 322

East L, Peters K and Jackson D, ‘Violated and Vulnerable: Women’s Experiences of Contracting a Sexually Transmitted Infection from a Male Partner’ (2017) 26 Journal of Clinical Nursing 2342

Edwards SS, ‘Consent and the “Rough Sex” Defence in Rape, Murder, Manslaughter and Gross Negligence’ (2020) 84 The Journal of Criminal Law

Eisinger R, Dieffenbach C and Fauci A, ‘HIV Viral Load and Transmissibility of HIV Infection Undetectable Equals Untransmittable’ (2019) 321 JAMA 451

Elliott C and de Than C, ‘The Case for a Rational Reconstruction of Consent in Criminal Law’ (2007) 70 Modern Law Review 225

Etienne De Harven and Jean-Claude Roussez, *Ten Lies about Aids* (Trafford Publishing 2008)

Fast-Track Cities London and National AIDS Trust, ‘HIV: Public Knowledge and Attitudes’ (*NAT,* July 2021) <www.nat.org.uk/sites/default/files/publications/HIV%20Public%20Knowledge%20and%20Attitudes.pdf> accessed 10 May 2024

Feinberg J, *The Moral Limit of the Criminal Law*, vols 1: Harm to Others (Oxford University Press 1984)

Fenton B, ‘Woman with HIV Who Deliberately Took a String of Lovers Is Jailed’ (*The Telegraph*, 20 June 2006) <www.telegraph.co.uk/news/uknews/1521732/Woman-with-HIV-who-deliberately-took-a-string-of-lovers-is-jailed.html> accessed 8 April 2025

Fidler S and others, ‘Position Statement on the Use of Antiretroviral Therapy to Reduce HIV Transmission, January 2013: The British HIV Association (BHIVA) and the Expert Advisory Group on AIDS (EAGA)’ (2013) 14 HIV Medicine 259 <https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/193689/Position_statement_on_the_use_of_ART_to_reduce_HIV_transmission__Jan_2013.pdf> accessed 20 July 2022

Findlay Stark, *Culpable Carelessness: Recklessness and Negligence in the Criminal Law* (Cambridge University Press 2016)

Fischhoff B, ‘Hindsight Is Not Equal to Foresight: The Effect of Outcome Knowledge on Judgment under Uncertainty’ (1975) 1 Journal of Experimental Psychology: Human Perception and Performance 288

Fitch JT and others, ‘Condom Effectiveness: Factors That Influence Risk Reduction’ (2002) 29 Sexually Transmitted Diseases 811 <https://pubmed.ncbi.nlm.nih.gov/12466725/> accessed 21 June 2024

Freling TH and others, ‘When Poignant Stories Outweigh Cold Hard Facts: A Meta-Analysis of the Anecdotal Bias’ (2020) 160 Organizational Behavior and Human Decision Processes 51

Frey J, ‘Jamestown and the Story of “Nushawn’s Girls”’ (*Washington Post*, 1 June 1999) <www.washingtonpost.com/wp-srv/style/features/jamestown0601.htm> accessed 24 October 2024

Gibson RB, ‘No Harm, No Foul? Body Integrity Identity Disorder and the Metaphysics of Grievous Bodily Harm’ (2020) 20 Medical Law International 73

Giroux ME and others, ‘Hindsight Bias and Law’ (2016) 224 Zeitschrift für Psychologie 190

Godfrey M, ‘Search Widens for Man Who Gave Lover HIV’ (*The Argus*, 25 September 2006) <www.theargus.co.uk/news/936455.search-widens-for-man-who-gave-lover-hiv/> accessed 16 September 2024

Gorski S, ‘Gonorrhea History’ (*News-Medical.net*, 4 November 2010) <www.news-medical.net/health/Gonorrhea-History.aspx#:~:text=The%20earliest%20treatment%20of%20gonorrhea> accessed 6 May 2025

Gov.UK, ‘HIV Testing, PrEP, New HIV Diagnoses and Care Outcomes for People Accessing HIV Services: 2023 Report’ (*GOV.UK*, 6 October 2023) <www.gov.uk/government/statistics/hiv-annual-data-tables/hiv-testing-prep-new-hiv-diagnoses-and-care-outcomes-for-people-accessing-hiv-services-2023-report#pre-exposure-prophylaxis-prep> accessed 14 May 2024

Gov.UK, ‘UK’s Largest Survey of People Living with HIV Published’ (*Gov.UK*, 12 January 2024) <www.gov.uk/government/news/uks-largest-survey-of-people-living-with-hiv-published#:~:text=In%202022%2C%20the%20survey%20found> accessed 13 May 2024

Griffiths D and Sanders A (eds), *Bioethics, Medicine and the Criminal Law; v. 2: Medicine, Crime and Society.* (Cambridge Cambridge Univ Press 2013)

Grover A, ‘Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health, Anand Grover’ (United Nations Human Rights Council, 14th Session 2010)

Harsono D and others, ‘Criminalization of HIV Exposure: A Review of Empirical Studies in the United States’ (2016) 21 AIDS and Behavior 27 <www.ncbi.nlm.nih.gov/pmc/articles/PMC5218970/> accessed 6 May 2025

Hastings C, Kazatchkine C and Mykhalovskiy E ‘HIV Criminalization in Canada: Key Trends and Patterns’ (*Canadian HIV/AIDS Legal Network*, 2017) <https://sagecollection.ca/wp-content/uploads/2018/07/hiv_stats_info_sheet-final-en.pdf> accessed 24 October 2024

Health Protection Agency, 'Health Protection Legislation (England) Guidance 2010' (*Health Protection Agency,* 25 March 2010) <www.haringey.gov.uk/sites/haringeygovuk/files/hpa_-_guidance_notes.pdf> accessed 18 November 2024

Herpes Virus Association, 'About Herpes Simplex Virus' (*Herpes Viruses Association*, 20 February 2025) <https://herpes.org.uk/frequently-asked-questions/herpes-simplex-virus/> accessed 6 May 2025

Herrero Sáenz R and Hoppe T, 'Disease on Trial: Medical Risk and Molecular Responsibility in HIV Exposure and Disclosure Jury Trials (1994–2015)' (2018) 68 Current Sociology 97

HIV Ireland, 'HIV Terminology and Appropriate Language Use Guidelines' (*HIV Ireland,* 2020) <www.hivireland.ie/wp-content/uploads/HIV-Terminology-Appropriate-Language-Guidelines-V1.3-09-2020.pdf> accessed 12 November 2024

HIV Justice Network, 'Canada | HIV Justice Network' (*HIV Justice Network*, November 2023) <www.hivjustice.net/country/ca/> accessed 24 October 2024

HIV Justice Network, 'UK: Michael Fielder Sentenced (UK Reckless Transmission Case Thrown out due to Lack of Evidence)' (*HIV Justice Network*, 14 July 2007) <www.hivjustice.net/cases/uk-michael-fielder-sentenced-uk-reckless-transmission-case-thrown-out-due-to-lack-of-evidence/> accessed 16 September 2024

Home Office, Violence: Reforming the Offences against the Person Act 1861 (1998)

House of Commons, The Anti-Terrorism, Crime and Security Bill: Parts I, II, VIII, IX & XIII: Property, Security & Crime, research paper 01/99 (19 November 2001)

I-Base, 'Introduction to ART | Guides | HIV I-Base' (*i-base.info*) <https://i-base.info/guides/starting> accessed 31 May 2024

ILO & WHO, 'Joint WHO/ILO Guidelines on Post-Exposure Prophylaxis (PEP) to Prevent HIV Infection' (*WHO*, March 2007) <https://iris.who.int/bitstream/handle/10665/43838/9789241596374_eng.pdf?sequence=1> accessed 31 May 2024

James R, ‘What Do Court Transcripts Reveal about Judges’ Understanding of the Medical Impact of HIV Infection and What Are the Implications for Healthcare Professionals Giving Advice to the Court?’ (2009) 10(S1) HIV Medicine 17 <https://onlinelibrary.wiley.com/toc/14681293/2009/10/s1> accessed 06 May 2025

Jones A, ‘Side-Effects of HIV Treatment’ (*aidsmap.com*, February 2018) <www.aidsmap.com/about-hiv/side-effects-hiv-treatment> accessed 16 March 2025.

Kamin KA and Rachlinski JJ, ‘Ex Post ≠ Ex Ante: Determining Liability in Hindsight.’ (1995) 19 Law and Human Behavior 89

Kershaw H, ‘Remembering the “Don’t Die of Ignorance” Campaign’ (*London School of Hygiene & Tropical Medicine: Placing the Public in Public Health: Public Health in Britain, 1948-2010*, 20 May 2018) <https://placingthepublic.lshtm.ac.uk/2018/05/20/remembering-the-dont-die-of-ignorance-campaign/> accessed 13 May 2024

Kirkup K, ‘Law’s Sexual Infections’ (2023) 46 Dalhousie Law Journal 609

Kneer M and Skoczeń I, ‘Outcome Effects, Moral Luck and the Hindsight Bias’ (2023) 232 Cognition 105258

Law Commission, ‘A Criminal Code for England and Wales / Vol. 2, Commentary on Draft Criminal Code Bill.’ (Law Com No 177, 1989)

Law Commission, ‘Legislating the Criminal Code: Offences against the Person and General Principles’ (Law Comm No 218, 1993)

Law Commission, ‘Reform of Offences against the Person: A Scoping Consultation Paper’ Law (Comm No 217, 2014)

Lawrence J, ‘A History of HIV Survival in the UK’ (*The Pharmaceutical Journal*, 26 November 2015) <https://pharmaceutical-journal.com/article/infographics/a-history-of-hiv-survival-in-the-uk> accessed 16 September 2024

Lehman JS and others, ‘Prevalence and Public Health Implications of State Laws That Criminalize Potential HIV Exposure in the United States’ (2014) 18 AIDS and Behavior 997

LeMessurier J and others, ‘Risk of Sexual Transmission of Human Immunodeficiency Virus with Antiretroviral Therapy, Suppressed Viral Load and Condom Use: A Systematic Review’ (2018) 190 Canadian Medical Association Journal <www.ncbi.nlm.nih.gov/pmc/articles/PMC6239917> accessed 16 May 2024

Lightfoot G, ‘Virus Fears as Middlesbrough HIV Man Jailed’ (*TeessideLive*, 5 October 2011) <www.gazettelive.co.uk/news/local-news/virus-fears-middlesbrough-hiv-man-3680067> accessed 16 September 2024

Lord Hodge, ‘Sentencing Statement’ (*BBC News*, 5 April 2007) <http://news.bbc.co.uk/1/shared/bsp/hi/pdfs/05_04_07_mola.pdf> accessed 17 June 2024

Marcus JL and others, ‘Comparison of Overall and Comorbidity-Free Life Expectancy between Insured Adults with and without HIV Infection, 2000-2016’ (2020) 3 JAMA Network Open

Martin SL and others, ‘Domestic Violence and Sexually Transmitted Diseases: The Experience of Prenatal Care Parents’ (1999) 114 Public Health Reports 262

Mayo Clinic, ‘Thinking of Getting a Tattoo? Know What to Expect’ (*Mayo Clinic*, 2024) <www.mayoclinic.org/healthy-lifestyle/adult-health/in-depth/tattoos-and-piercings/art-20045067#:~:text=An%20infection%20might%20be%20due> accessed 17 July 2024

McCrea M, ‘How the Media Shapes Perception of HIV and AIDS’ (Frank Crooks ed, *Healthline*, 25 April 2020) <www.healthline.com/health/media-and-perception-of-hiv-aids#celebrities> accessed 18 March 2025.

Medical News Today, ‘HIV Viral Load: What It Means, Detection, and CD4 Levels’ (*www.medicalnewstoday.com*, 30 November 2018) <www.medicalnewstoday.com/articles/323851#cd-4-count> accessed 6 May 2025

Metro Reporter, ‘Man Jailed for Lying to Girlfriends and Knowingly Infecting Them with HIV’ (*Metro*, 21 September 2018) <https://metro.co.uk/2018/09/21/man-jailed-for-lying-to-girlfriends-and-knowingly-infecting-them-with-hiv-7968061/> accessed 18 November 2024

Mill JS, *On Liberty* (Cambridge University Press 1859)

Moncivaiz A, ‘CD4 vs. Viral Load: What’s in a Number?’ (*Healthline*, 18 July 2013) <www.healthline.com/health/hiv-aids/cd4-viral-count#cd-count> accessed 7 May 2025

Morton T, ‘“Dirty Little Secret”: Journalism, Privacy and the Case of Sharleen Spiteri’ (2012) 18 Pacific Journalism Review 46

National AIDS Trust, ‘WHY IS PrEP NEEDED?’ (*NAT*, 2016) <www.nat.org.uk/sites/default/files/Why%20is%20PrEP%20needed.pdf> accessed 31 May 2024

NHS England, ‘HIV Prophylaxis in Women and New-Borns’ (*england.nhs.uk*) <www.england.nhs.uk/patient-safety/patient-safety-insight/learning-from-patient-safety-events/how-we-acted-on-patient-safety-issues-you-recorded/hiv-prophylaxis-in-women-and-new-borns/> accessed 29 March 2025

NHS England, ‘NHS England Announces World’s Largest Single PrEP Implementation Trial to Prevent HIV Infection’ (*england.nhs.uk*, 3 August 2017) <www.england.nhs.uk/2017/08/nhs-england-announces-worlds-largest-single-prep-implementation-trial-to-prevent-hiv-infection/#:~:text=From%20September%2C%20pre%2Dexposure%20prophylaxis> accessed 31 May 2024

NHS, ‘Gonorrhoea - Complications’ (*nhs.uk*, 6 July 2018) <www.nhs.uk/conditions/gonorrhoea/complications/#:~:text=In%20men%2C%20gonorrhoea%20can%20cause> accessed 19 November 2024

NHS, ‘How and When to Take Pre-Exposure Prophylaxis (PrEP)’ (*nhs.uk*, 13 March 2023) <www.nhs.uk/medicines/pre-exposure-prophylaxis-prep/how-and-when-to-take-pre-exposure-prophylaxis-prep/> accessed 31 May 2024

NHS, ‘Symptoms - HIV and AIDS’ (*nhs.uk*, 22 April 2021) <www.nhs.uk/conditions/hiv-and-aids/symptoms/> accessed 19 November 2024

NICE, ‘HIV Infection and AIDS’ (*NICE*, May 2021) <https://cks.nice.org.uk/topics/hiv-infection-aids/> accessed 12 November 2024

Nicol MR, Adams JL and Kashuba AD, 'HIV Pre-Exposure Prophylaxis Trials: The Road to Success' (2013) 3 National Library of Medicine 295

NIH, 'Antiretroviral Drug Discovery and Development | NIH: National Institute of Allergy and Infectious Diseases' (*Nih.gov,* 2018) <www.niaid.nih.gov/diseases-conditions/antiretroviral-drug-development> accessed 25 March 2023

NIH, 'Condom Use for Preventing HIV Infection,' (*Nih.gov*, 29 November 2018) <www.niaid.nih.gov/diseases-conditions/condom-use> accessed 6 May 2025

NIH, 'HIV Treatment, the Viral Reservoir, and HIV DNA,' (*Nih.gov*, 27 November 2018) <www.niaid.nih.gov/diseases-conditions/hiv-treatment-viral-reservoir-hiv-dna> accessed 6 May 2025

NIH, 'HIV Undetectable=Untransmittable (U=U), or Treatment as Prevention | NIH: National Institute of Allergy and Infectious Diseases' (*Nih.gov*, 21 May 2019) <www.niaid.nih.gov/diseases-conditions/treatment-prevention> accessed 31 May 2024

NIH, 'Pre-Exposure Prophylaxis (PrEP) to Reduce HIV Risk (*Nih.gov*, 16 October 2018) <www.niaid.nih.gov/diseases-conditions/pre-exposure-prophylaxis-prep> accessed 13 April 2025

Ormerod D, Laird K and Gibson M, *Smith, Hogan, and Ormerod's Criminal Law* (17th edn., Oxford Univ Press 2024)

Park A, 'The Story behind the First AIDS Drug' (*Time*, 2017) <https://time.com/4705809/first-aids-drug-azt/> accessed 4 March 2025

Parsons B, 'Brighton Man Who Intentionally Infected Partner with HIV Jailed' (*The Argus*, 18 February 2010) <www.theargus.co.uk/news/5013575.brighton-man-who-intentionally-infected-partner-with-hiv-jailed/> accessed 16 September 2024

Patel P and others, 'Estimating Per-Act HIV Transmission Risk' (2014) 28 AIDS 1509 <www.ncbi.nlm.nih.gov/pmc/articles/PMC6195215/> accessed 31 May 2024

Patterson S and others, ‘Awareness and Understanding of HIV Non-Disclosure Case Law and the Role of Healthcare Providers in Discussions about the Criminalization of HIV Non-Disclosure among Women Living with HIV in Canada’ (2019) 24 AIDS and Behavior 1

Pett W, ‘Do Condoms Work?’ (*aidsmap.com*, February 2019) <www.aidsmap.com/about-hiv/do-condoms-work> accessed 13 April 2025

Poberezny-Lynch T, ‘Criminalising Infection: Questioning the Assumption That Transmitting HIV Constitutes Grievous Bodily Harm’ (2019) 44 Alternative Law Journal 138

Pool HA, ‘Porter’s Real Crime: She Slept with Black Men’ (*The Guardian,* 20 June 2006) <www.theguardian.com/world/2006/jun/21/aids.hannahpool> accessed 19 November 2024

Prevention Access Campaign, ‘Who We Are and What We Do’ (*Prevention Access Campaign*) <https://preventionaccess.com> accessed 30 May 2024

Public Health England, ‘Progress towards Ending the HIV Epidemic in the United Kingdom 2018 Report – Summary, Key Messages and Recommendations’ (*Public Health England*, 2018) <https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/759407/HIV_annual_report_2018_-_Summary_key_messages_and_recommendations.pdf> accessed 11 October 2024

Raza S and others, ‘Adverse Clinical Sequelae after Skin Branding: A Case Series’ (2009) 3 Journal of Medical Case Reports

Roberts D, ‘New Bill Seeks to Repeal Outdated State HIV Discrimination Laws’ (*The Guardian*, 10 December 2013) <www.theguardian.com/world/2013/dec/10/us-house-hiv-bill-discrimination> accessed 7 May 2025

Ryan S, ‘“Active Deception” v Non-Disclosure: HIV Transmission, Non-Fatal Offences and Criminal Responsibility’ (2019) 1 Criminal Law Review 4

Ryan S, ‘Disclosure and HIV Transmission’ (2015) 79 The Journal of Criminal Law 395

Ryan S, ‘Risk-Taking, Recklessness and HIV Transmission: Accommodating the Reality of Sexual Transmission of HIV within a Justifiable Approach to Criminal Liability’ (2007) 28 Liverpool Law Review 215

Scott K, ‘HIV Man Jailed for Knowingly Infecting Lover’ (*The Guardian*, 19 March 2001) <www.theguardian.com/society/2001/mar/19/publichealth> accessed 7 May 2025

Sentencing Council, ‘Assault – Sentencing’ (*Sentencing Council*, 2022) <www.sentencingcouncil.org.uk/outlines/assault/> accessed 7 May 2025

Shute S and Simester AP, *Criminal Law Theory: Doctrines of the General Part* (Oxford University Press 2005)

Spencer J, ‘Liability for Reckless Infection’ (2004) 154 New Law Journal 384

Strohmaier N and others, ‘Hindsight Bias and Outcome Bias in Judging Directors’ Liability and the Role of Free Will Beliefs’ (2020) 51 Journal of Applied Social Psychology 141

Strudwick P, ‘Man Charged with Rape and Possible Transmission of HIV to Men in Edinburgh’ (*BuzzFeed News*, 25 February 2016) <www.buzzfeednews.com/article/patrickstrudwick/man-charged-with-rape-and-possible-transmission-of-hiv> accessed 8 November 2022

Teed P, ‘Mark James due to Appear at Isleworth Crown Court for Sentencing’ (*Richmond and Twickenham Times*, 12 February 2010) <www.richmondandtwickenhamtimes.co.uk/news/5004755.gay-man-passed-hiv-lover-arrested-three-years-run/> accessed 16 September 2024

Terrence Higgins Trust, ‘First TV Ad on HIV since “Tombstones” 40 Years Ago Set to Tackle Attitudes Stuck in the 1980s | Terrence Higgins Trust’ (*Terrence Higgins Trust*, 2023) <www.tht.org.uk/news/first-tv-ad-hiv-tombstones-40-years-ago-set-tackle-attitudes-stuck-1980s> accessed 13 May 2024

The Center for HIV Law and Policy, ‘Arrests and Prosecutions for HIV Exposure in the United States, 2008–2019’ (*The Center for HIV Law and Policy*) <www.hivlawandpolicy.org/sites/default/files/Chart%20of%20U.S.%20Arrests%20and%20Prosecutions%20for%20HIV%20Exposure%20in%20the%20United%20States%20%28June%202019%29_0.pdf> accessed 24 October 2024

The Center for HIV Law and Policy, ‘Essential Facts on the Nushawn Williams Case’ (The Center for HIV Law & Policy) <www.hivlawandpolicy.org/sites/default/files/Essential%20Facts%20on%20the%20Nushawn%20Williams%20Case%2C%20CHLP%202021.pdf> accessed 24 October 2024

The Center for HIV Law and Policy, ‘HIV Criminalization in the United States’ (*The Center for HIV Law and Policy*, 2022) <www.hivlawandpolicy.org/sites/default/files/HIV%20Criminalization%20in%20the%20US%2C%20CHLP%20062822.pdf> accessed 24 October 2024

The Center for HIV Law and Policy, ‘Timeline of State Reforms and Repeals of HIV Criminal Laws’ (*The Center for HIV Law and Policy*, June 2022) <www.hivlawandpolicy.org/resources/timeline-state-reforms-and-repeals-hiv-criminal-laws-chlp-updated-2022> accessed 24 October 2024

The Herald Staff, ‘Italian Guilty of Passing HIV Virus onto Girlfriend’ (*The Herald*, 8 February 2007) <www.heraldscotland.com/default_content/12757528.italian-guilty-passing-hiv-virus-onto-girlfriend/> accessed 16 September 2024

Trickey A and others, ‘Life Expectancy after 2015 of Adults with HIV on Long-Term Antiretroviral Therapy in Europe and North America: A Collaborative Analysis of Cohort Studies’ (2023) 10 The Lancet HIV 295 <www.thelancet.com/journals/lanhiv/article/PIIS2352-3018(23)00028-0/fulltext#:~:text=We%20estimated%20that%20women%20with> accessed 18 May 2024

UNAIDS, ‘Report on the Global HIV/AIDS Epidemic’ (*UNAIDS* July 2002)

U.S. Centers for Disease Control and Prevention, ‘About HIV’ (*CDC.gov*, June 2022) <www.cdc.gov/hiv/basics/whatishiv.html> accessed 31 May 2024

U.S. Centers for Disease Control and Prevention, ‘HIV Treatment’ (*CDC.gov*, 21 November 2023) <www.cdc.gov/hiv/basics/livingwithhiv/treatment.html> accessed 31 May 2024

U.S. Centers for Disease Control and Prevention, ‘HIV Treatment as Prevention’ (*CDC.gov*, 2019) <www.cdc.gov/hiv/risk/art/index.html> accessed 31 May 2024

U.S. Centers for Disease Control and Prevention, 'Pre-Exposure Prophylaxis (PrEP) | HIV Risk and Prevention | HIV/AIDS | CDC' (*CDC.gov,* 4 June 2020) <www.cdc.gov/hiv/risk/prep/index.html#:~:text=Pre%2Dexposure%20prophylaxis%20(or%20PrEP> accessed 17 June 2024

U.S. Centers for Disease Control and Prevention nPEP Guidelines Writing Team, 'Updated Guidelines for Antiretroviral Postexposure Prophylaxis after Sexual, Injection Drug Use, or Other Nonoccupational Exposure to HIV— United States, 2016 from the Centers for Disease Control and Prevention, U.S. Department of Health and Human Service' (*CDC.gov*, 2016) <www.cdc.gov/hiv/pdf/programresources/cdc-hiv-npep-guidelines.pdf> accessed 31 May 2024

U.S. Food and Drug Administration, 'The History of FDA's Role in Preventing the Spread of HIV/AIDS' (*FDA*, 2021) <www.fda.gov/about-fda/fda-history-exhibits/history-fdas-role-preventing-spread-hivaids> accessed 6 May 2025

Van Empel E and others, 'Older Adults Vastly Overestimate Both HIV Acquisition Risk and HIV Prevalence in Rural South Africa' (2021) 50 Archives of Sexual Behavior 3257

Vernazza P and others, 'HIV-Infizierte Menschen Ohne Andere STD Sind Unter Wirksamer Antiretroviraler Therapie Sexuell Nicht Infektiös [HIV-Infected People Free of Other STDs Are Sexually Not Infectious on Effective Antiretroviral Therapy]' (2008) 89 Schweizerische Ärztezeitung 165

Vitinghoff E and others, 'Per-Contact Risk of Human Immunodeficiency Virus Transmission between Male Sexual Partners' (1999) 150 American Journal of Epidemiology 306

Wainberg M, 'Pre-Exposure Prophylaxis against HIV: Pros and Cons' (2012) 9 Retrovirology <www.ncbi.nlm.nih.gov/pmc/articles/PMC3360281/> accessed 18 September 2024

Warburton D, 'A Critical Review of English Law in Respect of Criminalising Blameworthy Behaviour by HIV+ Individuals' (2004) 68 The Journal of Criminal Law 55

Watson S, 'The History of HIV Treatment: Antiretroviral Therapy and More' (*WebMD*, 9 June 2020) <www.webmd.com/hiv-aids/hiv-treatment-history> accessed 6 May 2025

Weait M, ‘Criminal Law and the Sexual Transmission of HIV: *R v Dica*’ (2005) 68 Modern Law Review 121

Weait M, ‘UK: Gonorrhoea Prosecution “a Dangerous Development”’ (*Criminal HIV Transmission*, 23 April 2009) <http://criminalhivtransmission.blogspot.com/2009/04/uk-gonorrhoea-prosecution-dangerous.html> accessed 2 August 2022

Weait M, *Intimacy and Responsibility* (Routledge 2007)

Weller SC and Davis-Beaty K, ‘Condom Effectiveness in Reducing Heterosexual HIV Transmission’ (2002) Cochrane Database of Systematic Reviews

White G, ‘Pre-Exposure Prophylaxis (PrEP) and Criminal Liability under State HIV Laws’ (2016) 126 Yale Law Journal Forum 77 <www.yalelawjournal.org/forum/pre-exposure-prophylaxis-prep-and-criminal-liability-under-state-hiv-laws#:~:text=2016%2D2017-,Pre%2DExposure%20Prophylaxis%20(PrEP)%20and%20Criminal,Liability%20Under%20State%20HIV%20Laws&text=Every%20state%20imposes%20criminal%20penalties,aggravating%20factor%20for%20sentencing%20purposes.> accessed 24 October 2024

Wilson-Raybould HonJ, ‘Minister Wilson-Raybould Issues Statement on World AIDS Day - Canada.ca’ (*Canada.ca*, 2016) <www.canada.ca/en/department-justice/news/2016/12/minister-wilson-raybould-issues-statement-world-aids.html> accessed 24 October 2024

Wright J, ‘Remembering the Early Days of “Gay Cancer”’ (*NPR*, 8 May 2006) <www.npr.org/2006/05/08/5391495/remembering-the-early-days-of-gay-cancer?t=1583448714976> accessed 31 May 2024

Yin Wu M and others, ‘Effect of Syphilis Infection on HIV Acquisition: A Systematic Review and Meta-Analysis’ (2020) 97 Sexually Transmitted Infections 531.

Young S, ‘Imprisoned over HIV: One Man’s Story’ (*CNN*2, August 2012) <https://edition.cnn.com/2012/08/02/health/criminalizing-hiv/index.html> accessed 24 October 2024

Cases

Alan Roger Plater v Sonatrach [2004] EWHC 146 (QB)

A mother v A father, A, B and C (the children) (by their Children's Guardian Hazel Borthwick) [2022] WL 00119519

An NHS Trust v P (By Her Litigation Friend, the Official Solicitor) [2021] EWCOP 27

Assange v Sweden [2011] EWHC 2849 (Admin)

Atwal v. Massey [1971] 3 All ER 881

Attorney-General's Reference (No 51 of 2007) [2007] EWCA Crim 1752

Aubrey v The Queen [2017] 260 CLR 305.

Billingsley v Davis, 2018 WL 2013046 (Texas 2018)

Brown v Stott 2001 SLT 59

Canada Square Operations Ltd v Mrs Beverley Potter [2021] EWCA Civ 339

Child and Family Agency v AA [2018] IEHC 112

Darrell Stewart Jones v Ministry of Defence [2020] EWHC 1603 (QB)

Director of Public Prosecutions v Smith [1961] AC 290

Director of Public Prosecutions v Smith [2006] 2 Cr App R 1

High Quality Lifestyles Ltd v Mr Scott Watts [2004] WL 62159

HMA v Devereaux [2010] Edinburgh High Court, Case No 38/10

HMA v Kelly [2001] ScotHC 7 (unreported)

HMA v M 2007 SLT 462

HMA v Mola [2007] HCJ 02 (unreported)

In Re C. (A Child) v (H.I.V. Testing) [2000] 2 WLR 270.

Re P (Non Disclosure of HIV Status) [2006] 2 FLR

Kathleen K. v. Robert B., 198 Cal. Rptr. 273 (U.S. Cal. Ct. App. 2 Dist., 1984)

Kettering General Hospital NHS Foundation Trust v C, Northamptonshire Council [2023] EWHC 239 (Fam)

London Borough of Barking & Dagenham v R M L S the Children (through their Children's Guardian, Rosemary Boulton) [2023] EWHC 777 (Fam)

London Borough of Brent v Mr & Mrs N, The Minor's Foster Carers, P, a minor (appearing by her Guardian) [2005] EWHC 1676 (Fam)

Neal v The Queen [2011] 32 VR 454

People v Uver A [2021] 195 A.D.3d 61 (New York)

Re AB [2016] EWCOP 66

Regina (National Aids Trust) v National Health Service Commissioning Board (NHS England), [2016] PTSR 1093

R v Adaye [2004] Liverpool County Court, Case No T20037703 (unreported)

R v Aitken [1992] 1 W.L.R. 1006

R v Ashman [1858] 175 ER 638

R v BM [2018] EWCA Crim 560

R v Bollom [2004] 2 Cr App R 6

R v Brady [2006] EWCA Crim 2413

R v Brown [1993] UKHL 19; [1994] 1 AC 212

R v Chan Fook [1994] 1 WLR 689

R v Clarence (1888) 22 QBD 23

R v Collins [2006] The Crown Court at Kingston Upon Thames, Case No T2040664 (unreported)

R v Cuerrier [1998] 2 SCR 371 (Canada)

R v Cunningham [1957] 2 QB 396

R v DC [2012] 2 SCR 626

R v Dica (Mohammed) [2004] EWCA Crim 1103; [2004] QB 1257 (CA (Crim Div))

R v Dica (Mohammed) [2005] EWCA Crim 2304

R v Donovan [1934] 25 Cr.App.R. 1; [1934] 2 K.B. 498

R v Fielder [2007] The Crown Court at Preston, Case No T 20060473 (unreported)

R v G and Another [2003] UKHL 50

R v Golding [2014] EWCA Crim 889

R v Goodyear [2005] EWCA Crim 888

R v Ireland; R v Burstow [1998] AC 147

R v Janjua [1999] 1 Cr App R 91

R v Jones [1986] 83 Cr App R 375

R v Konzani (Feston) [2005] EWCA Crim 706; [2005] 2 Cr App R 14 (CA (Crim Div)); [2005] EWHC 1676 (Fam)

R v Mabior [2012] 2 SCR 584

R v Marangwanda [2009] EWCA Crim 60

R v McClure [2011] In the Crown Court at Teesside, Case No T20110659 (unreported)

R v Murphy 2022 ONCA 615

R v. Murphy 2013 CarswellOnt 11952

R v. Murphy [1980] QB 434

R v Navarro [2019] WL 4926839

R v Porter [2006] Inner London Crown Court,T20060260 (unreported)

R v Pringle [2012] In the Crown Court at Newcastle Upon Tyne, Case No: T20120437 (unreported)

R v R [1992] 94 Cr App R 216

R v Rowe [2018] EWCA Crim 2688; [2019] 1 Cr App R (S) 38

R v Vantandillo 4 M&S 73.

R v Vickers [1957] 41 Cr App 189

R v Wilson [1997] QB 47

R v Woolin [1999] AC 82

Rhoades v. State, 848 N.W.2d 22 (Iowa 2014)

State v Keen, 629, N.W.2d 360 (Iowa 2001)

State v. Lankford, 102 A. 63 (Delaware 1917)

State v Musser, 721 N.W.2d 734 (Iowa 2006)

State v Richardson, 289 Kan. 118 (Kansas 2009)

State v Stevens, 719 N.W. 2d 547 (Iowa 2006)

Stevens v State, 924 N.W.2d 876 (Iowa 2018)

The Child and Family Agency v AA & Anor [2018] IEHC 112.

Zaburoni v The Queen (2016) 256 CLR 482

Correspondences

E-mail from author to Dr Robert James (07 February 2019)

E-mail from Dr Robert James to author (08 February 2019)

E-mail from author to Dr Yusef Azad (01 March 2019)

E-mail from Dr Yusef Azad to author (23 April 2019)

Statutes

Abusive Behaviour and Sexual Harm (Scotland) Act 2016

Anti-social Behaviour, Crime, and Policing Act 2014

Cal. Health & Safety Code § 120290

Canada Criminal Code § 273

Children (Equal Protection from Assault) (Scotland) Act 2019 section 1

Children (Abolition of Defence of Reasonable Punishment) (Wales) Act 2020 section 1

Contagious or Infectious Disease Transmission Act §709D.3

Criminal Justice Act 1998

Criminal Law Act 1967

Health and Social Care Act 2008

H.R.1305—117th Congress (2021-2022

H.R.1843 — 113th Congress (2013-2014)

H.R. 6111—117th Congress (2021-2022)

Offences Against the Person Act 1861

Pub. L. No. 106-345, § 301(a), 114 Stat. 1345 (2000)

Public Health (Control of Disease) Act 1984

Public Health etc. (Scotland) Act 2008

Ryan White Comprehensive AIDS Resources Emergency Act of 1990, Public Law 101-381; 104 Stat. 576

Sexual Offences Act 2003

Sexual Offences (Scotland) Act 2009