Criminal Law and the Sexual Transmission of HIV: *R* v *Dica*

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INTRODUCTION

In what circumstances should those who, during sexual intercourse, transmit serious disease to others, be subject to criminal sanctions? Despite the relative dearth of domestic appellate decisions, this question has provided a feast of academic and policy-oriented commentary and analysis;[1] and it is a question that has been rendered even more urgent by recent revelations about the dramatic increase in the rate at which Sexually Transmitted Infections (STIs) are being spread.[2] The interest generated by the subject has, one suspects, two principal causes. First, it is a topic that reflects, insofar as it concerns the transmission of HIV, a more general interest in the ways in which criminal law can and should respond to a new and hugely significant challenge to human health[3]. Second, it is a subject which, because it brings into sharp relief complex and particular problems of fault, causation and harm, allows lawyers to explore, and test the limits of, established crim-

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1 For domestic academic commentary prior to *R* v *Dica* see A. Lynch, 'Criminal Liability for Transmitting Disease' Crim LR (1978) 612; G.T. Laurie, 'AIDS and Criminal Liability Under Scots Law' 36 JLSS (1991) 312; K.J.M. Smith, 'Sexual Etiquette, Public Interest and the Criminal Law' 42 NILQ (1991) 309; S.H. Bronitt, 'Criminal Liability for the Transmission of HIV/AIDS' 16 Crim LJ (1992) 85; P. Alldridge, 'Sex, Lies and the Criminal Law' 44 NILQ (1993) 250; S.H. Bronitt, 'Spreading Disease and the Criminal Law' Crim LR (1994) 21; D.C. Ormerod and M.J. Gunn, 'Criminal Liability for the Transmission of HIV' 1 *Web Journal of Current Legal Issues* (1996); J. Dine and B. Watt, 'The Transmission of Disease During Consensual Sexual Activity and the Concept of Associative Autonomy' 4 *Web Journal of Current Legal Issues* (1998); M.J. Weait, 'Taking the Blame: Criminal Law, Social Responsibility and the Sexual Transmission of HIV' 23 JSWFL (2001) 441; J. Chalmers, 'Criminalizing HIV Transmission' 28 *Journal of Medical Ethics* (2002) 160. For a comprehensive review of the international literature see R. Elliott, *Criminal Law and HIV/AIDS: Final Report* (Montreal: Canadian HIV/AIDS Legal Network and Canadian AIDS Society, 1997).

2 The Health Protection Agency reports that in England, Wales and Northern Ireland there was a 9 per cent rise in the rate of chlamydia infection and a 28 per cent rise in syphilis between 2002 and 2003 (http://www.hpa.org.uk/hpa/news/articles/press_releases/2004_040727_sti_inc_2003.htm). For the most recent data on the epidemiology and prevalence of HIV in England and Wales see http://www.hpa.org.uk/infections/topics_az/hiv_and_sti/epidemiology/epidemiology.htm

3 A significant number of academic discussions – primarily in the U.S. literature – make explicit the respective (dis)benefits of criminal and public health law interventions. See, for example, K.M. Sullivan and M.A. Field, 'AIDS and the Coercive Power of the State' 23 *Harvard Civil Rights-Civil Liberties Law Review* (1988) 139; L. Gostin, 'The Politics of AIDS: Compulsory State Powers, Public Health and Civil Liberties' *Ohio State Law Journal* (1989) 1017; J. Dwyer, 'Legislating AIDS Away: The Limited Role of Legal Persuasion in Minimizing the Spread of HIV' *Journal of Contemporary Health Law and Policy* (1993) 167; Z. Lazzarini et al., 'Evaluating the Impact of Criminal Laws on HIV Risk Behavior' 30 *Journal of Law, Medicine and Ethics* (2002) 239.

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inal law doctrine and potential criminal justice responses in an ethically complex yet clearly delineated context.

In *R* v *Dica*[4] the Court of Appeal has, for the first time since 1888, provided an indication of the circumstances in which those who do in fact transmit serious disease to their partners during sex will be criminalised.[5] Mohammed Dica was convicted under s 20 of the Offences Against the Person Act 1861 (OAPA 1861) for having recklessly transmitted HIV to two female sexual partners.[6] The Court held, allowing the appeal and ordering a retrial, that the trial judge had been wrong to accept the Prosecution's submission that the harm inflicted on the complainants was such that the defence of consent was unavailable. Both the original conviction and the appeal decision have provoked widespread discussion, both among academics and from those working in NGOs in the HIV/AIDS sector.[7] The purpose of this Comment is not only to provide an account of the decision but also to identify some of the wider implications of the Court of Appeal's reasoning, and to explore some of the assumptions apparent in both the judgment of Judge LJ and in the arguments of those who believe that criminalisation of reckless HIV transmission is, as a matter of principle, to be welcomed.

R v CLARENCE

Of the nineteenth century cases concerning the interpretation of the OAPA 1861 one which has remained obdurately authoritative is that of *R* v *Clarence*.[8] *Clarence* was authority for the proposition that an offence under s 20 could only be committed where there was a battery, in the sense of a direct infliction of physical force to the body of the victim. In *Clarence*, the majority of the Court for Crown Cases Reserved concluded that where the harm (infection with gonorrhoea) had occurred as the result of lawful sexual intercourse, there was no assault and therefore no offence. Despite important recent developments in the law of assault, the consequence of which was to abandon the implication that 'inflict' in s 20

4 [EWCA] Crim 1103 (05 May 2004), [2004] 3 All ER 593. For another commentary see Crim LR (2004) 944.

5 *R* v *Dica* is one of a trio of cases, albeit the only one to have gone to appeal, in which those transmitting HIV to their sexual partners have been prosecuted and convicted. In May 2004 Feston Konzani was sentenced at Teesside Crown Court to 10 years imprisonment for recklessly transmitting HIV to three female partners, and in January 2004 Kouassi Adaye was sentenced to 6 years at Liverpool Crown Court after pleading guilty to infecting one female partner.

6 S 20 of the OAPA 1861 reads: "[W]hosoever shall unlawfully and maliciously wound or inflict any grievous bodily harm upon any person, either with or without any weapon or instrument shall be guilty [of an offence]". "Inflict" simply means cause, and grievous means serious (a question of fact).

7 For academic commentary see J. Spencer 'Liability for Reckless Infection: Part 1' *NLJ* (12 March 2004) 384, 'Liability for Reckless Infection: Part 2' *NLJ* (26 March 2004) 448; J. Spencer, 'Reckless Infection in the Court of Appeal: R v Dica' *NLJ* (21 May 2004) 762; M.J. Weait, 'Dica: Knowledge, Consent and the Transmission of HIV' *NLJ* (28 May 2004) 826. For the response of HIV/AIDS organisations and the communities they serve see, for example the discussion on the UK Coalition's site at http://www.ukcoalition.org/discus/messages/327/326.html, the response of the National AIDS Trust at http://www.nat.org.uk/documents/CRIMINALISATION.OF.HIV.doc, and the concerns of the Terrence Higgins Trust at http://www.tht.org.uk/press.desk/press.pdf/tht.comment.pdf.

8 (1888) 22 QBD 23.

requires an assault,[9] *Clarence* was never expressly over-ruled. Had it been followed by the Court of Appeal in *Dica* the conviction would have been quashed and there would have been no grounds for a retrial. However, in a clear nod to prevailing political sensibilities the Court of Appeal has used *Dica* as an opportunity finally to consign *Clarence* to the dustbin. In an elaborate account of *Clarence*, Judge LJ approved the reasoning in Hawkins J's dissenting judgment and that of Lords Hope and Steyn in *R* v *Ireland; R Burstow*[10] and concluded that the trial judge had been correct in directing the jury that they could, notwithstanding the decision in *Clarence*, convict.

The conclusion that *Clarence* is no longer relevant in cases whose facts are analogous to those of *Dica* is welcome. It is, however, important to emphasise that it is a conclusion reached within the context of a case where the moral turpitude of the appellant was relatively transparent. It was therefore relatively easy for Judge LJ to hold that *Clarence* should no longer be a barrier to

> 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[11]

and, further, that

> to the extent that *Clarence* suggested that consensual sexual intercourse of itself was to be regarded as consent to the risk of consequent disease, again, it is no longer authoritative.[12]

It should be noted in particular that the first of these conclusions is relatively limited in its scope. The interpretation of *Clarence* provided by Judge LJ is not one that would necessarily deny the relevance of the case to a person ignorant of his HIV positive status (or infected with another STI), who has consensual sexual intercourse and infects his partner; nor would it necessarily be irrelevant where a person knows this and does not conceal the fact from a partner who consents to the risk of transmission (on which, see below).

CONSENT

It is because the Court recognised the critical position which consent to the risk of harm occupies in the question of the lawfulness or otherwise of potentially infective intercourse that it dedicated such attention to it, and why its decision to order a retrial was based on the trial judge's error in not allowing the question of whether there had indeed been consent to go to the jury.

The reason why this question was not raised is perfectly comprehensible. His Honour Judge Philpot had considered himself bound by the decision of the

9 *R* v *Wilson* [1984] AC 242; *R* v *Ireland* ; *R* v *Burstow* [1998] 1 Cr App R 177.
10 See n 9 above.
11 *R* v *Dica*, n 4 above, para 59.
12 *R* v *Dica*, n 4 above, para 59.

House of Lords in *R* v *Brown*,[13] that consent to bodily harm in fact does not constitute a consent recognised at law, other than in certain socially accepted and established activities which are themselves lawful.[14] Given that it was not possible to characterise HIV transmission as such an activity, the Court of Appeal had therefore to find a way of distinguishing between consent to bodily harm, and consent to the risk of such harm. It started from the proposition that the decision in *R* v *Brown*, and approach taken in other similar cases,[15] was undoubtedly correct. In Judge LJ's words:

> These authorities demonstrate that violent conduct involving the deliberate and intentional infliction of bodily harm is and remains unlawful notwithstanding that its purpose is the sexual gratification of one or both participants. Notwithstanding their sexual overtones, these cases were concerned with violent crime, and the sexual overtones did not alter the fact that both parties were consenting to the deliberate infliction of serious harm or bodily injury on one participant by the other. To date, as a matter of public policy, it has not been thought appropriate for such violent conduct to be excused merely because there is a private consensual sexual element to it. The same public policy reason would prohibit the deliberate spreading of disease, including sexual disease.[16]

It is with its emphasis on the fact that the appellants in *Brown* engaged in the deliberate infliction of injury that the Court establishes the legally relevant distinction with the facts of *Dica*. In its view, there is a fundamental difference between deliberate harming and the deliberate taking of risks that result in harm. In the context of consensual sexual intercourse, such risks are, and have always been, present – whether those be the risk of disease or the risks associated with pregnancy and childbirth.[17] To criminalise the taking of such risks, by denying the defence of consent to those who create them, would not only be impracticable in enforcement terms, but would involve an unwarranted intrusion into the pre-eminently private sphere of adult sexual relations. In sum

13 [1994] 1 AC 212. For discussions of the decision in *Brown* see N. Bamforth, 'Sado-Masochism and Consent' Crim LR (1994) 661; M.J. Weait, 'Fleshing it Out' in L. Bently and L. Flynn (eds), *Law and the Senses: Sensational Jurisprudence* (London: Pluto Press, 1996).

14 For example, surgery and organised contact sports.

15 *R* v *Boyea* [1992] 156 JPR 505 and *R* v *Emmett* (unreported, 18th June 1999). The Court did not refer to its own decision in *R* v *Wilson* (1996) 2 Cr App R 241 in which the opposite conclusion was reached.

16 *R* v *Dica*, n 4 above, para 46.

17 A recent clinical study has shown that among a population of women aged 18–34, 0.78 per cent suffered pre-eclampsia, 0.66 per cent developed a genital tract infection, 0.05 per cent experienced pulmonary embolism, 8.65 per cent underwent an emergency caesarean section and 1.46 per cent had a postpartum haemorrhage in which they lost a litre or more of blood: M. Jolly et al, 'The Risks Associated with Pregnancy in Women aged 35 years and Older' 15 *Human Reproduction* (2000) 2433. These figures compare favourably with the health risks to a woman who has sexual intercourse which carries the risk of HIV transmission. According to current clinical estimates, the risk of a woman being infected with HIV during unprotected vaginal intercourse with an infected man lies somewhere between 1:250 and 1:2000. Put another way, there is at worst a 0.4, and at best, a 0.05 risk of infection. In short, there is as much (if not greater) risk of physical harm to a woman who consents to intercourse which carries the risk of pregnancy than to one who consents to intercourse which carries the risk of HIV transmission.

> . . . interference of this kind with personal autonomy, and its level and extent, may only be made by Parliament.[18]

It follows from this line of reasoning that while the defence of consent would not be available to a person who intentionally transmitted HIV or any other serious STI to another, irrespective of that person's actual consent, it would be available as a matter of principle where a person transmitted the virus recklessly, and where it is established that his partner had consented to that risk.

Summarised in this way, the decision in *Dica* appears relatively straightforward. The Court's approach to consent does, however, raise a number of interesting and problematic questions. The first concerns whether the degree of risk associated with the Defendant's conduct is or should be relevant to the availability of the defence of consent. Although this is not addressed directly by the Court in *Dica*, it has been a relevant consideration in those cases from which *Dica* is distinguished. In *Emmett*[19] the Court of Appeal held that where the appellant set fire to his partner's breasts with lighter fuel and almost asphyxiated her, the fact that he and she were, *per* Wright J, "deeply involved in an energetic, very physical sexual relationship which both greatly enjoyed" did not mean that he should have been entitled to rely on her consent as a defence to a charge under s 47 of the OAPA 1861. In the Court's view the facts of the case were different in kind from those in *Wilson*[20] (where a husband who branded his wife's buttocks with his initials had his s 47 conviction quashed) on the basis that the degree to which Mr Emmett had exposed his partner to the risk of unintended injury was, as in *Brown*,[21] unacceptably high. While the Court of Appeal in *Dica* may not specifically address the relevance or otherwise of the degree of risk to the question of consent in cases of reckless HIV transmission, there appears to be an implicit assumption that the magnitude of the risk makes no difference. Either a person consents to the risk of transmission or they do not, and this is simply a question of fact. For reasons explained more fully below,[22] this approach is a welcome one. It would, however, have been helpful if the Court had indicated more explicitly whether, in holding that the defence of consent should be available in principle, it considered the degree of risk to be irrelevant.

The second question concerns the way in which the Court in *Dica* makes use of the cases concerning the intentional infliction of injury for the purposes of sexual or physical gratification. These provide the background and authority for the Court's analysis of the availability of the defence of consent where HIV is transmitted during consensual intercourse. Superficially at least this might make sense, and it is unsurprising that the trial judge in *Dica* was persuaded by the analogy. In both cases serious physical injury is caused, and in both cases there arise legitimate questions of public policy as to whether consent in fact should, given the context, provide a defence in law. The Court deals with the issue by concluding that there is a legally relevant difference between consent to the risk of physical injury (e.g.

18 *R* v *Dica*, n 4 above, para. 52.
19 n 15 above.
20 n 15 above.
21 *R* v *Brown* n 13 above.
22 n 26 below and accompanying text.

the risk of HIV transmission during unprotected penetrative intercourse) and consent to the inevitability of physical injury (e.g. the inevitability of burnt flesh if a branding iron is applied to a partner's skin). Even though these injuries may each correspond to the same legal definition of injury (grievous bodily harm), and even though each must in fact have been caused (rather than merely anticipated) before a charge under s 20 of the OAPA 1861 can be brought, and even though each may have occurred in the context of sex, the fact that HIV or STI transmission is represented as somehow incidental to the physical contact between the partners, and burning flesh as integral to it, justifies a different legal response. One reason for this analytical differentiation may be the fact that in cases of reckless transmission (as in *Dica*) there is no intention to bring about the effect that is in fact produced, whereas in cases of injury to which consent is given in the context of sado-masochistic sex that intention exists. However, if this were the correct analytical distinction, the availability of the defence of consent would depend not on the degree of injury caused (as was established in *Brown*) but on the presence or absence of an intention to cause it (a proposition for which there is no authority). Alternatively, the distinction, and hence the availability of the defence, might be thought to rest on the nature of the relationship between the injurious conduct and the harm such conduct produces. Thus, consent might be unavailable in cases of sado-masochistic injury because there is a temporal and physical immediacy between the conduct to which the person injured consents and the harm caused by the injury, whereas in cases of reckless HIV transmission there may be a significant delay before the infection is experienced as harm by the person infected. However, if this were the basis for the distinction it would suggest that criminal liability for non-fatal offences against the person depends on the felt experience, rather than the empirical fact, of injury (e.g. being conscious of the pain caused by a wound rather than simply having been wounded); and this is simply not the case.[23] It is suggested that a more compelling rationale for the distinction may be that just as the appellants in *Brown* were denied the defence of consent on grounds of public policy, so public policy justifies a different legal response to conduct which, at the relevant time, carries the risk of injury from that in which injury is a more or less foregone conclusion.

KNOWLEDGE

Although the Court of Appeal stated that the consent of the person infected was the critical issue when determining the liability of a Defendant who recklessly transmitted HIV, it was also profoundly exercised by the relevance or otherwise of the knowledge which the person infected had of their sexual partner's HIV positive status at the relevant time. This stemmed in part from the fact that *Clarence*, which formed the background context for the Court's reasoning, concerned an appellant who had concealed the fact of his gonorrhoea infection from his wife and because the women whom Dica had infected alleged that they too

23 A person who wounded someone in a coma would not be absolved of liability simply because that person did not (and might never) experience the pain which a conscious person would have felt.

were ignorant of his condition. Because the jury in Dica's trial had been denied the opportunity to consider the question of consent, the truth or otherwise of the complainants' allegation had not been explored. The Court of Appeal had therefore to determine whether such knowledge would, and should, make a difference given that the issue would be addressed in Dica's retrial, and in any other future case involving analogous facts.

In the Court's view, knowledge was not the principal consideration in determining the availability of consent as a defence. This must surely be right. If it were the decisive factor, its only possible relevance could be to allow the defence where there was proof that the person infected was aware of their partner's HIV positive status prior to intercourse, and to deny it where they were not. To reason thus would effectively result in the conclusion the Court sought to avoid – that an HIV positive person who has unprotected sexual intercourse with a partner who is unaware of this fact has committed rape. It was for this reason that the Court, while recognising that knowledge and consent are 'inevitably linked', chose instead to focus on the presence or absence of consent to the risk of harm.

This would not be a problem, but for the narrow way in which knowledge is understood in Judge LJ's judgment, and the way in which it is related there to the question of consent. This is because it is stated (a) that it is 'unlikely' that a person would consent to the risk of a major consequent illness were they to be ignorant of that risk, and (b) that there could be a successful prosecution where a person who knew that he was HIV positive, recklessly transmitted HIV to a partner during sexual intercourse where "the risk is concealed" and where a partner is not consenting to it (i.e. the risk).

These two assertions are, it is suggested, of critical importance to an understanding of the wider implications of *Dica*. As for (a), it may be true that a person is unlikely to consent to the risk of contracting a serious illness if they are unaware of that risk. Indeed, it is not an abuse of language to suggest that a person who is ignorant of a risk can never properly be said to consent to it (this is, after all, the underlying principle of informed consent). As for (b), this adds little to (a) other than to imply that concealment of known HIV positive status in some way renders consent even less probable. The difficulty lies not in the statements themselves, but in the implicit assumption that the relevant source of knowledge for the person who must give consent is the person who may transmit HIV to them, and that if such a person fails to disclose this information then the likelihood of consent being established is significantly reduced.

The fact is that knowledge of the risk of transmission may have a number of different sources, of which disclosure by an HIV positive partner is but one. For example, a person may know that her partner is HIV positive despite his concealment (having seen a hospital letter to this effect, for example).[24] In both of these

24 In an unfortunate use of the passive voice, the judgment indicates that a person may be convicted for infecting a person 'from whom the risk is concealed'. If this is interpreted as 'from whom *he* has concealed the risk', then the fact that she knows his HIV positive status would not preclude a conviction. This would be a decidedly odd interpretation, since in these circumstances she would still be knowingly consenting to the risk of transmission. It is therefore suggested a conviction on these facts would be wrong in law.

situations the person consenting to the risk of transmission knows of their partner's HIV positive status as fact. But there are other ways of thinking about both facts and knowledge, and about risk in respect of these. For example, a person to whom HIV is transmitted may know that there was a possibility that her partner was HIV positive at the relevant time. She may know for a fact that one of his previous sexual partners is HIV positive, or that he was sexually active with a number of people and did not practise safer sex (or may not have done so), or that he belongs to a group with a higher prevalence of HIV infection than exists in the general population.[25] Or she may recognise that, in the absence of conclusive proof to the contrary, there is always a *risk* that a partner may be HIV positive (or be infected with an STI). Would her partner be able to avail himself of the defence of consent where knowledge was of this kind? According to *Dica*, the answer depends not on knowledge, but on consent to the risk of infection. It is submitted that where a person consents to sexual intercourse with knowledge of these facts, and becomes infected, the defence should be available because in each of these cases that person aware of the risk of transmission. They may be ignorant of a partner's HIV positive status in the sense that this has not been disclosed to them by him, but to deny the defence if there is in fact knowledge of the risk, and a willingness to accept it, would be tantamount to saying that the person infected bears no responsibility for their own sexual and physical health.[26]

This argument, and the conclusion to which it leads, is not an easy one to make, and – where I have made it elsewhere – has been called 'astonishing'.[27] It is certainly an argument that demands a radical shift in the way we think about responsibility in this area of criminal law.[28] However, it is not, it should be emphasised, an argument which seeks to deny the moral turpitude of those who fail to provide their sexual partners with information which may enable them to make better informed decisions about the kind of sex they are willing to have. In an ideal world we would be sure that our partners will always be open, honest and

25 For example, men from sub-Saharan Africa, or intravenous drug users.

26 Although there is room for disagreement here, I would maintain that this conclusion should apply both where the person infected believes the risk of their partner being infected to be low and where they believe it to be high. In part this is because a person is either HIV positive or they are not, and partly because HIV may be transmitted during one incident of low risk activity or not transmitted during a number of incidents of high risk activity. Thus, a person who consents to sex which carries the risk of transmission on the basis that they know or believe their partner to have engaged in a limited number of low risk activities may in fact be putting themselves as at much risk on the relevant occasion as a person who consents to such sex with a person who they know or believe to have engaged in a large number of high risk activities. To argue and conclude otherwise would amount to accepting (a) that the individual and social responsibility of a person who knowingly risks infection by having unprotected sex, and is in fact infected, should be contingent on immanently unreliable predictive assessments of risk by them; and (b) that the criminal liability of their partner should somehow depend on whether their partner's risk-taking was justifiable on this basis or not. Neither of these are conclusions I can accept, or ones which I think the law should sanction.

27 J. Spencer ,'Liability for Reckless Infection: Part 2', n 7 above.

28 In particular, it is an argument that requires us to think critically about how we conceptualise and allocate blame. The classic formulation of criminal liability where blame + harm (in the absence of a defence) = liability depends on an individualist, rather than a shared, notion of fault that is dependent (where liability is grounded in the bringing about of harm) on treating causation – and therefore responsibility – as unidirectional. I make the argument more fully in an earlier article (see M.J.Weait, n 1 above).

frank. But we do not, nor are likely ever to, live in that world. Furthermore, if we are to treat the transmission of HIV and STIs as first and foremost a public health issue (as I, and many national and international HIV/AIDS organisations,[29] believe), then it is not inconsistent, absurd, or – indeed – astonishing, to suggest that the criminal law acknowledge, so far as is possible within current legislative provisions and judicial interpretation of them, both individual and shared responsibility for health. To punish the person who infects another, where that other is in a position to avoid infection and elects to run the risk, simply serves to reinforce the predominant view that HIV/AIDS is someone else's problem; and if the decision in *Dica* has this effect it will have done all of us a great disservice.

RECKLESSNESS

If the way in which the knowledge of the person infected is problematic, the knowledge of the person who transmits HIV is no less so. Mohammed Dica was charged with, and convicted under, section 20 of the OAPA 1861. The *mens rea* requirement of this section is subjective recklessness – advertent, unjustified, risk-taking. In the specific context of section 20, the prosecution is obliged to establish that, at the time of the commission of the *actus reus* (the infliction of grievous bodily harm), the defendant was aware of the risk of causing some degree of bodily harm, albeit not of the gravity which in fact resulted.[30] On the basis of the facts before them the trial jury were evidently satisfied that Dica, who knew of his HIV positive status, must have been aware of the risk of transmitting the virus through unprotected sexual intercourse. This much is unremarkable. It is, however, important to reflect on the wider implications of the use of recklessness in cases where HIV or other STIs are transmitted during sex and, in particular, on the way in which recklessness is understood by the courts in such contexts.

In its 1993 Report on the reform of offences against the person,[31] the Law Commission concluded that its proposed new offences of intentional and reckless serious injury, and intentional or reckless injury, could and should be used in appropriate cases of disease transmission.[32] It further concluded that the wide scope of such liability could be effectively tempered by the judicious use of prosecutorial discretion, such that only the most serious incidences of transmission would be proceeded against. These proposals did not meet unqualified Government approval. In its 1998 consultation document,[33] the Home Office rejected the Commission's suggestion that the transmission of normally minor illnesses should be criminalised, despite the fact that the vulnerability or predispositions of some people might result in their being more seriously affected than others.[34] It also rejected the suggestion that those who transmit a serious disease (such as

29 See, for example, UNAIDS, *Criminal Law, Public Health and HIV Transmission: A Policy Options Paper*, (UNAIDS: Geneva, 2002).
30 *R* v *Savage; R* v *Parmenter* [1992] 1 AC 699.
31 *Offences Against the Person and General Principles* (Law Com No 218 1993).
32 Law Com No 218, n 31 above, paras 15.15–15.17.
33 *Violence: Reforming the Offences Against the Person Act 1861* (Home Office 1998).
34 Home Office 1998, n 33 above, para 3.15.

HIV) should be criminalised unless such transmission was intentional.[35] It was the Government's view that such an approach struck a sensible balance between ensuring that those who deliberately perpetrated 'evil acts' could be punished, while at the same time precluding the prosecution and conviction of those who infected others unintentionally or recklessly. More importantly, the Government believed (presumably on the basis of legal advice) that its approach was 'close to the effect of the present law', despite the acknowledged absence of recent definitive decisions in the area.

The fact that Mohammed Dica was not charged under section 18 of the OAPA 1861, and that it was never alleged that he had sought deliberately to infect his partners, graphically demonstrates that the Government's belief was without foundation. Furthermore, its failure to legislate its proposals has allowed the Crown Prosecution Service to pursue a prosecution policy at odds with the preferred Home Office approach. When René Barclay[36] stated of *Dica* that

> This was a ground-breaking prosecution, which was the result of a massive team effort. The implications are that in the future people who are reckless in this way will be vigorously prosecuted[37]

he expressed in categorical terms a willingness to use the OAPA 1861 in a way that, perfectly legitimately, ignores the principles set out in the Home Office consultation; for this, the Government has only itself to blame.

These observations would constitute no more than an interesting aside if it were universally accepted that the meaning of recklessness should be narrowly interpreted, and one could be sure that s 20 would be charged only in respect of the most egregious behaviour;[38] but neither of these is the case. The essence of recklessness is unjustified risk-taking by a person who has the capacity to recognise the relevant risk and in fact recognises it at the relevant time. For the purposes of this discussion I assume that risk-taking with respect to HIV transmission will, in most instances, be unjustifiable and so I concentrate here on risk-awareness. The critical question in this context is whether the person who in fact transmits the virus must know that he is HIV positive before he can be held to have been reckless. In *Dica* the question was not explicitly addressed because the appellant was aware of his status. However, Judge LJ indicated, that the effect of the judgment

> . . . 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 . . .[39] [my emphasis]

This passage is extremely important, given that it appears to approve a narrower approach to the question of recklessness than that suggested by Professor John

35 Home Office 1998, n 33 above, paras 3.17–3.18.
36 CPS Director of Serious Casework, London Area.
37 http://www.cps.gov.uk/news/pressreleases/archive/131_03.html
38 For example, where a person knows his HIV positive status and lies about it.
39 *R* v *Dica*, n 4 above, para 59.

Spencer in an article published immediately before the appeal was heard. In that article, Spencer had said 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.[40] [my emphasis]

In Spencer's view, recklessness exists not only where a person is aware that they are HIV positive (or infected with another serious STI), but where they are aware that they may be. Had the Court of Appeal accepted what it acknowledged as Spencer's "illuminating conclusion", a person who had ever had unprotected sex with a person of whose HIV or other health status they were unsure, and who had not established that they were free of infection prior to unprotected sex with a new partner, would presumably be reckless for the purposes of s 20 if they in fact transmitted serious disease and the consent of that new partner could not be established. This would result in the imposition of such novel and significant positive obligations on sexually active people, that the Court's rejection of such an approach is to be welcomed.[41] Its rejection should also be emphasised, given that in his commentary on the appeal case Spencer, who welcomed it as striking an "appropriate balance", said that it

> means that criminal liability arises where one partner, knowing that he is infected *or he may be*, fails to take precautions and infects a trusting partner who is unaware of it.[42] [my emphasis]

With respect, this is not what the Court held. In this context a subjective approach to recklessness must mean an awareness of the risk of causing some degree of bodily harm, for which a necessary condition is a person's actual knowledge of their HIV positive status, or of their infection with an STI.[43]

40 J. Spencer, 'Liability for Reckless Infection: Part 2', n 7 above.

41 In this context it is worth noting that in the most comprehensive recent UK survey, less than half of men (45.9 per cent), and just over one-third of women (36.7 per cent) who had started a new sexual relationship in the four weeks prior to being interviewed had used a condom during sex: B. Erens *et al.*, *National Survey of Sexual Attitudes and Lifestyles II: Reference Tables and Summary Report* (London: National Centre for Social Research, 2003).

42 J. Spencer, 'Reckless Infection in the Court of Appeal . . .' n 7 above. It should also be noted that Lord Templeman, when upholding the conviction of the appellants in *Brown*, stated that the sterilization of the instruments used "could not have removed the danger of infection, and the assertion that care was taken demontrates the possibility of infection" (*R* v *Brown* [1994] AC 212 at 220). It is therefore optimistic to assume that the taking of precautions against infection would necessarily be treated as something negating recklessness on the part of the Defendant – on the contrary, it may provide evidence of it.

43 There is obviously room for legitimate disagreement here. It is possible to argue that a person who is aware that they may be HIV positive (and is) should be treated as reckless if they engage in conduct which carries the risk of transmission, and it does result in transmission; but such an approach would result in the criminalisation of all those transmitting HIV who are aware that they have at some time engaged in conduct which itself carried the risk of transmission and who have

KINDS OF RELATIONSHIP

There is one final matter which needs to be addressed. In drawing it's conclusion that consent rather than knowledge was the critical issue in cases of disease transmission under s 20, the Court of Appeal paid some attention to the differing kinds of relationship which those who infect, and are infected, have with each other. In its words

> At one extreme there is casual sex between complete strangers, sometimes protected, sometimes not, when the attendant risks are known to be higher, and at the other, there is sexual intercourse between couples in a long-term and loving, and trusting relationship, which may from time to time also carry risks.[44]

As for the former, the Court said that this was 'self-explanatory and needs no amplification', which may be interpreted to mean that in such contexts people are in fact, or ought to be, more aware of the risks associated with sex. As for the latter, the Court posited the example of the Roman Catholic couple who are conscientiously prevented form using condoms and where the husband is HIV positive, and the couple who wish to conceive a child and are advised that a pregnancy may result in adverse consequences for the mother's health. It is because in neither of these latter cases could the Court countenance the imposition of criminal liability on the man who is aware of the risks to his partner's health and does in fact cause her harm that it was obliged to assert that

> These, and similar risks, have always been taken by adults consenting to sexual intercourse. Different situations, no less potentially fraught, have to be addressed by them. Modern society has not thought to criminalise those who have willingly accepted the risks, and we know of no cases where one or other of the consenting adults has been prosecuted, let alone convicted, for the consequences of doing so.[45]

The Court must surely be right in concluding that the kind of relationship those who are infected have with their partner is irrelevant to the question of liability, correct in its observations about the ubiquity of risk-taking by couples, and applauded for affirming the lack of contemporary will to punish such risk-taking. To have concluded otherwise would have resulted in juries convicting people of serious offences on the basis of an evaluation of the partners' relationship – a decision fraught with difficulties, especially where that relationship does not fit within established or traditional categories (the long-term, non-monogamous, homosexual or heterosexual relationship, for example), where transmission

not established their HIV positive status. Such a person would only avoid liability if they were able to establish the consent of a partner – a precondition for which would, presumably, be disclosing their own uncertainty. It is therefore an approach which would, by implication, impose a duty of disclosure of some kind on all people who engage in unprotected sex and who are not categorically sure of their own freedom from infection, as well as an obligation to establish consent to the risk of transmission if that were denied. While this may be a preferred option for some, such a significant shift is surely a matter for Parliament.

44 *R* v *Dica*, n 4 above, para 47.

45 *R* v *Dica*, n 4 above, para 50.

occurred during a casual relationship which subsequently became committed, or where the partners had differing perceptions about the seriousness of the relationship at the relevant time.

The irrelevance of relationship type, though acknowledged, needs to be emphasised because it may be all too easy for a jury when confronted with the question of whether there was in fact consent to the risk of transmission to base their conclusion on an evaluation of what they think it would be reasonable for one partner to expect from another given the kind of relationship they had (or believed they had). This is so because of the Court's suggestion that concealment of known HIV positive status is relevant and its observation that

> unless you are prepared to take whatever risk of sexually transmitted infection there may be, it is unlikely that you would consent to a risk of major consequent illness if you were ignorant of it.[46]

It is not inconceivable that a jury would consider that a person infected by a partner within the context of what that person believes to be a sexually monogamous marriage or long-term committed relationship, should be entitled to assume an absence of risk unless there is disclosure to the contrary by that partner, whereas this would not be so where the relationship was a casual one, or where sex is paid for. If this is no idle hypothesis, it would mean that husbands who infect their wives, or men who infect male or female partners to whom they have explicitly or impliedly represented their sexual fidelity, are extremely unlikely to be able to convince a jury that there was consent to the risk of infection.

This may, of course, reflect contemporary expectations about appropriate relationship behaviour; and it may well be that in many such cases there has been an absence of consent. However, if consent and knowledge are inextricably linked, as the Court of Appeal recognises, and it is established that a wife, husband or other long term partner is aware of the risk of infection because of knowledge about the lifestyle or past of their spouse or partner, then it is at least arguable that such consent exists despite any representations that may have been made to them.

CONCLUSION

Much of the difficulty in *Dica* stems from the fact that he was charged and convicted under s 20 of the OAPA 1861. This is not a provision that was designed to deal with the transmission of disease, let alone the complexities associated with the transmission of disease in the context of intimate sexual relations. The very fact that the critical issue has been identified as consent, which is not included as an element of the offence, demonstrates this. In the absence of any clear legislative strategy or political will to address the deficiencies of the law in this area people

46 *R* v *Dica*, n 4 above, para 59.

who infect others will continue to be prosecuted selectively[47] and convicted on the basis of inevitably subjective evaluations by juries about whether the relationship they had with their partner was one in which consent to the risk of infection was likely. The potential for discrimination against certain categories of people – the Black African refugee, the gay or bisexual man, the IV drug user – will also remain unless some definite action is taken, and soon.[48] People who infect others with serious diseases they know they have may lack any moral capital; but the same charge may be leveled at a legal framework which fails adequately to acknowledge our shared responsibility for reducing the incidence and spread of HIV and STIs, and which reinforces social stigma against those who, though they may have infected others, are also people who have themselves been infected.

47 Although, in principle, any person who recklessly transmits HIV or an STI resulting in actual or grievous bodily harm may be prosecuted, it is a matter of record that the only people so far prosecuted and convicted in England and Wales have been men of black African origin who have transmitted HIV to their partners.

48 See, generally, T. de Bruyn, *HIV/AIDS and Discrimination: A Discussion Paper* (Montréal: Canadian HIV/AIDS Legal Network, 1998).