Faculty of Forensic & Legal Medicine

Frequently Asked Questions (FAQs) on Police Requests for Tests from Detainees in Custody for Sexually Transmitted Infections

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Introduction

The FFLM have previously published a position statement on this topic, which, on the publication of this document, has been archived.

On rare occasions, the presence (or absence) of a sexually transmitted infection (STI) may be relevant in the investigation of a crime; examples of this might be:

- Alleged reckless transmission of an infection e.g., human immune-deficiency virus (HIV)[1,2]
- The presence of an STI in a child which may support an allegation of sexual assault[3]
- The acquisition of an STI following an alleged rape, where the complainant/complainer has never had sexual intercourse before, or not in the orifice where the infection has been found.[4]

Questions

1. **I am a healthcare professional, (HCP), based in the local constabulary's custody suite. I am trained to take intimate samples, e.g., penile swabs from a detainee arrested for an alleged rape. I have also been asked to take samples for gonorrhoea from the detainee, are they the same sort of sample?**

   No, the samples are different. These are clinical samples, which must be sent to a clinical pathology laboratory, to undergo microbiology for gonorrhoea (but in other circumstances, samples may be for virology tests), using defined and accredited standard operating procedures (SOPs) and processes.

   They must be the most appropriate clinical sample, taken by a trained and competent clinician, and the sample must be sent to a suitable laboratory, using a chain of evidence protocol.[5]

   Specialist laboratories exist for this type of testing and not all laboratories will be able to provide such a service. Moreover, the results require interpretation by a specialist clinician, usually of consultant level, in relation to their significance, if any, which in turn would influence their potential use in criminal justice proceedings.

   Furthermore, when taking a sample, the clinician retains their therapeutic role, so would need to ensure they can notify the person from whom the sample was taken, with the result and provide advice and/or onward referral for treatment, if necessary.

2. **So if I can't take these samples, who can/will?**

   As noted above, it must be a suitably trained and competent clinician.

   The FFLM recommend that each constabulary makes an arrangement, for example, a service level agreement, (SLA) with a local Genito-Urinary Medicine, (GUM) or sexual health clinic and an accredited microbiology and virology laboratory/laboratories, who have chain of evidence protocols in place and suitably knowledgeable and competent senior clinicians to interpret the findings. The clinic and the laboratory may or may not be in the same hospital.

   When a detainee is required to have samples taken as part of a criminal investigation, this would be discussed with the clinicians in the clinic and the laboratory. An appointment would be made for the detainee to attend the clinic and have samples taken, with an explanation by the clinician:

   - To obtain properly informed consent, which will include addressing confidentiality issues.
   - To make arrangement for giving the results of STI tests, which are usually confidential. As well as the medico-legal aspects, the detainee, at this point is also a patient of the clinic and needs to be fully aware of this process.[6] The clinician will also take-responsibility for informing both the patient and the police of the result(s).
   - It is essential to appreciate the patient might require treatment and contact tracing of other partners may need to be considered, from a public health perspective.

3. **It is a bank holiday weekend, and the Inspector says the 'custody clock' is running out and so they want me to take the sample, before they must release the detainee. I have been told I must do it and I've not been able to speak to the senior doctor in the service for advice.**

   All clinicians are required to work within their scope of practice and competency. Unless you also happen to work in a GUM/sexual health clinic and are up to date with all their SOPs and protocols, and you can manage the results of such tests, you would be working outside your scope of practice, and this is not ethical and could put you at risk in terms of your professional registration.

   Furthermore, you are unlikely to have the appropriate swabs or blood bottles for preservation and appropriate transport of such samples to the laboratory.

   It is for these reasons the FFLM recommend that there should be an SLA as described above so that such situations do not arise and these samples, which have the potential to be important evidence, are taken in such a way that they are not compromised.

4. **I've been asked to take blood from someone who has been arrested under the Offences Against the Person Act, 1861 for reckless transmission of HIV. I've got a forensic kit to take blood, so it's OK for me to do this, isn't it? After all, I take blood all the time e.g. in relation to offences in the Road Traffic Act.**

   All the forgoing comments apply. The blood kits available in custody are for forensic purposes and may not have a suitable preservative in the specimen bottle.

   A suitable clinical laboratory with chain of evidence procedures already in-place is required.

   The detainee requires a pre-test discussion/counselling along with an explanation of how the results may be used, to be able to consent.

5. **I've been asked to see a detainee who was been arrested for rape and he told the police he has a painful rash. The police think it is herpes and want me to have 'a quick look' to diagnose it and then do a test in case the detainee can be charged with reckless transmission. What should I do?**

   You will know whether you have the competence to obtain a history and examine the detainee, assuming he consents to this, (as opposed to you having a 'quick look') and then offer a clinical opinion on what the rash may be. If you do not have the competence, then you should not. Either way, you will not have the appropriate swabs, nor be able to provide appropriate follow up care for the detainee.

   You can of course advise him to seek advice from his GP or a sexual health clinic once he is released. It is advisable to seek advice from the senior doctor on duty.

   In England and Wales, there would have to be an individual who had made a complaint of acquisition of HSV, and that the detainee is responsible for the police to be investigating this under section 20 of the Offences Against the Person Act, (OPA) 1861.

6. **I work in two different custody suites: one is in Scotland and one a little further South in Northeast England. What might I need to know about the law relating to reckless transmission?**

   In general, you might wish to be aware of differences in law, but any charging decisions are the responsibility of the Crown Prosecution Service (CPS) in England and Wales and the Crown Office and Procurator Fiscal Service (COPFS) in Scotland.

   The approach to charging in Northern Ireland is similar to that in England and Wales and is the responsibility of Public Prosecution Service of Northern Ireland (PPSNI).

   Please see the 'further reading section'.

7. **The police have asked me for advice - if person A has, say gonorrhoea, or chlamydia, and they are alleged to have raped person B, and person B gets gonorrhoea, or chlamydia, does that help prove the rape? Do tests need to be done to prove they have the same infection?**

   As described above, this needs an expert clinical opinion (in the field of GUM) and it is not simply a matter of the presence or absence of a particular infection.

   Sometimes tests can be done to show the infection is of the same or different subtype or serovar.

   The FFLM advises the police should refer to their SLA and seek advice from the GUM/SH clinicians and the laboratory as to what investigations may be appropriate; it is likely that expert evidence would be needed to inform a charging decision and for the presentation of that evidence in Court.

References

1. Phillips M, Poulton M. HIV transmission, the Law and the work of the Clinical Team. 2013. British HIV Association (BHIVA)
   Reckless HIV transmission FINAL January 2013 (bhiva.org)
2. Terence Higgins Trust. Legal Issues
   Legal issues | Terrence Higgins Trust (tht.org.uk)
3. British Association of Sexual Health and HIV (BASHH)
   BASHH National Guideline on the Management of Sexually Transmitted Infections and Related Conditions in Children and Young People (2021)
4. British Association of Sexual Health and HIV (BASHH)
   UK National Guidelines on the Management of Adult and Adolescent Complainants of Sexual Assault 2011 (bashhguidelines.org)
5. Institute of Biomedical Science (IBMS) and the Royal College of Pathologists (RCPath)
   Guidance for handling medicolegal specimens and preserving the chain of evidence (2017) (ibms.org)
6. Faculty of Sexual and Reproductive Healthcare, (FSRH)
   Service Standards for Confidentiality in Sexual and Reproductive Health Services (2020)

Further Reading

- The Crown Prosecution Service (CPS) have published guidance on Intentional or Reckless transmission of Sexually Transmitted Infection.
  Intentional or Reckless Sexual Transmission of Infection | The Crown Prosecution Service (cps.gov.uk)
- The Crown Office and Procurator Fiscal Service (COPFS) has published guidance on the Intentional or reckless sexual transmission of, or exposure to, infection. This was last updated in January 2022
  Prosecution policy on the sexual transmission of infection | COPFS
- R v Golding (2014) EWCA Crim 889
  Golding, R v [2014] EWCA Crim 889 (08 May 2014) (bailii.org)
- R v Dica (2004) EWCA Crim 1103
  Dica, R. v [2004] EWCA Crim 1103 (05 May 2004) (bailii.org)

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Send any feedback and comments to forensic.medicine@fflm.ac.uk