



HIV, Crime and the Law in Australia: Options for Policy Reform – a law reform advocacy kit

Prepared by Sally Cameron¹

for the Australian Federation of AIDS Organisations



Introduction

Recent Australian cases involving public health, civil and criminal law have renewed interest in the intersection of HIV and the law, particularly those laws that impact upon non-commercial, consensual sex. During 2011, AFAO will be working with its Member Organisations and other partners to roll out a project targeting the nexus between these laws and HIV. This background paper is intended to inform development of that project and other related advocacy.

This resource is divided into two sections: **part one is a discussion paper** outlining the operation and effect of Australian public health law, criminal law and civil law in relation to HIV-related prosecutions. **Part two, beginning on page 14, is an advocacy kit** designed to assist organisations and individuals considering options for policy advocacy around these issues.

Australia's response to HIV: the legal framework

Australia's HIV response is based on a public health framework informed by human rights protections. Shared by governments, the health sector and community organisations alike, the fundamental precepts are that:

- All people must take responsibility for preventing HIV transmission: both those living with HIV and those who are not HIV-positive;
- It is vital to maximise engagement by those most at risk of acquiring HIV and those living with HIV through the creation of an enabling legal and policy environment. This requires strong privacy protections, efforts to minimise stigma and discrimination, and mechanisms to ensure the meaningful participation of people living with HIV and affected communities;
- Research and analysis provides the evidence to maximise opportunities for HIV prevention, so that the HIV response is evidence-based;
- Peer education and support is frequently the most effective means of engaging with communities affected by HIV. Consequently, governments have funded groups of gay men, sex workers, injecting drug users and people living with HIV to organise to develop prevention and support strategies;

- Innovative prevention strategies may be required, for example, the installation of condom vending machines, needle and syringe programs, and campaigns that mention drugs and sex and which may include explicit language and imagery; and
- Initiatives must be adequately resourced.

The Australian HIV response embodies a bold departure from public health responses to other epidemics, reflecting the significant involvement of affected communities and efforts to avoid punitive responses to transmission and infection. Public health agencies and policy-makers have focused on the protection of public health through HIV prevention strategies targeted at people in affected communities, while individual health-based interventions are delivered by medical and other healthcare practitioners. Supporting legislation, policies and guidelines based on a sound understanding of the complex and often subtle nature of the inter-relationships between criminal law, public health measures, and prevention, care and support strategies have been crucial to the success of the HIV response.

Following the first AIDS diagnosis in Australia in 1982, law reform advocates and legislators were quick to recognise potential legal issues associated with HIV transmission and exposure. Governments and HIV community-based agencies funded legal projects and working parties to inform the development of supportive legal frameworks to enable HIV

prevention, care and support strategies. A range of privacy protections was introduced, including those covering health records of patients' HIV status. Legislation made it unlawful to discriminate on the grounds of actual or presumed HIV status in areas such as employment, accommodation, education and access to services. Public health laws and guidelines were developed and, following the advice of the Australian *Intergovernmental Committee on AIDS Legal Working Party, Final Report*², state and territory criminal laws generally excluded specific reference to HIV. Although not all these Commonwealth and state/territory laws are ideal or ideally implemented, they generally provide a strong framework to support the broad HIV response.

Media interest in HIV over the years has waxed and waned; recent cases involving criminal charges for HIV exposure or transmission have sparked renewed media interest in HIV. That coverage has triggered increased interest among community and legal advocates about the impact of these cases on people living with HIV. The issues involved are complex, requiring careful analysis and the need to confront whether priority should be accorded to law reform which superficially affects only a small number of people.

Arguably, the experiences of the few people directly affected by the 30 Australian criminal trials to date pale in significance compared with other issues faced daily by the more than 20,000 HIV-positive people living in Australia today. However, the experiences of those involved in criminal matters - accused, witnesses, their families and friends - can be extreme and the apparent arbitrariness of some of the decisions to prosecute is cause for concern. Moreover, criminal and civil trials have dominated Australian reporting of HIV-related issues over the last few years, and in the absence of other mainstream HIV public health campaigns since the 1987 'grim reaper' ads, reports of these cases represent

continued overleaf

the only HIV-related messages many outside affected communities hear. Those messages are frequently accusatory and vitriolic, and they significantly impact those living with HIV.

This paper reviews the intersection of public health, criminal and civil law regarding HIV. Conduct that involves HIV transmission, exposure to the risk of HIV transmission, or non-disclosure of HIV status to sexual partners is subject to the concurrent operation of these three areas of law. The recent increase in criminal prosecutions for HIV exposure and transmission and the findings of the first Australian civil case for HIV transmission have the potential to adversely reshape the Australian response to HIV. An innovative, sophisticated coalition response is required.

1. PUBLIC HEALTH LAW

The basic need for widespread education and enlightenment that lay at the heart of the endeavours to promote safer sexual and other behaviour ... emphasised self-empowerment and mutual responsibility. The epidemic has taught, particularly sexual minorities, that it was not good enough, or safe enough, to blame others for the transmission of the virus. If transmission were to be reduced, it was essential for each and every person, particularly those at special risk, to be familiar with the risks; to be acquainted with the risky modes of transmission; and to take personal responsibility to ensure that precautions were taken aimed at elimination or minimising the chances of transmission.³

— Michael Kirby, 2009

Every Australian jurisdiction (i.e., every state and territory) has legislation designed to protect public health. That legislation is also supported by formal policy directives and guidelines on particular aspects of HIV information/case management.

HIV is a notifiable disease in all states and territories, providing a mechanism for doctors to mandatorily report de-identified HIV diagnoses. Medical records remain confidential, and laboratories and state, territory and national databases (maintained by Departments of Health and the National Centre in HIV Epidemiology and Clinical Research [NCHECR]) are given coded information regarding each HIV diagnosis and related data (such as age, location, mode of transmission) but not the identity of the individual concerned. It is also possible for individuals who do not wish to disclose their name, Individual Healthcare Identifier (assigned under Australia's electronic health information system), or Medicare number to have 'anonymous' HIV testing. The

notification system protects privacy, while facilitating national data collection and its subsequent analysis by epidemiologists, public health departments, and medical and social researchers.

Each jurisdiction except the Northern Territory has specific laws relating to individuals' obligations to prevent HIV transmission, and to health professionals' obligations when treating a person with HIV (for a summary see *Guide to Australian HIV Laws and Policies for Healthcare Professionals: Public Health Offences*). Although there are some similarities across jurisdictions, there is no uniformity of public health laws relating to persons' obligations to prevent HIV exposure or transmission (see **Table 1**, opposite).

Responsibilities of health professionals post-diagnosis

In the vast majority of cases, issues around minimising the possibility of HIV infection are dealt with by a person's treating doctor, HIV specialist physician, or associated healthcare professionals. The *National HIV Testing Policy*¹ clearly states that following an HIV-positive test result, clinicians should provide information and support about engaging in safe behaviours, and discuss with their patient whom they should tell and how, including information around the person's rights and obligations regarding disclosure.

Additional to the *National HIV Testing Policy* guidelines, four jurisdictions have specific laws or guidelines outlining healthcare providers' obligations at the time of informing a person of an HIV-positive test result. Those obligations include:

- **ACT:** The doctor or nurse must provide information about how to prevent transmission and, if the patient agrees, make reasonable arrangements for the patient to receive counselling (*Public Health Act 1997*, section 102);
- **NSW:** The medical practitioner is required to provide information on means of minimising the risk of transmission, public health implications, obligation to disclose HIV status prior to sex (*Public Health Act 1991*, section 12, and *Public Health (General) Regulation 2002*, part 2, clause 5);
- **Northern Territory:** The doctor must explain the nature of HIV and the measures necessary to prevent the spread of HIV (*Notifiable Diseases Act 1999*, section 10); and
- **Tasmania:** The doctor must provide information about prevention of HIV transmission, and must provide or arrange for the person to receive counselling and information appropriate

to HIV (*Public Health Act*, section 50, and *Guidelines for Notification of Notifiable Diseases, Human Pathogenic Organisms and Contaminants* – 15.2).

Management of people who may place other at risk

Each jurisdiction has a prescribed process in place through which individuals considered at risk of endangering others may be referred to health authorities. In rare instances, a doctor may ask for assistance from expert health department staff. Although these systems differ, each jurisdiction's guidelines are intended to be consistent with the *National Guidelines for the Management of People with HIV Who Place Others at Risk*. The National Guidelines established the important principle that measures which are least restrictive of individual liberties should be applied first when addressing behaviour that place others at risk of HIV. The guidelines recommend prosecution only as a last resort. There is a risk that this principle is being undermined by the recent increase in prosecutions under criminal laws at the state and territory level.

State and territory guidelines for managing people who put others at risk are available at:

- ACT** *Management of People With HIV Infection Who Knowingly Risk Infecting Others;*
- NSW** *Management of People with HIV Infection Who Risk Infecting Others;*
- NT** *Guidelines for the management of people with infectious diseases who put other people at risk of infection;*
- QLD** *Protocol for the Management of People with HIV who Place Others at Risk, August 2008;*
- SA** *Code for the Case Management of Behaviours that Present a Risk for HIV Infection;*
- TAS** Tasmania does not have comparable guidelines. Instead, relevant sections are listed under sections 20 to 23 of the *Public Health Act 1997*;
- VIC** *Guidelines for the management of people living with HIV who put others at risk; and*
- WA** *HIV Case Management: A program for individuals with HIV infections who knowingly expose others to the risk of infection.*

The state and territory guidelines provide guidance to doctors about the information that may lawfully be disclosed to health authorities regarding a patient who is placing others at risk. Generally, information may only be shared with professionals engaged in the intervention and strong legal protection of medical records continues to offer some privacy protections.

Table 1 Public health laws relating to persons' obligations to prevent HIV exposure or transmission by individual state and territory jurisdiction

JURISDICTION	PUBLIC HEALTH LAW
ACT <i>Public Health Regulation 2000, regulation 21</i>	A person who knows or suspects that he or she has a transmissible notifiable condition [including HIV], or knows or suspects that they are a contact of such a person, must take reasonable precautions against transmitting the condition.
New South Wales <i>Public Health Act 1991, section 13(1)</i> Pending: <i>Public Health Act 2010, section 79</i>	A person who knows that he or she suffers from a sexually transmitted infection [including HIV] is guilty of an offence if he or she has sexual intercourse with another person unless, before the intercourse takes place, the other person: <ul style="list-style-type: none"> ● has been informed of the risk of contracting a sexually transmitted infection from the person with whom intercourse is proposed; and ● has voluntarily agreed to accept the risk. <p>In 2010, the NSW Parliament passed new public health legislation, the <i>Public Health Act 2010</i> (the Act), which will replace the 1991 Act. The date of effect of the new Act is yet to be proclaimed at the time of writing, and regulations associated with the Act must be drafted. It is anticipated that the 2010 Act will take effect from early 2012. In the meantime, the 1991 Act continues in force. Once it takes effect, section 79 of the 2010 Act will provide a defence 'if the court is satisfied that the defendant took reasonable precautions to prevent the transmission of the sexually transmitted infection.'</p>
Northern Territory	Not specifically defined.
Queensland <i>Public Health Act 2005, section 143</i>	A person must not recklessly put someone else at risk of contracting a controlled notifiable condition [including HIV] or recklessly transmit HIV. A person does not commit an offence if the other person knew the person had the condition and voluntarily accepted the risk of contracting the condition.
South Australia <i>Public and Environmental Health Act 1987, section 37</i>	A person with a controlled notifiable disease [including HIV], shall take all reasonable measures to prevent transmission of the disease to others.
Tasmania <i>HIV/AIDS Preventive Measures Act 1993, section 20</i> <i>Public Health Act 1997, section 51</i>	The <i>HIV/AIDS Preventive Measures Act 1993</i> requires a person who has and is aware of having HIV infection, or is carrying and is aware of carrying the HIV antibodies, to: <ul style="list-style-type: none"> ● take all reasonable measures and precautions to prevent the transmission of HIV to others; ● inform in advance any sexual contact or person with whom needles are shared of that fact; and ● ensure he or she does not knowingly or recklessly place another person at risk of acquiring HIV infection, unless that other person knew that fact and voluntarily accepted the risk of infection. <p>A similar provision is found in the <i>Public Health Act 1997</i>, which states that a person who is aware of having a notifiable disease must take all reasonable measures and precautions to prevent transmission of the disease, and must not knowingly or recklessly place another person at risk of transmitting the disease. It is a defence for a person to prove that the other person knew of, and voluntarily accepted the risk of, contracting HIV.</p>
Victoria <i>Public Health and Wellbeing Act 2008, section 111</i>	A person who has, or suspects that they may have, an infectious disease [including HIV] should <ul style="list-style-type: none"> ● ascertain whether he or she has an infectious disease and what precautions he or she should take to prevent any other person from contracting the infectious disease; and ● take all reasonable steps to eliminate or reduce the risk of any other person contracting the infectious disease. <p>A person at risk of contracting an infectious disease should take all reasonable precautions to avoid contracting the infectious disease.</p>
Western Australia <i>Health Act 1911, section 264</i>	Provisions in the <i>Health Act 1911</i> dealing with infectious diseases are directed at control of diseases that may be transmitted through casual contact or inadequate public sanitation. Under section 264, a person with an infectious disease who 'wilfully exposes himself in any public house, or public place, or public vehicle without proper precautions for spreading the infection', commits an offence. HIV was declared an infectious disease in 1991. The government intends to modernise its public health legislation in the near future.

Guidelines for managing those who put others at risk of HIV infection are based on the understanding that reducing HIV transmission risk requires behavioural change. As HIV is a lifetime infection, risk management requires techniques that will be effective in modifying behaviours over a lifetime. Management by health authorities includes individualised and intensive case management, a variety of responses to other health and social service needs, and an escalating series

of behavioural management techniques that may include counselling, behavioural supervision, formal warnings and public health orders and detention. Notably, the severity of interventions need not escalate as most people respond to a supportive, 'modest' intervention. A more intrusive intervention may be imposed in the first instance if health department staff deem this to be necessary given the person's behaviour.

It is important to note that the number of individuals to whom these mechanisms apply at any one time is small. In mid 2009, some 20 HIV-positive individuals were subject to public health orders (from a population of more than 20,000 people living with HIV in Australia).

It is clear that the overwhelming majority of people with HIV in Australia actively take

continued overleaf

steps to ensure that transmission of HIV to others does not occur. However, owing to a range of psychological, social and other factors, there are inevitably some people who engage in behaviour that could or does place their sexual partners at risk of HIV infection. Anecdotal evidence suggests that a high proportion of those brought to the attention of health authorities have co-morbidities including intellectual or other cognitive disability, are mentally ill, or have drug and/or alcohol issues. Targeted interventions require the involvement of medical and other health professionals with expertise appropriate to each person's case.

Impact of the public health response

There is significant 'buy in' to the public health response by people living with HIV organisations, and community-based HIV service and advocacy agencies. Although at times uncomfortable with the notion of government intervening in private matters such as consensual sex between individuals, public health officials have worked to build community trust. This work has included consultation with clinicians and HIV-based community organisations about the ways in which interventions should operate. In most jurisdictions, regulation guarantees representation by key community-based HIV organisations or associated community members on the health department convened panels that consider individual case management of people who may put others at risk of HIV infection. In short, the community sector has responded to a shared understanding that sexual relationships must be understood within norms of human behaviour, and that those behaviours include agency by, and responsibility of, both parties.

The community sector has also responded to assurances that any moves to regulate or control the behaviour of individuals will be accompanied by significant support wherever possible. Such in-built assurances have been based on the oft cited 'partnership approach' between community organisations, researchers, clinicians, and health sector workforce organisations, as well as representation of community and other experts on government convened advisory committees.

2007–2008 saw renewed attention to the need for improved frameworks for managing people with HIV who risk infecting others. Questions concerning public health officials' management of individuals who were later prosecuted in high profile criminal cases in South Australia and Victoria triggered numerous reviews:

- The Victorian Government commissioned two reviews: one by

Professor Robert Griew and Tim Leach⁴ and another by Associate Professor John Scott and Robert Falconer⁵, as well as a report by Associate Professor Patricia Daly, Chief Medical Health Officer, Vancouver Coastal Health, British Columbia⁶. The Victorian Health Minister then made a formal response⁷;

- The South Australian Government commissioned a briefing by Stephen Walsh QC⁸, which included 18 recommendations which were considered by parliament; and
- National reports were prepared by Professor John McNeil for the Department of Health and Ageing, and by Griew, Russell and Buchanan for the sub-committee of the Australian Health Ministers' Advisory Council⁹. The latter report included the recommendation that national guidelines be developed to facilitate greater uniformity of responses by the states.

In 2008, the *National Guidelines for the Management of People with HIV Who Place Others at Risk* were approved by the Australian Health Ministers' Conference, with agreement that all states and territories review their current policies and where necessary, introduce a new policy to ensure consistency with the National Guidelines. Some states have now done so. Monitoring of the implementation of the National Guidelines is one of the priority actions in human rights and anti-discrimination under the *Sixth National HIV Strategy 2010–2013*.

Although most jurisdictions have public health laws under which people may be charged for failing to disclose their HIV status and/or take precautions to prevent HIV exposure or transmission, those laws have rarely been used. For example, the NSW legislation criminalising failure to disclose HIV-positive status to a sexual partner (irrespective of transmission risk, including instances where condoms are used), has been applied only twice since its enactment two decades ago (see Table 2).

These prosecutions failed to secure convictions. The 2005 case apparently failed because the

presiding magistrate was not satisfied that police evidence proved the charge. In the 2009 case, the magistrate accepted a guilty plea, but decided a conviction (and penalty) was inappropriate given the behaviour of the accused. That is, the accused had committed the offence but his actions did not warrant a penalty or, indeed, the impact a conviction may have had on his life. (The NSW *Public Health Act 2010* includes a defence if an accused person takes reasonable precautions to prevent transmission. The date of effect of the new Act was yet to be proclaimed at the time of writing – see Table 1 on page 3¹³).

Victoria has recently taken a different approach: entrenching mutual responsibility for safe sexual practice by making not only those with an infectious disease but also people at risk of contracting an infectious disease responsible for taking reasonable measures to avoid transmission (section 111 of the *Public Health and Wellbeing Act 2008*). Importantly, while that section describes responsibility, no penalty is attached to failure to comply: drafting intended to entrench the Act's purpose as an enabling instrument for a public health system based on support rather than punishment.

Victoria's rethinking of public health law means that HIV exposure and transmission 'offences' can only be dealt with by criminal law, which to date has carried onerous and potentially excessive penalties. While most Victorians whose behaviours place others at risk of HIV infection will continue to be dealt with under the state's *Guidelines for the management of people living with HIV who put others at risk*, those deemed to have committed an offence must be charged under criminal (not public health) law, which operates oblivious to the rationale and methodology of the public health system and attracts substantial penalties.

In one sense, lamenting the loss of punitive public health laws may seem redundant as they have rarely been used. However, given increasing interest in the 'punishment' of 'HIV offenders' (which appears to attract mainstream support), the loss of public health offences removes that option for police and prosecutors.

Table 2 Finalised charges under section 13 (1)¹⁰, *Public Health Act 1991* (NSW), from enactment to 2010

YEAR	PLEA	RESULT	FACTORS
2005 ¹¹	Not guilty	Dismissed	No evidence
2009 ¹²	Guilty	Discharged without conviction	Mitigating factors: <ul style="list-style-type: none"> ● Use of condoms; ● Accused disclosed shortly after the 'offence' as soon as he recognised a risk episode may have occurred; and ● Accused made follow up phone call to advise partner of the availability of post-exposure prophylaxis (PEP).

During the last few years, some other Australian jurisdictions have commenced reviews of their public health legislation, seeking community input to inform the development of a best practice response. By and large, the HIV sectoral response has been to ensure that laws do not unduly target HIV, that they reflect mutual responsibility for safe sexual practice messages, and that they minimise the possibility of public health laws undermining the HIV response. Given increasing interest in the intersection of criminal and public health responses, now may be a good time to revisit the role of public health laws and whether, if prosecutions relating to HIV exposure or transmission must proceed, they might be more appropriately dealt with by public health than criminal law.

Falconer and Scott's¹⁴ review of the public health management of a number of specific Victorian cases also noted the need for community engagement in nutting out an appropriate public health response:

'What is needed is an approach that is inclusive of the community of people living with HIV and AIDS, the Gay community, organisations that represent small subsets of the population with special needs, and the community more broadly. Legislation is a legitimate Public Health approach but it is one that just be reserved for the last resort, one that must be understood and supported by the community and one that is administered with the wholehearted endorsement of its elected representatives. If they are unable to give their support or endorsement then they must be prepared to define the alternatives that will ensure public health and safety.'

2. CRIMINAL LAW

The behaviours sought to be controlled or punished are highly engrained, intimate and

deeply human activities. Coercive state action is a particularly crude tool to use in changing in these behaviours. Each of the usual rationales for the criminal law – retribution, incapacitation and deterrence – appear ill-suited to deal with a disease epidemic.¹⁵

— Lawrence Gostin and Zita Lazzarini, 1997

All Australian states and territories have criminal laws that may be applied to cases of HIV transmission. In theory, none of these laws is HIV specific, generally relating to causing a serious or grievous bodily disease, causing grievous bodily harm, causing serious harm or injury, or endangerment. In practice, HIV appears to be the only disease to have been targeted by the criminal justice system in recent history (see **Table 3**, overleaf).

While it has been possible to discover basic information about Australian cases to date¹⁶, research has been stymied by a number of factors. Firstly, there is no mechanism for collecting data on HIV related criminal cases, so some cases – particularly old cases – may be unidentifiable, and only minimal information is available about others. Data limitations also mean that some old cases have only lately come to light during the course of recent research. **Figure 1** represents all known prosecutions commenced since 1991 (as at 1 February 2011).

It assigns Australian cases according to the year each prosecution was concluded up to 2008. Unfortunately, it is not possible to compile data according to the year in which cases were initiated (arguably a more accurate reflection of the application of criminal laws by year), as this information is not available for all cases. Figures for 2009, 2010 and 2011 reflect the years cases were concluded (dark blue), or for cases not yet concluded, the years cases commenced (light

blue). There are, in fact, five cases pending as at February 2011.

Secondly, in most instances there is no record of proceedings as charges have either been dismissed pre-trial or cases have been heard by lower courts which do not keep full transcripts. Thirdly, due to the sensationalist nature of allegations and evidence and/or a possible conflict with public (health) interest, in some cases the court has made a suppression order resulting in the court being closed and no records except the verdict being available.

Finally, cases are spread across completely independent legal jurisdictions which reflect the separate target areas of state AIDS Councils and PLHIV organisations. This has operated to minimise perception of the full extent of prosecutions (see **Table 4**, overleaf).

There have been 31 prosecutions related to HIV exposure or transmission in Australia over almost twenty years. Of those, a number have been dropped pre-trial, and in four cases the accused has pleaded guilty. All those charged were male, except for one of two sex workers (against whom charges were dropped pre-trial in 1991). In cases where the gender of the victim(s) is/are known, 16 have involved the accused having sex with female persons (one of those cases involves assault against minors) and 10 involved the accused having sex with men. This suggests that heterosexual men, who constitute only about 15% of people diagnosed with HIV, are over-represented among the small number of people charged with offences relating to HIV transmission. Further, men of African origin are over-represented among those prosecuted (7 of 30), given the small size of the African-Australian community.

continued overleaf

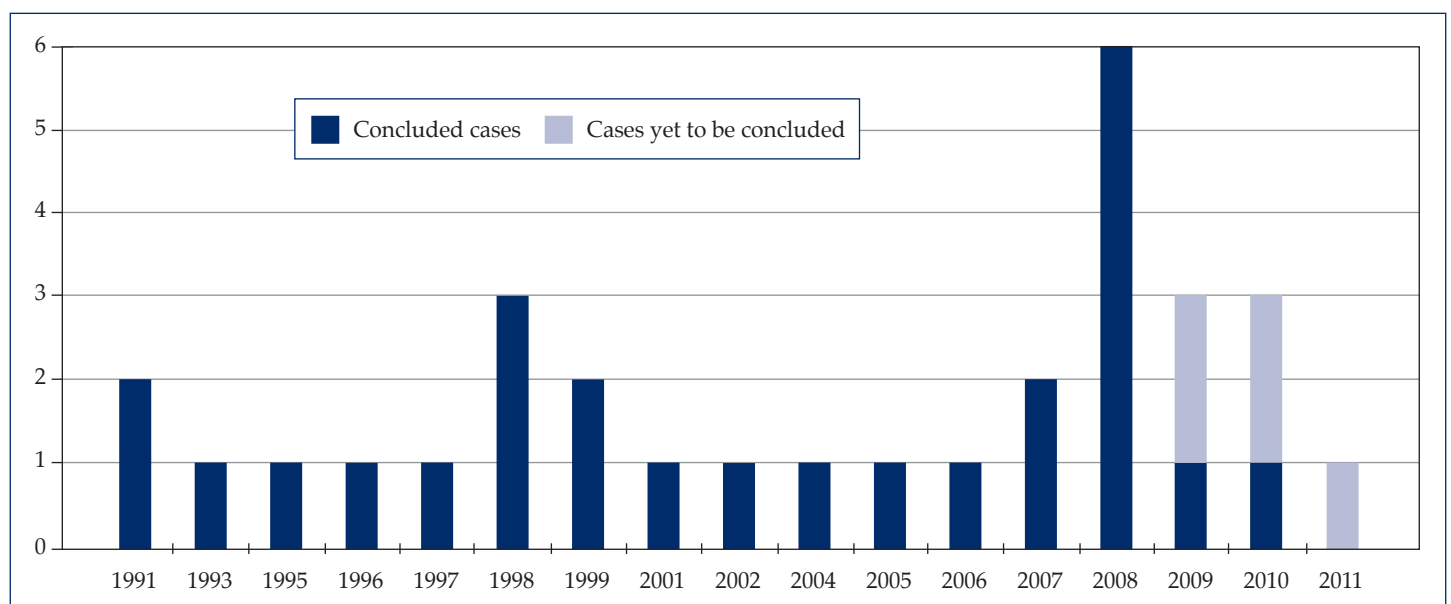


Figure 1 Known Australian prosecutions for HIV exposure or transmission by year

Table 3 Criminal charges most likely to be applied to cases of HIV exposure or transmission¹⁷

JURISDICTION	OFFENCE (Offences which have been used are marked in bold)	MAXIMUM PENALTY (Years of imprisonment)
ACT <i>Crimes Act 1900</i>	s19: Intentionally causing grievous bodily harm s20: Recklessly causing grievous bodily harm s25: Causing grievous bodily harm by unlawful or negligent act or omission	15 years 10 years 2 years
New South Wales <i>Crimes Act 1900</i>	s33: Inflicting grievous bodily harm with intent s35: Reckless grievous bodily harm or wounding s54: Causing grievous bodily harm by unlawful or negligent act or omission <hr/> s35 (repealed): Maliciously inflict grievous bodily harm	25 years 10 years 2 years <hr/> 10 years
Northern Territory <i>Criminal Code</i>	s186: Causing bodily harm s174E: Negligently causing serious harm s181: Unlawfully causing serious harm to another s177: Intending to cause serious harm and causing harm by any means <hr/> s154 (repealed): Act or omission causing serious danger (and may cause grievous bodily harm)	5 years 10 years 14 years Life <hr/>
Queensland <i>Criminal Code 1899</i>	s328: Negligent acts causing harm s339: Assault occasioning bodily harm s32: Unlawfully causing grievous bodily harm s317(b): Any person who, with intent to cause grievous bodily harm or transmit a serious disease, and who does grievous bodily harm or transmits a serious disease	2 years 7 years 14 years Life
South Australia <i>Criminal Law Consolidation Act 1935</i>	s29(1): Doing an act or omission knowing that the act or omission is going to endanger the life of another, and intending to endanger the life of another or being reckless as to whether the life of another is endangered. s29(2): Doing an act or omission knowing that the act or omission is likely to cause serious harm to another, and intending to cause such harm, or being reckless as to whether such harm is caused.	15 years 10 years
Tasmania <i>Criminal Code Act 1924</i>	s170: Intentionally maiming, disfiguring or disabling or causing grievous bodily harm to any person, by any means whatever s172: Causing grievous bodily harm to any person by any means whatever	21 years 21 years
Victoria <i>Crimes Act 1958</i>	s16: Intentionally causing serious injury to another person s19A: Intentionally causing a very serious disease s22: Reckless conduct placing another person in danger of death s23: Reckless conduct that places or may place another person at risk of serious injury	20 years 25 years 10 years 5 years
Western Australia <i>Criminal Code 1913</i>	s297: Unlawfully causing grievous bodily harm to another person s294(8): Intentionally doing any act likely to result in a person having a serious disease s320: Acts or omissions causing bodily harm or danger	10 years 20 years 5 years

continued from previous page

Renewed interest in the application of Australian criminal laws to cases of HIV exposure or transmission is likely the result of a number of intersecting factors:

■ **The frequency of cases appears to be increasing**

Although the numbers are relatively low, prosecutions for HIV exposure or transmission appear to be occurring with increasing frequency, as are such prosecutions internationally¹⁸ (see **Figure 1** on page 5). When reviewing frequency of Australian prosecutions, it is important to note that the prosecutions concluded in 2007 and 2008 include three prosecutions initiated after Victoria

Health notoriously inadvertently handed over a large set of files in response to a subpoena relating to a single client. Also, there is often a substantial delay between commencement and conclusion of trials, which can skew data (for example, **Figure 1** suggests significant activity in 2001, however, all but one of those five trials were commenced in 2009 or 2010.

Figure 1 maps cases but not verdicts. Notably, no case prior to 1997 resulted in a guilty verdict, and one of the 1997 cases was overturned on appeal in 1998. In fact, the first conviction to stand for HIV transmission was recorded in 1998. Arguably, this suggests criminal law

only gained traction in relation to HIV transmission and exposure after seven cases failed – seven years after the first charges were laid, and some 15 years after the first cases of HIV transmission in Australia. We are currently without sophisticated analysis of this apparent trend.

■ **Prosecutions have occurred in most jurisdictions**

Prior to 2001, nine of the 12 known prosecutions for HIV exposure or transmission were in Victoria. A case in WA related to assault of a minor, and in the other two cases (one in NSW and one in NT), charges were dismissed. Since 2001,

Table 4 Prosecutions for HIV exposure or transmission through sexual conduct since first known case (1991)¹⁹

JURISDICTION	NO. OF PROSECUTIONS	CONVICTED	NOT GUILTY ²⁰ / CHARGES DISMISSED	PENDING
ACT	1 ²¹	1		
NSW	4	2	1	1
NT	1		1	
QLD	3	1	1	1
SA	4	2		2
VIC	15	6	8	1
WA	3	3		
TOTAL	30	14	11	5

19 prosecutions have occurred across all states except the Northern Territory and Tasmania. The fact that prosecutions have recently occurred in most jurisdictions suggests that the increasing number of prosecutions is not attributable to particular legislation or idiosyncratic policing in one jurisdiction alone. Again, we are without evidence as to the reasons for such prosecution creep.

■ **Charges are being applied in an increasing range of circumstances**

As the number of prosecutions has increased, so too has the range of circumstances in which criminal charges have been laid. Cases now include instances of transmission/exposure relating to men and women, during casual and committed relationships, and during new and long-term relationships. Some accused have been charged in relation to one partner and others in relation to multiple partners. Some of the people involved had previously come to the attention of public health officials, some had not. Some clearly lied about their HIV status (including forging documents); in other instances, whether or not the accused lied has been difficult to establish. In some cases, transmission occurred recently, while in others it occurred many years ago. Recently, two cases were pursued (in NSW and Victoria) involving transmission a decade ago or longer.²² Notably, the Victorian man was convicted despite the two parties having married five years after the woman had been infected and diagnosed.²³

■ **Media coverage of trials is affecting the HIV response**

HIV prosecutions affect the general public's understanding of HIV. This is particularly so given media interest in the salacious details of trials (issues of fidelity, deception and of course, sex, including non-mainstream sexual

conduct), and the general lack of coverage of 'human interest' stories relating to HIV to provide a more diverse representation of people living with HIV. Witnesses' evidence is reported, whether or not it is corroborated or accepted as accurate by the court. There is no guarantee of the quality of reporting given journalists' tendency to paraphrase scientific and behavioural evidence, which can compound the effects of loss of specificity and accuracy when judges and magistrates use their own language to summarise expert evidence in their judgements.

This type of media coverage has the potential to increase stigma against people living with HIV and spread misinformation about HIV, including the experience of living with HIV and how it is transmitted. Media coverage also impacts people living with HIV by increasing their sense of stigma. It has the potential to misrepresent the rationale and the mechanics of the primary HIV response (the public health-based response) by undermining confidence in the confidentiality of medical records and suggesting that an overly vigilant government is waiting to pounce on individual's presumed indiscretions.

Impact of criminal law

The application of criminal law to cases of HIV transmission/exposure during consensual sex is highly problematic for a range of reasons including:

1. **HIV-related prosecutions negate public health mutual responsibility messages**

All Australian prosecutions to date have successfully maintained the premise that HIV-positive people must disclose their HIV status to sexual partners prior to sex. That argument creates a false sense of expectation (and hence a false sense of security) that HIV-positive people

will disclose²⁴, which is not necessarily the case (see below). The expectation of disclosure enables those who believe themselves to be HIV-negative to waive responsibility for their own and their partners' sexual health. That message can have dire consequences, particularly when applied against Australian and international evidence about HIV transmission by those who believe themselves to be HIV-negative. For example, in 2008, the NCHECR undertook scientific modelling based on surveillance data and estimated that 30% of new HIV infections among men who have sex with men (MSM) in Australia occur as a result of transmission from the estimated 9% of MSM who are unaware they are HIV-positive.²⁵ Further, the National Centre in HIV Social Research's (NCHSR) E-male study found that men were less likely to use a condom with casual sexual partners who disclosed their HIV status. In fact, some of those men disclosing what they honestly believe to be their HIV-negative status may be HIV-positive, which may trigger mutually agreed unsafe sex with an HIV-negative partner.²⁶

2. **HIV-related prosecutions fail to fully consider the intersection of risk and harm**

HIV transmission during sex is not automatic. Transmission risk relates to physiological conditions associated with types of sexual activity, the amount of HIV in a person's bodily fluid, the presence of abrasions or sexually transmitted infections, and whether or not a man's penis has been circumcised.²⁷

Numerous rigorous studies have been conducted to estimate transmission risk associated with specific sexual acts.

■ **Unprotected vaginal intercourse:**

Risk of HIV transmission from a man to a woman during a single instance of vaginal intercourse has been calculated at between one chance in 1,250 and one chance in 333. Risk of transmission from a woman to a man during a single instance of vaginal intercourse is estimated at between one chance in 2,500 and one chance in 263.²⁸

■ **Unprotected anal intercourse:**

Risk of HIV transmission from an HIV-positive insertive partner is estimated at between one chance in 122²⁹ and one chance in 70³⁰, with risk lower if the insertive partner does not ejaculate: one

continued overleaf

chance in 154. Risk is understood to be similar whether or not the receptive partner is a man or a woman³¹. Risk of transmission from a male receptive partner to a circumcised insertive partner is estimated at one chance in 909, and to an uncircumcised receptive partner it is one chance in 161³².

- **Unprotected oral sex:** Risk of transmission from an insertive partner to a receptive partner during fellatio (penis-mouth sex) is estimated as ranging from a risk of zero to a risk of one in 2,500³³. Researchers suggest the throat is less susceptible than genital and anal tissue, that saliva actually inhibits HIV, and that digestive enzymes in a person stomach may destroy HIV. Risk for the insertive partner in fellatio is so low that it is deemed impossible to calculate a risk.

These estimates of risk indicate a clear difference between the risk of harm associated with having unprotected sex and the risk of harm from an assault with a weapon like a knife or gun. In HIV-related prosecutions, the defendant's desire to have unprotected sex is frequently conflated with a desire to transmit HIV, however, the risk of harm from a single unprotected sexual encounter is minimal compared to the risks from a person who stabs with a knife or fires a gun.

The question of appreciable risk was successfully used by the defence in three early Victorian cases involving HIV exposure/transmission, with courts considering whether the risk involved in a specific act or acts in question was *significant* enough for the accused to be considered culpable.³⁴ In *R v B* (1995)³⁵, which involved a single act of anal intercourse, the judge decided the possibility of an uninfected person contracting HIV from an isolated act of receptive anal intercourse was one in 200 or less, and that this level of risk did not present an appreciable danger of death. In *R v D* (1996)³⁶, the accused was found to have engaged in unprotected sexual intercourse with two women on four separate occasions. In that case, the judge accepted that the risk of transmission in respect of an act of vaginal intercourse was one in 1,000 to 2,000, and again found that this did not present an appreciable risk

– thereby undermining the notion of 'recklessness'. In *Mutemeri v Cheesman*³⁷, a conviction recorded in 1997 was overturned on appeal – again on the basis of the relatively low risk of transmission. Questions of risk have either failed to be argued or have not been successfully argued by defence teams since that time.³⁸

It is perhaps surprising that prosecutions appear to be increasing at a time when the potential harm resulting from HIV infection has decreased. Many of those who were infected by HIV during the 1980s and early 1990s developed AIDS, experienced rapid disease progression and died. However, since the mid-1990s combination antiretroviral therapy has dramatically changed the clinical manifestations of chronic HIV infection. Most people living with HIV in Australia can now expect to live long lives; a recent analysis of 14 studies finding projected life expectancy for an HIV-positive person on optimal treatments to be more than 35 years post-infection.³⁹ HIV is now frequently considered to be a chronic, manageable disease.

Acknowledging that harm from HIV infection was generally greater for Australians two decades ago does not deny the impact of HIV diagnosis. While many people living with HIV experience no or minimal symptoms some do experience debilitating conditions and illnesses, particularly with ageing. Many struggle with HIV's unpredictability, and HIV-related stigma continues to affect HIV-positive people's psychological wellbeing and enjoyment of life. For many people living with HIV, concerns about the risk of transmission affect attitudes to sex, undermining enjoyment of sexual relationships and development and maintenance of longer-term relationships. Fear of vertical transmission has a serious impact on attitudes to and experience of fertility and childbirth; and as the cohort of people living with HIV in Australia grows older, the interactions of ageing, HIV infection and long-term antiretroviral use are only beginning to be understood.

Rather than argue that HIV infection does not cause harm, this paper argues that criminal law treats HIV differently from other diseases and that differential treatment is not necessarily the result of a sound understanding of harm caused by HIV infection.

*The way in which the 'harm' of HIV is constructed and reproduced through law... is no different from being beaten or poisoned. And yet is this the experience of infection?*⁴⁰

Out-dated notions of HIV can combine with other social or cultural 'filtering' of the 'meaning' of HIV infection, affecting the decisions of all parties involved in complaints: of complainants to go to the police, police to investigate, prosecution offices to pursue charges, and judicial officers to hear these cases but not cases of other disease transmission (hepatitis, syphilis, herpes, chlamydia, measles, swine flu, for example)⁴¹.

Interpretations of 'harm' impact the application of criminal law in numerous ways including whether the degree of harm merits criminal charges being laid at all, and if so, which specific charges should be laid: an important point of difference given that different charges attract more or less severe penalties.

While degrees of risk and interpretations of harm are important, more attention is required to the *intersection* of harm and risk which informs whether cases of HIV exposure merit criminal law attention. The relevance of this intersection was recently raised by a Canadian judge who found an HIV-positive man not guilty of an HIV-related exposure offence based on the evidence that the sexual encounters in question did not represent a 'significant risk of serious bodily harm': the legal threshold set out by the Supreme Court of Canada for triggering a duty to disclose known HIV-positive status. In that case, the accused was exclusively the receptive partner during three instances of anal sex; acts which the prosecution's medical expert estimated totalled a cumulative risk of transmission at 12 in 10,000. The Canadian judge then applied her understanding of that risk to consideration of the likely harm that might have resulted had transmission occurred: particularly in the light of expert testimony that HIV infection is now generally considered a chronic, manageable condition in Canada. The judge outlined that the intersection of risk of transmission and potential harm was relevant because as the severity of the possible harm decreases; the risk of harm must increase or criminal prosecution is not warranted.

Similar questions must be raised in the Australian context, particularly in terms of the intentions of respective Australian state governments when drafting the laws currently being applied to HIV exposure and transmission, many of which are general assault laws. Does the gravity of harm from HIV exposure/infection require criminal prosecution when considered against the risk arising from the particular actions of the accused?

3. HIV-related prosecutions ignore the reality that failure to disclose HIV status is not extraordinary

Regardless of ethical considerations about what people living with HIV should and should not do, not all people will disclose their HIV-positive status before every single risk event throughout their lifetime. People may fail to disclose for a range of reasons including:

- **the use of risk reduction strategies, such as the use of condoms**

HIV cannot pass through condoms. Research on the correct use of condoms has revealed a small risk of condom slippage or breakage. Correct condom use reduces the risk of HIV transmission to a point that is almost unquantifiable.⁴²

- **the belief that having a low viral load equates to low or no transmission risk**

Viral load describes the amount of HIV in a person's body, with high viral load describing a high level of HIV. Low viral load is associated with decreased risk of HIV transmission.⁴³

Undetectable viral load, frequently the goal of antiretroviral treatment regimes and indeed a goal under the *Sixth National HIV Strategy*⁴⁴, describes the presence of HIV that is so reduced it can no longer be measured by scientific tests. The 2008 publication of *The Swiss Statement*⁴⁵ generated enormous publicity. That statement by a number of HIV-expert Swiss analysts asserted that a person without sexually transmissible infection who has had an undetectable viral load for at least six months cannot transmit HIV through vaginal sex if they consistently adhere to antiretroviral therapy.

In 2009, in the first ruling of its kind in the world, the Geneva Court of Justice quashed an 18-month prison sentence of a man convicted of HIV exposure.⁴⁶ The Court of Justice accepted expert testimony from Professor Hirschel (one of the *Swiss Statement* authors) that the risk of sexual HIV transmission during unprotected sex on successful treatment is one in 100,000.⁴⁷ That decision was upheld by the Swiss Federal Court, although the Federal Court

decision does not explicitly address viral load. A comparable decision was recently made in Quebec, Canada where the conviction against a woman, 'D. C.', was overturned on the basis that risk of transmission where viral load is undetectable was assessed as 1 in 10,000 (characterised as 'very low', 'truly minimal', or 'very, very low'), and did not present a 'significant risk' of harm as required by Canadian law.⁴⁸

The message that low or undetectable viral load greatly reduces HIV transmission risk has been broadly taken up by many HIV-positive people (as well as many clinicians). Some believe undetectable viral load precludes HIV transmission during any sexual act, despite the lack of scientific data on its application to anal sex.

- **the belief that a behaviour, such as oral or insertive sex, contains no risk**

As outlined in the section on risk above, different sexual acts include different risk of HIV transmission. Many people living with HIV (and many others as well) apply their understanding of HIV transmission risk when making choices about sexual activities.

In 2005, a New Zealand case provided a landmark decision weighing up an HIV-positive person's obligation to disclose his or her HIV status against the issue of transmission risk. The accused man was charged with endangering a female sexual partner's health by exposing her to HIV (i.e. HIV was not transmitted). The accused had used a condom during vaginal sex and had engaged in oral sex without a condom but had not informed the woman that he was HIV-positive. The judge considered an earlier case which had found that reasonable precautions and reasonable care require condom use. The judge then drew on scientific and medical evidence and determined oral sex did not include a significant transmission risk and the use of a condom was 'sufficient to constitute reasonable precautions against and reasonable care to avoid the transmission of the HIV virus'.⁴⁹

- **the belief that they have disclosed and know their partner's HIV status**

The term 'serosorting' has gained usage among gay men and other MSM to describe the process whereby men engage in sexual acts only with men they believe to be of the same HIV-status as themselves. Some men (occasionally, sometimes or frequently) practise forms of non-verbal serosorting, for example, deciding a person's HIV status based on their appearance or their initiation of condom use. Researchers and HIV advocates have described instances of miscommunication (including instances when an HIV-positive person believes an HIV-negative person has communicated their HIV-positive status – and vice-versa) as 'seroguessing'.⁵⁰ In numerous locations, HIV health promotion campaigns aimed at MSM have been developed to specifically address serosorting practice.

If such a practice is well established and understood in particular communities, it is important that legislation and the legal process are able to take account of such practices. The issue of 'community norms' (i.e. practices within a particular community) may be relevant to an accused's state of mind, particularly if the accused believes he has indirectly communicated his HIV-positive status and that his partner has done the same.

- **fear of loss of privacy**

Once disclosed, even in a very specific context, a person loses control over who else may learn they are HIV-positive and particularly, how people may respond. Information about individuals' HIV-positive status can and does travel. Notably, the Australian Research Centre in Sex, Health and Society's (ARCSHS) *HIV Futures 6* reports that 51% of HIV-positive respondents (from all Australian states and territories) are aware of their HIV status being disclosed to a third party (or parties) without their permission.⁵¹

continued overleaf

■ **fear of rejection**

Fear of rejection may include sexual rejection but also a sudden end to a long-term or a developing relationship. The possibility of rejection is real, with 62% of respondents to the Project Maleout study responding that HIV-positive participants avoided having sex with people they believed were HIV-positive.⁵² Van de Ven found some 80% of HIV-negative men said they always or sometimes avoided sex with people they think are HIV-positive.⁵³ *HIV Futures 6* found 57.1% of people living with HIV expressed some fear of rejection from potential partners if they disclose their HIV status.⁵⁴ Unpublished data from the Positive Health study shows that as many as 27% of HIV-positive men surveyed have been sexually rejected due to their HIV serostatus.⁵⁵ Fear of rejection in long-term and developing relationships has been raised unsuccessfully by the defence in a number of cases including *Parenzee*⁵⁶ and an unnamed man convicted in Victoria in 2009.

■ **fear of violence, ostracism and abandonment**

People living with HIV are well aware of the stigma and discrimination HIV attracts. *HIV Futures 6* records significant levels of discrimination experienced by the more than 1000 people living with HIV surveyed (health care 25%, insurance 17%, workplace 16% and accommodation 8%). Discrimination and stigmatisation extends into private life. Notably, recent research by NCHSR found HIV-negative men who relied on HIV status disclosure were more likely to stigmatise people living with HIV than those who did not. The study also strongly suggested that reliance on disclosure to reduce transmission risk increases stigma and discrimination.⁵⁷ Disclosing HIV infection may trigger any of a wide range of reactions. Two recent NSW murder cases are a reminder that not all people will behave rationally. In the 2010 trial for the 1991 murder of Felipe Flores, the Crown's case relied on the

supposition that Mr Flores' disclosure of his HIV-positive status triggered his attackers' violence.⁵⁸ An August 2008 murder was sparked by the belief that the accused's mother's boyfriend was HIV-positive.⁵⁹ The accusation turned out to be a 'prank'.

Recognising that not all people living with HIV disclose before every risk event is not an argument against disclosure. Instead it recognises the reality of science surrounding transmission risk and the lived reality of the many thousands of people living with HIV, and argues that disclosure is ill-conceived as core HIV prevention policy. The potential to maximise disclosure is most likely in an enabling environment: a social environment in which HIV disclosure is facilitated by the absence of fear, blame or other hysteria. That environment is undermined by the potential for criminal prosecution. Notably, the Australian *HIV Futures 6* found that 42.4% of those surveyed reported being worried about disclosing their HIV status to sexual partners 'because of the current legal situation'⁶⁰.

4. **HIV-related prosecutions reduce trust in healthcare practitioners**

Healthcare practitioners are the frontline in HIV prevention and support. There is growing awareness that the confidentiality provisions applying to medical and associated health records are not absolute, and that healthcare practitioners may be called to give evidence against former patients. There is also a perception that healthcare practitioners may report a patient to an overly intrusive health department or to police on the basis of risk behaviours or the presence of sexually transmitted infections (STIs).

The possibility of criminal sanctions makes people living with HIV less likely to seek support or disclose information about risky behaviour, or to disclose behaviours and seek treatment for symptoms from a single service provider, thereby undermining the advantages of consistency of care. Despite those fears being largely at odds with current practice, the resulting distrust impedes the open therapeutic relationship that has proven fundamental to HIV treatment and prevention, and consequently affects both quality of care of the individual,

and health practitioners' role in impeding HIV transmission. Healthcare professionals have in turn been affected by criminal prosecutions, reporting uncertainty and requesting support from specialist agencies, including the Australasian Society for HIV Medicine (ASHM), which recently developed and published the *Guide to Australian HIV Laws and Policies for Healthcare Professionals*⁶¹.

5. **HIV-related prosecutions increase stigma against people living with HIV**

While media reportage of HIV-related prosecutions has been about a very small number of individuals in the context of legal action, this media coverage affects public perceptions of 'who HIV-positive people are'. HIV-related prosecutions reinforce stigma based on the othering of all HIV-positive people.⁶² Such stigma not only makes it difficult for individuals to come to terms with and manage their illness, it undermines prevention efforts as willingness to be tested and seek treatment has a profound impact on the course of the HIV epidemic.

6. **HIV-related prosecutions are unacceptably arbitrary**

There has only been one known prosecution to date that has included the allegation that the accused had intended to infect another with HIV⁶³, and those allegations were not proven (*Neal*⁶⁴). All other known cases have related to people who intentionally engaged in unprotected sex without disclosing their HIV status. In some instances, those accused transmitted HIV. In others, they did not. The Joint United Nations Programme on HIV / AIDS argues that while prosecutions may be warranted in cases of intentional transmission, they should not be pursued in cases of reckless or negligent transmission, or exposure without transmission.⁶⁵ Australian criminal laws and prosecutions to date are at odds with this principle. Behavioural research affirms community based agencies' assertions that most people living with HIV take very seriously their responsibility to prevent HIV transmission but it also confirms that although rare, some persons living with HIV will engage in unsafe sex without disclosure. There have been more than 28,000 instances of HIV diagnosis in Australia to date, and there are currently more than 20,000 people living with HIV. Given that there are approximately 1000 cases of HIV transmission each year, of which at least 90% are acquired through

sexual contact⁶⁶, it is clear that unsafe sex is occurring. When these figures are considered in the context of the range of circumstances that have now attracted criminal convictions, the laying of only 30 charges over two decades means that criminal prosecutions are unacceptably arbitrary. While some cases have involved accused who have exposed numerous partners to HIV infection, others involve circumstances that are strikingly similar to cases that are dealt with by public health systems or cases that do not come to the attention of authorities. As prosecutions become more frequent, those working in HIV services have become unsettled by increasing questions about the possibility/probability of prosecution (as complainants/victims or accused) from their clients.

7. HIV-related prosecutions do not decrease HIV transmission risk

There is no evidence to suggest that laws which explicitly seek to regulate the sexual conduct of people living with HIV impact sexual conduct or moderate risk behaviours.⁶⁷ Similarly, there is no evidence to suggest Australian prosecutions for HIV exposure or transmission have decreased transmission risk, either generally or among people in any specific population. To the contrary, (as noted above) many people living with HIV have reported increased fear about disclosing their HIV-positive status 'because of the current legal situation'⁶⁸.

The UN Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Anand Grover, notes:

'... criminal law does not influence the circumstances in which most HIV transmission occurs. ... Private sexual conduct invariably persists in the face of possible prosecution⁶⁹, but when prosecution actually occurs, these behaviours are driven underground, providing less opportunity for regulation and inhibiting access to preventive activities, diagnostic services, treatment and support⁷⁰.

8. HIV-related prosecutions that result in custodial sentences increase the population of HIV-positive people in custodial settings

The implications of imposing long custodial sentences on HIV-positive people found to have knowingly transmitted HIV are multifarious. HIV prevalence within the Australian inmate population is low, however, people in custodial settings are named as a priority

population group in the *Sixth National HIV Strategy* because of concerns about a possible increase in HIV transmission among people in correctional facilities and the increased risk of transmission by inmates on their return to the community. Each jurisdiction has different systems for providing health services for people in custody. Services may be the responsibility of health or justice jurisdictions, and may be supplied directly or contracted in by public or private custodial facilities. Minimal thought has been applied to the consequences of incarcerating persons judged to have put others at risk of HIV infection, where:

*'... the frequency of risk practices such as unsafe injecting drug use, unsafe tattooing, unprotected sex (including through sexual assault), and an over-representation of priority populations (including Aboriginal and Torres Strait Islander peoples and people who inject drugs) heighten the risk of exposure to HIV during incarceration.'*⁷¹

Moreover, there is no systematic linking of persons convicted of HIV-related offences back into the public health system (where behaviour modification expertise is located) while people are on remand, post-sentencing, while incarcerated or after their release. As noted by the UN Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health:

*'... the rehabilitative effect of incarceration for those infringing HIV-related laws is questionable, particularly in cases of unintentional transmission, as there is no criminal behaviour amenable to rehabilitation. Furthermore, there is no compelling evidence to suggest that incarceration positively modifies risk factors or behaviours around HIV transmission, diminishes the risk of future transmission or results in similar beneficial outcomes.'*⁷²

The negative consequences associated with incarceration and its incompatibility with behaviour modification systems beg the question of whether offender diversion programs should be considered, as these would enable referral into a system designed to trigger HIV-risk related behaviour change. The possibility is complicated by diversionary programs generally being applicable only to lower level (summary) offences, which then relates back to judgements of risk and harm and the types of offences with

which people are charged. Diversionary programs, however, may offer advantages to offenders, the communities and to those persons against whom offences have been committed as they generally increase 'victims' power in the legal process by seeking the victim's input as to whether diversion is appropriate and ensure victims receive an apology for the behaviour that has occurred (an event that is sadly lacking in those instances when defence teams intent on preventing a conviction pursue a 'not guilty' plea).

Criminal Law Summary

There is a narrow category of circumstances in which prosecutions may be warranted, involving deliberate and malicious conduct, where a person with knowledge of their HIV status engages in deceptive conduct that leads to HIV being transmitted to a sexual partner. A strong, cohesive HIV response need not preclude HIV-related prosecutions per se. Further work is required by those working in the areas of HIV and of criminal law:

- To consider what circumstances of HIV transmission should be defined as criminal;
- To define what measures need to be put in place to ensure that prosecutions are a last resort option and that public health management options have been considered; and
- To ensure those understandings are part of an ongoing dialogue that informs the development of an appropriate criminal law and public health response.

When considered against the public health response, there has been little effort by governments to engage community-based organisations or the medical profession in shaping the criminal law response to HIV. The HIV partnership approach that has helped shape the public health response to HIV is glaringly absent from the criminal law response. The reasons for that are not altogether clear but are likely the result of a combination of factors including a long term focus on managing difficult clients/patients through the public health system, a sense that (until recently at least) criminal cases are few and far between and must not divert resources from major HIV issues affecting large numbers of people, a lack of legal expertise among HIV workers, the absence of law based networks with HIV expertise, and a sense that the legal system is somehow precious, particularly in relation to individual cases. There is also the lingering hope that the apparent surge in case numbers may just go away.

continued overleaf

Indeed, the law sets clear boundaries around types of engagement and matters that may be discussed in relation to individual cases, however, that is no different from boundaries being set around the provision of health care.

Perhaps in the drive to modernise public health (with an increased focus on social determinants rather than punishment of individuals), policy makers have sought to keep public health separate from criminal law and public health policy expertise has had little engagement with the criminal law agencies concerned. That need not be the case, for example, in the UK, public health policy expertise informed guidelines for prosecutors and police considerations of HIV exposure and transmission cases.

Perhaps it is the law and order offices that are unreceptive to public health and community responses, considering public health and community agencies to be inappropriately sympathetic to people accused of such 'criminal' behaviour. This would point to a need for public health and community organisations to more effectively position themselves as agencies with an HIV prevention imperative founded on expertise in working with affected communities.

The *Sixth National HIV Strategy* includes a commitment to consider the application of criminal and public health law to HIV transmission and/or exposure offences, referencing the National Association of People Living With HIV / AIDS (NAPWA) 2009 monograph *The Criminalisation of HIV Transmission in Australia: Legality, Morality and Reality*. It fails, however, to name a priority action in this area. It is hoped that will be addressed in the National HIV Strategy's implementation plan.

Australia's HIV response requires the development of thinking within the criminal justice system informed by the broad HIV response, including HIV epidemiological and behavioural research and public health practice. That can only occur through high level dialogue and the allocation of time and resources to the task. Current prosecutions for HIV exposure and transmission may not be informed by Australia's HIV response, but they do not sit outside that response. Their impact is keenly felt.

3. CIVIL LAW (TORTS)

*The Court does not consider that the compensatory and aggravated damages awarded sufficiently express the Court's disapproval of the defendant's disgraceful conduct.*⁷³

For some time, legal analysts have theorised that it may be possible to bring civil action for damages caused by sexual transmission of HIV. That theory was confirmed in April 2010 with a finding against a NSW man for lying about his HIV-positive status and infecting his former partner. Damages of \$750,000 were awarded. It is believed that at least four further civil actions involving HIV infection have now been commenced in NSW.

Key differences between Civil Law and Criminal and Public Health Law

A civil law action differs from public health and criminal law in that:

- Under public health and criminal law, an individual who has been put at risk or harmed is considered a victim and a 'witness' but (in normal circumstances) charges are laid by police. In short, 'the state' pursues charges against persons who offend the state or state order. Under civil law, the injured individual initiates and funds the legal action, employing the services of solicitor or barrister. A civil case is a dispute between two private individuals;
- Under public health and criminal law, a convicted person may incur a penalty, for example, incarceration or a fine. The fine is payable to the state. In the case of a successful civil action, damages which must be paid by the defendant are awarded to the injured person; and
- Criminal law includes a higher standard of proof than civil law. Under criminal law, a charge must be proved 'beyond reasonable doubt'. Under civil law, the plaintiff must only prove the facts of the case 'on the balance of probabilities'. This means that if a person wishes to pursue legal action, it is often easier to prove a civil claim than to succeed in a criminal prosecution.

While the legal principles are complex, the basics of tort law involve an individual suing another (seeking a monetary sum referred to as 'damages') for an injury or interference to the person, their reputation or property. It may be possible to sue for damages for sexual transmission of HIV based on a claim of negligence or battery. In the NSW case, injury to the Plaintiff through sexual transmission of HIV formed the basis of a claim for damages. It is assumed that this claim was based on the intentional tort of battery because exemplary damages were awarded (not available in negligence claims in NSW).

Facts of the Civil Case

The only information available about the NSW case is the evidence and considerations described in the judgement. Despite being served with a summons in 2008, and subsequent proceedings commencing in 2009, the Defendant did not appear in court and no evidence was presented in his defence or to counter the Plaintiff's claims and those who provided evidence. The Plaintiff was able to provide documentary evidence (including affidavits) and was not required to give oral evidence or to be cross examined. Default judgement was entered against the Defendant with the amount of damages the only issue determined by the court. Consequently, we are without an example of a judge's deliberation and weighing up of conflicting evidence or the Defendant's reasons for certain actions (which may or may not have been relevant to the awarding of damages).

According to the judgement:

- The two parties met through a gay internet site in January 2004 and soon commenced a relationship. The Defendant assured the Plaintiff he was HIV-negative and the two engaged in unprotected 'sexual relations' on numerous occasions;
- In July 2004, while overseas on holidays with the Defendant, the Plaintiff received a phone call from the Defendant's former boyfriend telling him the Defendant was HIV-positive. The Plaintiff initiated several conversations with the Defendant on this point but the Defendant consistently maintained he did not have HIV;
- After returning to Australia in August 2004, the Plaintiff undertook an HIV test and was soon informed he was HIV-positive;
- The Plaintiff then attended his treating doctor with the Defendant. The doctor informed the Defendant that the Plaintiff was HIV-positive. The Defendant informed the doctor he was waiting for his HIV test results;
- The Plaintiff then assumed he may have infected the Defendant with HIV (who, at the time, maintained he was undiagnosed) and became very distressed. Soon after his diagnosis, the Plaintiff attempted suicide by drug overdose. He was found by the Defendant and rushed to hospital;
- In October, the Plaintiff and the Defendant attended another senior HIV-expert doctor. After being questioned by that doctor, the Defendant stated he had infected the Plaintiff. The Plaintiff saw the Defendant give the doctor HIV-positive test results dated 2003;

- Tests ordered by that doctor indicated the Plaintiff and the Defendant had ‘the identical strain’ of HIV;
- Following diagnosis, the Plaintiff suffered severe depression and anxiety, stating HIV ‘destroyed’ him. In 2005, he overdosed on Valium and in 2006, he suffered a ‘complete breakdown’ and was scheduled under the *Mental Health Act*. His psychologist considers he meets the diagnostic criteria for a chronic post-traumatic stress disorder and a recurrent major depressive disorder;
- The Plaintiff’s clinical immunologist consultant physician states the Plaintiff has a serious disability, associated with a number of conditions relating to HIV and its treatment, including venous thrombosis and a stroke-like episode which may be linked to a genetic predisposition; and
- The Plaintiff was a highly qualified nurse who had worked in Australia and overseas. He is no longer able to cope with his usual work and is ineligible for overseas nursing work.

This case (the only Australian civil law sexual HIV transmission case concluded to date) included a number of distinct characteristics:

- **Witness testimony was provided:** The case did not rely solely on testimony about conversations that had occurred in private. Two medical practitioners provided evidence of the Defendant’s deceit: the first his lie that he was awaiting the results of an HIV test, and the second his admission that he had infected the Plaintiff;
- **HIV diagnosis had a severe impact:** The Plaintiff was able to provide expert medical evidence that his HIV diagnosis has significantly affected his physical and mental health. Notably, the psychological impact of his HIV diagnoses had been clinically diagnosed and was also supported by evidence of a number of serious episodes requiring immediate medical intervention;
- **The Defendant is understood to have considerable assets:** Civil action involves pursuit of an individual (not the state) for monetary ‘compensation’. In instances where an individual is *unwilling* to pay, mechanisms are available to force release of assets (for example, a sheriff arriving at a plaintiff’s home and seizing things of monetary value). In the event that a plaintiff is *unable* to pay, there is no mechanism available. That is, a civil action would be pointless in a case where a plaintiff had few or no assets;
- **Scientific evidence was provided:** Scientific evidence was provided although it is not clear that the

judgement has accurately summarised the evidence provided. Also, there was no opportunity to test the scientific evidence by cross examination; and

- **Exemplary damages were awarded:** As the judgement states, ‘exemplary damages are exceptional and rarely awarded’. In this case, exemplary damages were awarded because compensatory and aggravated damages did not ‘sufficiently express the Court’s disapproval of the defendant’s disgraceful conduct’, which would suggest the Court wants to make an example of the defendant so that others may be deterred from similar behaviour.

Impact of civil law

The application of civil law to HIV exposure through consensual sex poses a number of concerns. The defence of contributory negligence (which is similar to ‘mutual responsibility’) would be available if a claim was based in negligence but is not available to intentional torts. This is significant because although a plaintiff’s own lack of care (for example, not using or insisting on the use of condoms) may be seen as a contributing factor to HIV exposure, it is not relevant to the finding of liability under an intentional tort action. ‘Consent’ is a defence to legal actions of this nature, although it is unclear what facts the defendant would be required to prove to establish this defence.

Previous discussions around HIV-related criminal and public health laws have included the possibility of interventions at structural level to minimise harms to the HIV response.⁷⁴ Unfortunately, the structure of civil law (i.e. being driven by cases between individual parties) severely limits possibilities for HIV sector intervention to ensure the ‘best fit’ of civil cases with the HIV response: whatever shape that fit might take. The development of this area of law will be driven by individuals approaching solicitors for legal advice, and the actions of solicitors in taking on cases. Lawyers have a duty to act in the best interests of their individual clients. Lawyers are not required to consider the impact of the advice provided to individual clients on the broader HIV response.

While it is theoretically possible that the government may be lobbied to intervene and preclude cases of HIV infection from civil law actions, that possibility (which may not be appropriate at all) seems unlikely to succeed, particularly in cases where there has been intentional conduct rather than negligence.

The application of civil law to cases of HIV exposure and transmission has real implications for HIV-related service provision, and arguably requires dialogue and the development of internal agency policies on the

management of issues related to civil action. In the first instance, it will be important to understand the approach of HIV-related legal services in managing this issue, and how that response ‘fits’ with the priority of services which are primarily health and welfare based.

Notably, criminal action has recently been launched against the Defendant (now ‘the accused’ in the pending criminal case)⁷⁵ from the above cited NSW civil case. That case will provide the first Australian example of the different ways in which civil and criminal law processes operate when considering the same set of circumstances surrounding allegations of HIV transmission through sex, as well as the opportunity for the accused to defend his actions. Civil action is also being pursued in a NSW case that has previously resulted in a criminal conviction.

CONCLUSION

Australia’s early response to HIV has been explicitly informed by a human rights approach, representing a clear departure from earlier punitive models of public health management which had involved isolating and quarantining infected individuals from the community. Instead, governments recognised that the greatest chance of minimising HIV transmission lay in full engagement of those with HIV and those at risk of HIV infection in voluntary behaviour change programs.

Aside from the harm to individuals caught up in legal proceedings, prosecutions for HIV exposure and transmission have the potential to undermine HIV prevention efforts. In short, a perceived increase in the possibility of prosecution or another punitive response is likely to reduce individuals’ willingness to disclose their HIV status, which has the real potential to result in increased HIV transmission rates.

Most laws and policies related to HIV transmission and exposure have been in place, without significant change, for a considerable period of time and the HIV sector has generally become complacent. The prosecution of people for HIV exposure/transmission during consensual sex requires stronger engagement by both public health officials and the community sector. The issues are confronting; strategic thinking is required around the issues of prosecution and civil actions, and perhaps, innovation unlike anything seen since the early HIV response.



POSSIBLE STRATEGIES TOWARDS POLICY REFORM

Australia's *Sixth National HIV Strategy 2010–2013* reasserts the principle that 'taking a human rights approach to HIV means creating a supportive social and legal environment', noting that legislative and regulatory measures have both supported and impeded HIV programs. The *Sixth National HIV Strategy* highlights consideration of 'the application of criminal and public health law to HIV transmission and/or exposure offences' as an essential part of Australian policy development.

Australian law impacts HIV in varied, complex ways. While the voicing of concerns regarding intersecting issues arising from the application of public health, criminal and civil law has triggered initiatives in some jurisdictions, the sector has been slow to develop clear strategies to deliver broad-based policy and law reform. This is hardly surprising given the myriad factors that must be understood and considered across eight jurisdictions. Many of these issues arise from the practice of law, and policy analysis and development of remedies

can be perceived to be outside the expertise of most in the sector.

The following tables set out possible actions to enable the development of better laws and policies, and improved practices on the part of the agencies enforcing existing laws. The strategies set out in the table are not intended to be prescriptive in any way; they are potential options for consideration. Strategic considerations can constrain law or policy reform activities in a particular jurisdiction, just as evolving case law can drive changes of focus.

POSSIBLE STRATEGIES FOR CONSIDERATION BY AGENCIES	POSSIBLE ACTIONS TO BE CONSIDERED	POSSIBLE PARTNERSHIPS
<p>Enable detailed discussion and policy development</p> <p>In August 2008, the UNAIDS <i>Policy Brief: Criminalization of HIV Transmission</i> recommended that civil society:</p> <p><i>'... monitor proposed and existing laws and advocate against those which inappropriately criminalize HIV transmission and impede provision of effective HIV prevention, treatment, care and support services.'</i>⁷⁶</p> <p>Such work requires the development of sophisticated networks among community, government and academic institutions across all eight state jurisdictions, as well as input from experts in law and public health administration. Further work is required to determine whether community support can drive policy and (possibly) law reform in this area. If so, specific strategies must be developed and clearly articulated.</p> <p>The <i>Sixth National HIV Strategy</i> names 'human rights, legislation and anti-discrimination' as one of four priority areas for action, including 'the application of criminal and public health law to HIV transmission and/or exposure offences' as an area for consideration. Other observations on public health management process or the criminalisation of HIV is absent. As such, there is no firm national policy directive on the issue. Notably MACBBVS has recently established a Legal Working Group, although the potential of that group, which is to operate without resources, is as yet unknown.</p> <p>One effect of related criminal and public health law falling under state jurisdiction has been a lack of movement towards effective harmonisation of such state/territory laws. Further work is required, firstly, to envisage whether such harmonisation would be beneficial, and, secondly, to determine how this work might be carried out. Basic questions remain unanswered, including whether the types and severity of criminal law being applied in each state are comparable, and whether states are now delivering greater consistency and the best possible public health management under the <i>National Guidelines for the Management of People with HIV Who Place Others at Risk</i> (close monitoring of which is listed as a priority action in the <i>Sixth National HIV Strategy</i>).</p> <p>Many agencies are likely to be involved in work relating to the intersection of HIV and law. That work may benefit from the establishment of a focal point for canvassing these issues (possibly AFAO) to collect, analyse and redistribute state-based and international information so that key organisations have access to current domestic and relevant international research and legislative and policy analysis.</p>	<ul style="list-style-type: none"> ■ Provide mechanisms for experts from all relevant fields to develop ideas and strategies to inform the impact of law on the HIV response (AFAO) ■ Contribute to and resource the work of the MACBVSS Legal Issues Working Group (AFAO) ■ Resource member organisations and other relevant parties with relevant information (AFAO) ■ Develop a focal point on HIV and law (AFAO) 	<ul style="list-style-type: none"> ■ Public health officials ■ Police ■ Departments of Public Prosecution ■ Attorney General's Departments, including communication the Standing Committee of Attorneys General (SCAG) ■ Other experts in law ■ State-based and relevant peak HIV agencies ■ State/territory Legal Aid services ■ HALC services



POSSIBLE STRATEGIES FOR CONSIDERATION BY AGENCIES	POSSIBLE ACTIONS TO BE CONSIDERED	POSSIBLE PARTNERSHIPS
<p>Develop mechanisms to learn more about individual cases</p> <p>Analysis of criminal and civil cases to date is stymied by the absence of mechanisms to collect data on individual cases. Considerable benefit may be gained from the collection and analysis of information about individual trials. This could take a variety of forms including collection of court transcripts where available (currently a prohibitively expensive endeavour) or training of court observers to attend and provide comment on trials as they proceed.</p>	<p>Develop:</p> <ul style="list-style-type: none"> ■ a ‘court observer’ project, in partnership with law schools ■ a project to gain accurate case information from courts/legal representatives ■ links with academic institutions and relevant postgraduate students/academics 	<ul style="list-style-type: none"> ■ HIV / AIDS Legal Centres and other community legal centres ■ Law schools ■ Social science departments ■ State-based and relevant peak HIV agencies
<p>Research priorities</p> <p>The <i>Sixth National HIV Strategy</i> notes ‘research plays a critical role in providing much of the evidence base to inform policy and for designing, monitoring and evaluating programs at all levels’. The application of law to cases of HIV transmission/exposure through consensual sex is currently under-researched, which undermines development of an evidence-based response, including the development of policy priorities. Research is required on the intersection of public health and criminal law mechanisms (including analysis of cases), and on the role of gender, ethnicity and other social determinants (including the likelihood of public health intervention or prosecution and the differential impact of criminalisation on different communities).</p> <p>There is currently no mechanism to ascertain where and by whom research relevant to criminalisation and public health management is being undertaken. Establishment of a focal point may assist in this area.</p>	<ul style="list-style-type: none"> ■ Work with research institutions to integrate public health management and criminalisation into research priorities. ■ Develop links with academic institutions and relevant postgraduate students/academics 	<ul style="list-style-type: none"> ■ HIV and other research institutions ■ Law schools (post-graduate) ■ Social science departments (post-graduate)
<p>Work with police</p> <p>Policing policies, procedures and workforce cultures directly influence the experience of accused and witnesses as well as the likelihood of cases proceeding to court. Anecdotal evidence suggests that in some instances, police have instigated cases without consulting Directors of Public Prosecution (or public health authorities), and that investigation of exposure/transmission cases that include investigations of sexual relations are not always undertaken with appropriate levels of care and respect. There are also anecdotal reports that investigating police frequently fail to understand the basics of HIV transmission risk and the practice of risk behaviours.</p> <p>In August 2008, the UNAIDS <i>Policy Brief, Criminalization of HIV Transmission</i>, recommended that states:</p> <p><i>‘... issue guidelines to limit police and prosecutorial discretion in application of criminal law (e.g. by clearly and narrowly defining ‘intentional’ transmission, by stipulating that an accused person’s responsibility for HIV transmission be clearly established beyond a reasonable doubt, and by clearly indicating those considerations and circumstances that should mitigate against criminal prosecution).’⁷⁷</i></p> <p>Police handling of cases should be reviewed in each Australian jurisdiction with a view to developing improved protocols for gathering evidence, interacting with health departments, and engaging with witnesses and other stakeholders. Such work has been undertaken in comparable settings. For example, in the UK, the Terrence Higgins Trust in collaboration with the Association of Chief Police Officers [ACPO], the Metropolitan Police [London’s force] and other community groups⁷⁸ conducted a review of police handling of cases. Following the review, new protocols were produced by a working group which included police officers, representatives of the Crown Prosecution Service, the National Policing Improvement Agency, and the National AIDS Trust to assist police when investigating allegations of criminal transmission of HIV.</p> <p>Australian state-based protocols would be beneficial. Such protocols may include a process for formal engagement with state health departments and procedures for dealing with complaints in a fair and sensitive manner. They could also include accompanying resources to provide police officers with basic facts about HIV; current scientific, social and behavioural evidence; and the operation of the public health management system.</p>	<ul style="list-style-type: none"> ■ Literature review of research identifying how cases become police matters and how they proceed, including reason cases are selected/rejected and difficulties encountered ■ Commission research which identifies how Australian HIV transmission criminal cases have become police matters; and why they proceeded, including the reason cases are selected and difficulties encountered. ■ Develop relationships with key police contacts ■ Identify relevant police protocols for handling cases and analyse gaps and inconsistencies ■ Work with police to develop training/guidelines/protocols for managing cases from initial complaint to finalisation of matter. 	<ul style="list-style-type: none"> ■ Police ■ Universities ■ Community Legal Centres ■ HIV specialist health department officials ■ State-based and relevant peak HIV agencies ■ Australian Law Reform Commission ■ State/territory Ombudsman offices ■ Police industrial associations/unions ■ Police gay and lesbian liaison units



POSSIBLE STRATEGIES FOR CONSIDERATION BY AGENCIES	POSSIBLE ACTIONS TO BE CONSIDERED	POSSIBLE PARTNERSHIPS
<p>Work with justice agencies</p> <p>The <i>Sixth National HIV Strategy</i> states ‘it is essential that a partnership approach be reflected in all jurisdictional and non-government agency planning, implementation, monitoring and evaluation and that lessons learned are shared’. That mandate extends across departmental ‘silos’ within individual governments, and as well as across jurisdictions.</p> <p>Directors of Public Prosecutions directly influence whether cases proceed and how they are run. While it is a requirement that prosecution of a criminal case must be in the public interest, it is not known how the ‘public interest’ is determined in the context of criminal cases involving HIV transmission. When AFAO has endeavoured to discover basic information about concluded cases (including simple questions, like what specific charge was laid), various DPP offices have not been forthcoming.</p> <p>This situation contrasts to the UK experience, where the community sector persuaded the Crown Prosecution Service (CPS) to consider advice from the National AIDS Trust and the Terrence Higgins Trust when developing guidelines on prosecutions relating to sexual transmission of HIV.⁷⁹ The CPS ‘Policy for prosecuting cases involving the intentional or reckless sexual transmission of infection’ has clarified issues for the public and has provided important guidance for police and prosecutors.</p> <p>Further discussion is required to gauge whether other legal remedies may be appropriately applied to particular instances of HIV exposure or transmission, including the possibility of a renewed focus on public health offences, alternative dispute resolution mechanisms or diversionary programs.</p> <p>Similarly, it would be useful to undertake a review of laws being applied and the severity of penalties they attract. For example, do penalties attached to assault offences generally reflect the same culpability if harm is caused by a knife attack or as a result of consensual sex? Many international jurisdictions attach lower penalties to cases of HIV exposure/ transmission, and in India, for example, draft legislation provides that a ‘first offence’ for failure to disclose HIV-status or practise safe sex attracts a fine, with a more severe penalty if the behaviour is not corrected.</p>	<p>Develop:</p> <ul style="list-style-type: none"> ■ relationships with key DPP/ AG contacts ■ systems to enable reporting of basic information about cases that have concluded ■ policy guidelines on prosecutions ■ Undertake research identifying how cases become DPP matters, how they proceed (including reasons cases are selected), why particular charges are laid and difficulties encountered ■ Review current laws and their penalties, and undertake discussions with legal officers (including Departments of Attorneys-General) as to the appropriateness of those penalties. ■ Discuss alternative legal remedies 	<ul style="list-style-type: none"> ■ Departments of Public Prosecution ■ Attorney General’s Departments University law faculties ■ Community Legal Centres ■ HIV specialist health department officials ■ State-based and relevant peak HIV agencies
<p>Work with public health officials</p> <p>The <i>Sixth National HIV Strategy</i> commits to monitor ‘the effectiveness of the public health approach to HIV and implementation on the <i>National Guidelines for the Management of People with HIV who place others at risk of infection</i>’. That work must include the public health process/criminal law nexus.</p> <p>Input of public health expertise and due regard to public health principles have been noticeably absent from the criminal law response to HIV exposure/ transmission. Both public health officials and legal officers remain determined to keep their respective fields separate, indicating a commitment to safeguard the integrity (and separation) of their rationale and their processes. Of course, it is essential that public health and criminal law procedures remain distinct, however, considerable benefit would be gained from public health officials engaging with police and justice officials at a senior policy level to inform prosecution practice. Such inter-sectoral exchanges across policing, prosecution, health and social services are not new. For example, such exchanges revolutionised police and prosecution responses to sexual assault and domestic violence in the 1980s and 1990s. The new National HIV Strategy offers the potential for an informed cross-government response.</p> <p>Given at least four state health departments have recently been drawn into criminal law matters relating to HIV exposure/ transmission, their observations could inform development of a best practice police/ prosecution response. Further, the impact of prosecutions on public health officials’ work must be duly considered. The development of protocols (both from health to police and police to health) should be pursued.</p> <p>Consideration should also be given to the effectiveness of current public health responses, particularly the advantages/ disadvantages of increasing interventions for those who appear unwilling to alter their risk behaviours and the equity of a system that lacks formal provision of a support person (advocate or witness) for those on whom public health interventions are imposed.</p>	<ul style="list-style-type: none"> ■ Engage public health officials in discussions to inform law and order responses to HIV exposure/ transmission ■ Consult with public health practitioners to discuss the impact of their involvement in criminal cases to date, and implications for future practice ■ Consult with public health practitioners to discuss the potential benefits/ harms of increasing public health interventions and the possibility of including formal support persons for those experiencing public health interventions 	<ul style="list-style-type: none"> ■ HIV specialist health department officials ■ Public health practitioners ■ Clinicians ■ State-based and relevant peak HIV agencies



POSSIBLE STRATEGIES FOR CONSIDERATION BY AGENCIES	POSSIBLE ACTIONS TO BE CONSIDERED	POSSIBLE PARTNERSHIPS
<p>Judges’ understanding of HIV</p> <p>The expertise of lawyers, judges and magistrates directly impacts the course and outcome of matters involving HIV exposure/ transmission – affecting scrutiny and analysis of evidence, instructions to juries, sentencing, and future trials (through the use of precedents). There has been no work in Australia to date considering whether judicial education may be beneficial, or what form such education might take.</p> <p>Although formal judicial education is a comparatively recent practice, it is now well established with specialist judicial education organisations providing education on a wide range of subjects.</p>	<ul style="list-style-type: none"> ■ Develop a project with a judicial educational organisation to deliver HIV related training to judicial officers, having regard to best practice overseas (e.g., in Canada) 	<ul style="list-style-type: none"> ■ Judicial educational organisations (e.g. Judicial College of Victoria, Judicial Commission of NSW) ■ Community Legal Centres ■ State-based and relevant peak HIV agencies
<p>Work with correctional authorities</p> <p>The <i>Sixth National HIV Strategy</i> has reprioritised transmission risk in custodial settings, noting:</p> <p><i>‘... it is essential that the full range of BBV and STI prevention strategies be maintained ... including ... easily accessible education and counselling – including peer education and support on HIV.’</i></p> <p>Limited information is available about the care and support provided to those incarcerated as a result of an HIV exposure/ transmission conviction, with more work needed to determine the adequacy of such care. Of particular concern, is the lack of policy requiring interventions to change individuals’ risk taking behaviour; behaviour that has resulted in ‘criminal’ instances of HIV transmission. Clearly such work is directly relevant to the housing of individuals in correctional environments where ‘there are often impediments to best practice BBV prevention’ and risk taking behaviours are frequent (<i>Sixth National HIV Strategy</i>).</p> <p>People who have faced criminal prosecution for HIV exposure/ transmission are likely to require psycho-social care yet there is no system for linking those charged to formal HIV-related care and support while cases are being pursued, or following incarceration (or for that matter, following a ‘not guilty’ verdict). Processes for coordination of correctional and public health management of individuals upon release are unclear, uncoordinated and inconsistent across state. More attention is required to efforts to reduce risk of HIV transmission from these and other HIV-positive inmates upon release.</p>	<ul style="list-style-type: none"> ■ Research current Corrective Services’ practice for providing care and support services and behaviour intervention to individuals incarcerated as a result of an HIV exposure/ transmission offence ■ Analyse the corrective services/ public health management interface for those awaiting trial, incarcerated and post-release 	<ul style="list-style-type: none"> ■ State Departments of Corrective Services ■ Community Legal Centres ■ NCHSR ■ NAPWA ■ AIDS Dementia and HIV Psychiatry Service ■ Community Justice Centres ■ State-based and relevant peak HIV agencies
<p>Work with media</p> <p>In August 2008, the UNAIDS <i>Policy Brief: Criminalization of HIV Transmission</i> recommended that civil society:</p> <p><i>‘Engage with the media to ensure that coverage of [prosecutions for HIV exposure/transmission] is proportionate and well-informed, explaining the difficulties of disclosing HIV status and reiterating the shared responsibility for sexual health.’</i></p> <p>Insensitive or inaccurate media reporting of criminal prosecutions undermines the ‘enabling environment’ fundamental to the successful delivery of HIV prevention programs. It perpetuates myths about HIV infection and exacerbates stigma against people living with HIV.</p> <p>Proactive work is required to educate journalists and editors, and to increase coverage of the diverse lives and experiences of people living with HIV. Initiatives such as the media briefing by Positive Life (NSW) and the <i>AFAO Media Guide</i>⁸⁰ provide initial examples of such work. Insensitive or inaccurate media reporting of criminal prosecutions involving HIV can be damaging to people living with HIV, and to public health programs.</p>	<ul style="list-style-type: none"> ■ Develop stronger relationships with journalists and editors likely to report on HIV exposure/ transmission trials ■ Consider formal events/ publications to better inform journalists about HIV in Australia, aiming to produce a less hysterical mode of reporting 	<ul style="list-style-type: none"> ■ State-based and relevant peak HIV agencies ■ Media Entertainment and Arts Alliance (union) ■ University journalism/ communications departments



POSSIBLE STRATEGIES FOR CONSIDERATION BY AGENCIES	POSSIBLE ACTIONS TO BE CONSIDERED	POSSIBLE PARTNERSHIPS
<p>Work with state-based agencies</p> <p>While some Australian HIV services have provided support to complainants, defendants or witnesses involved in trials, this support has been ad hoc. Many of those who have gone through HIV exposure/transmission trials appear to have done so without accessing support from HIV-specialist services. Further work is needed to ensure that people encountering the criminal justice system are aware of the range of HIV support services available (including specialist legal services) and that appropriate support is made available both to those accused and to non-expert witnesses.</p> <p>Such processes may require a scaling up of skills related to working within a criminal justice framework and the development of agency protocols regarding identification of conflicts of interest and on-referrals. They may also require some scaling up related to service provision to those under corrective services' or public health management.</p> <p>Individual HIV services have been caught up in criminal proceedings in ways previously unanticipated, triggering review of administrative systems (including record keeping, filing and electronic data management) and clarification of agencies' legal obligations. Collection and discussion of those experiences within the HIV sector may be beneficial to better prepare agencies for issues that may encounter.</p> <p>In some international contexts, local service providers have been proactive in their response to individual trials. In New Zealand, HIV service providers supported both the accused and the witness in the Dalley (condom use) case. In Canada, the Coalition of Community Organizations Quebec Fight against AIDS (COCQ-SIDA) undertook significant fundraising and campaigning around the case of 'D.C.'. The Canadian HIV/AIDS Legal Network obtained 'intervener' status before the Court of Appeal, where they argued Canadian criminal law should not permit a person living with HIV to be convicted for non-disclosure if the sex was protected with a condom or viral was undetectable. While the Court failed to make a ruling relating to condom use, it did rule that undetectable viral load did not pose a 'significant risk' of harm, and D.C. was acquitted. That ruling is now binding on lower courts. Australian HIV services may wish to consider the implications of greater involvement in individual cases where important HIV prevention/human rights principles are involved.</p>	<ul style="list-style-type: none"> ■ Develop a strategy to increase HIV services' capacity to support those involved in criminal HIV exposure/transmission trials ■ Facilitate discussion among HIV services to facilitate greater understanding of the impact of criminal trials on HIV service agencies ■ Facilitate discussion among HIV services to discuss the implications of greater involvement in individual cases where important HIV prevention/human rights principles are involved 	<ul style="list-style-type: none"> ■ State-based and relevant peak HIV agencies, including HIV/AIDS Legal Centres ■ International HIV law-based agencies
<p>Use of expert witnesses</p> <p>It appears that in some criminal cases expert testimony has been lacking, incorrectly applied, misinterpreted or misreported. Some scientific research has been taken out of context and/or applied to situations for which it was not intended, e.g. phylogenetic analysis and 'superbug' theories. In other instances, prosecutors' access to experts pre-trial may have resulted in trials not proceeding or charges related to particular alleged 'victims' being dropped pre-trial. It may be constructive to consider mechanisms to ensure both prosecution and defence lawyers have ready access to information on current scientific research, and contact information for expert witnesses.</p> <p>There may also be some potential to expand the range of witnesses being asked to give evidence. It would be useful to consider accredited training for expert witnesses (as was undertaken in the development of a feminist response to sexual assault defences) as a means to broaden the type of evidence being provided, e.g. psycho-social testimony around sexual practices, disclosure tensions and expectations of intimacy. It may also be useful to consider the possibility of agencies seeking 'intervener' or 'amicus curiae' ('friend of the court') status (as in the Canadian case of D.C.) when there is a matter 'of public importance' at stake.</p>	<ul style="list-style-type: none"> ■ Develop mechanisms to ensure expertise of the HIV sector is made available to lawyers pre-trial ■ Consider the experience of expert witness in trials to date ■ Consider means to expand types of evidence being given to provide a clearer context for individuals behaviours 	<ul style="list-style-type: none"> ■ Judicial training bodies ■ University law schools ■ Departments of Public Prosecution ■ Scientific and medical experts with HIV trial experience ■ Australian Law Reform Commission



POSSIBLE STRATEGIES FOR CONSIDERATION BY AGENCIES	POSSIBLE ACTIONS TO BE CONSIDERED	POSSIBLE PARTNERSHIPS
<p>Address over-representation of African-born accused</p> <p>African-born, heterosexual men continue to be grossly overrepresented among those accused of HIV exposure/transmission offences. It is thus crucial that African Australians are active participants in consultation processes and project/policy development on HIV and the law, so as to identify the causes and effects of this over-representation. Importantly, regard must be had to the issues faced by African people living with HIV for each of the strategies set out in this paper.</p>	<ul style="list-style-type: none"> ■ Facilitate multi-sectoral stakeholder discussion about the disproportionate impact of criminalisation on African-born men as a means to develop strategies to address this issue ■ Conduct research to ascertain the experiences of police, public health officials, medical practitioners, nurses and support workers to better understand their experience in relation to African-born men among those accused of HIV exposure/transmission offences ■ Encourage or commission research on issues of sexuality and gender and its intersection with the over-representation of African-born men among those accused of HIV exposure/transmission offences 	<ul style="list-style-type: none"> ■ State-based and relevant peak HIV agencies ■ NCHSR ■ African Think Tank ■ African Black Diaspora Global Network



References

- 1 Thanks to Linda Forbes, John Godwin, Abi Groves, John Rule, David Scamell and Chris Ward, whose editorial assistance and collaborative efforts on this and earlier pieces of work inform the drafting of this discussion paper.
- 2 That report recommended that 'special, as opposed to existing general criminal law sanctions, be carefully considered by State governments because of the danger of stigmatising already alienated groups' (ICALWP 1992 at para 2.5.4.)
- 3 Kirby, M., 'Foreword' in Cameron, S., & Rule, J. (eds). (2009). *The Criminalisation of HIV Transmission in Australia: Legality, Morality and Reality*, Sydney, NAPWA.
- 4 Griew, R., & Leach, T. (2007). Review of the Guidelines for the management in Victoria of people living with HIV who put others at risk and the Protocol for management of HIV positive person who appear to be placing others at risk, Victorian Department of Human Services.
- 5 Scott, J., & Falconer, R. (2007). Review of Department of Human Services Management of a Specified Group of HIV Cases, Victoria.
- 6 Daly, P. (2007). Report from an international perspective of Victoria's system of response to persons with HIV who may be placing others at risk, Victorian Department of Human Services.
- 7 Minister for Health. (2008). *Maintaining world's best practice when managing people with HIV who put others at risk*, Published by the Victorian Government Department of Human Services, Melbourne.
- 8 Unpublished.
- 9 Griew, R., et al. (2007). *Review of policies for the management of people with HIV who risk infecting others*. Report commissioned by the Blood Borne Virus and STI Subcommittee (BBVSS) of the national Australian Population Health Development Principal Committee (APHDPC).
- 10 The charge is a summary offence so is solely administered by police without involvement of the Department of Public Prosecutions.
- 11 Data obtained from the NSW Bureau of Crime Statistics and Research.
- 12 Data supplied by the HIV/AIDS Legal Service (not yet in NSW Bureau of Crime Statistics and Research database).
- 13 There is speculation that such a defence may reduce the circumstances in which section 13(1) might be applied. However, given it has almost never been applied, that may not be the case. Its application seems more likely to be determined by the desire of individuals to complain to police and police response to those complaints
- 14 Falconer, R., & Scott, J. (2007). Review of Department of Human Services Management of a Specified Group of HIV Cases Melbourne, Victorian Government Department of Human Services.
- 15 Gostin, L., & Lazzarini, Z. (1997). *Human Rights and Public Health in the AIDS Pandemic*. New York: Oxford University Press, in Eliot, R., & Maluwa, M., (2002). *Criminal Law, Public Health and HIV Transmission: A Policy Options Paper*, UNAIDS.
- 16 Principally through the efforts of AFAO and NAPWA.
- 17 For a more detailed list of possible offences see Woodroffe, M., Criminal transmission of HIV in Australia in Cameron, S., & Rule, J. (eds). (2009). *The Criminalisation of HIV Transmission in Australia: Legality, Morality and Reality*, Sydney, NAWPA.
- 18 Cameron, S., & Reynolds, L. (2010). *Global Criminalisation Scan Report 2010: Documenting trends, presenting evidence*, GNP+, Amsterdam.
- 19 This table reflects data as consolidated at February 2011.
- 20 Includes the 1998 case of a guilty verdict overturned on appeal.
- 21 That charge was applied to a male sex worker charged in relation to HIV. The charge, titled 'Knowingly infecting', related to the sex worker working while HIV-positive. No evidence was submitted that the man infected anyone or placed any person at risk.
- 22 There is no statute of limitations on serious crimes (generally those to which gaol terms apply) so persons may be prosecuted for acts of HIV transmission that occurred many years previously.
- 23 For a basic outline of legal issues raised in Australian cases to date see Groves, A., & Cameron, S. (2009). *Criminal prosecution of HIV transmission: the policy agenda*, Sydney, AFAO. Available at www.afao.org.au
- 24 Dodds, C., et al. (2008). *Sexually charged: the views of gay and bisexual men on criminal prosecutions*, Sigma Research, UK.
- 25 Wilson, D., et al. (2008). *Mathematical models to investigate recent trends in HIV notifications among men who have sex with men in Australia*. Sydney: NCHECR. Fraser et al.'s analysis of Dutch and Zambian cohort data also suggested some 30% of transmissions were by people unaware of their HIV-positive status. Canada's Public Health Agency estimated that at the end of 2008, 26% of people living with HIV were unaware they were HIV infected.
- 26 Rawstorne, P., et al., (2009). *E-male survey 2008: key findings from a national online survey of men who have sex with men in Australia*. (Monograph 3/2009). Sydney: NCHSR.
- 27 Bailey, R. C., et al. (2007). Male circumcision for HIV prevention in young men in Kisumu, Kenya: a randomised controlled trial. *Lancet* 369; and Gray, R., et al. (2007). Male circumcision for HIV prevention in men in Rakai, Uganda: a randomised trial. *Lancet*, 369.
- 28 Boily, M., et al. (2009). Risk of HIV-1 infection per sexual act: systematic review and meta-analysis of observational studies. *Lancet Infectious Diseases*, 9.
- 29 Vittinghoff, E., et al. (1999). Per-contact risk of human immunodeficiency virus transmission between male sexual partners. *Am J Epidemiol*, 150(3).
- 30 Jin, F., et al. (2010). Per-contact probability of HIV transmission in homosexual men in Sydney in the era of HAART. *AIDS*, published online ahead of print.
- 31 Boily, M., et al. Op. cit.
- 32 Jin, F., et al. Op. cit.
- 33 Vittinghoff, E. Op. cit.
- 34 Groves, M. (2007). The transmission of HIV and the Criminal Law. *Criminal Law Journal (Australia)*.
- 35 *R v B*, Supreme Court of Victoria, Teague J, June/July 1995, Unreported.
- 36 *R v D*, Supreme Court of Victoria, Hampel J, May 1996, Unreported.
- 37 *Mutemeri v Cheeseman*, unreported Supreme Court decision of April 29, 1998.
- 38 It has, however, been recently applied in Canada in the Quebec Court of Appeal's decision in the case of D.C. See Claivaz-Loranger S. R. c. D.C.: Summary of the Decision of the Court of Appeal of Quebec, COCQ-SIDA, December 2010.
- 39 The Antiretroviral Therapy Cohort Collaboration, (2008). Life expectancy of individuals on combination antiretroviral therapy in high-income countries: A collaborative analysis of 14 cohort studies. *Lancet*, 372:293.
- 40 Weait, M., (2007). *Intimacy and Responsibility: The Criminalisation of HIV Transmission*. London and New York: Routledge-Cavendish.
- 41 Cameron, S., et al. (2009). Outside the HIV Strategy: challenges of 'locating' Australian prosecutions for HIV exposure and transmission, *The Criminalisation of HIV Transmission in Australia: Legality, Morality and Reality*, Sydney, NAPWA.
- 42 National Institute of Allergy and Infectious Diseases, National Institutes of Health, Department of Health and Human Services. (2001). *Scientific Evidence on Condom Effectiveness for Sexually Transmitted Disease (STD) Prevention*.
- 43 Wawer, M J., et al. (2005). Rates of HIV-1 transmission per coital act by stage of HIV-1 infection, in Rakai, Uganda. *J Infect Dis*, 191: 1403-1409; Das-Douglas, M., et al. (2010). Decreases in community viral load are associated with a reduction in new HIV diagnoses in San Francisco. Seventeenth Conference on Retroviruses and Opportunistic Infections, San Francisco, abstract 33; and Montaner, J., et al. (2010). Association of expanded HAART coverage with a decrease in new HIV diagnoses, particularly among injection drug users in British Columbia, Canada. 17th Conference on Retroviruses and Opportunistic Infections, San Francisco, abstract 88LB.
- 44 At page 10, 'Objective: Increase the proportion of people living with HIV on treatments with undetectable viral load'.
- 45 Vernazza, P., et al. (2008). *Les personnes séropositives ne souffrant d'aucune autre MST et suivant un traitement antirétroviral efficace ne transmettent pas le VIH par voie sexuelle*. *Bulletin des médecins suisses*, 89, 5.
- 46 A copy of that decision (in French, with official translation into English) is available at http://www.edwinbernard.com/pdfs/Accused%20S_Swiss%20Decision_EN-FR-affidavit.pdf.
- 47 Bernard, E. J. (2009). Swiss court accepts that criminal HIV exposure is only 'hypothetical' on successful treatment, quashes conviction (updated), *aidsmap*, NAM.
- 48 Claivaz-Loranger S. R. c. D.C. Op. cit.
- 49 Decision of Judge S E Thomas in *New Zealand Police v Justin William Dalley*, 4 October 2005.
- 50 Zablotska, I., et al. (2009). Gay men's current practice of HIV seroconcordant unprotected anal intercourse: serosorting or seroguessing? *AIDS Care*, 21.
- 51 Grierson, J., et al. (2006). *HIV Futures 6: Making Positive Lives Count*. The Living with HIV Program. Melbourne, The Australian Research Centre in Sex, Health and Society, La Trobe University.
- 52 *Project Maleout Study*, Sydney, NCHSR.
- 53 Van De Ven, P., et al. (2002). In a minority of gay men, sexual risk practice indicates strategic positioning for perceived risk reduction rather than unbridled sex. *AIDS Care*, 14, 471-480.
- 54 Grierson, J., et al. Op. cit.
- 55 Zablotska, I., et al. Op. cit.
- 56 *R v Parenzee* [2006], SADC, Unreported.
- 57 de Wit, J., et al. (2010). *Vicious circle of self-protection: reliance on serostatus disclosure to reduce risk of HIV is associated with greater stigma among HIV negative MSM in Australia*. Poster accepted to XVIII International AIDS Conference, Vienna (Abstract number 11886).
- 58 Catanzariti, K. (2010, 18 March). Court told of lover's lane murder of Felipe Flores, *The Daily Telegraph*. Available at: <http://www.dailytelegraph.com.au/news/nsw-act/court-told-of-lovers-lane-murder/story-e6freuzi-1225842396204> (accessed 14 February 2011).
- 59 Kontominas, B. (2008, 18 August). HIV 'prank' led son to kill mum's lover, *The Sydney Morning Herald*. Available at: <http://www.smh.com.au/news/national/hiv-prank-led-son-to-kill-mums-lover/2008/08/18/1218911533555.html> (accessed 14 February 2011).
- 60 Grierson, J., et al. Op. cit.
- 61 Cameron, S. (2009). *Guide to Australian HIV Laws and Policies for Healthcare Professionals*, ASHM.
- 62 See for example the stigmatising effects of such media coverage on the broader population of HIV positive people have been noted in Canovan, P., et al., (2007). Sex Crime: Two Men Jailed for Transmitting HIV, *Positive Living*, Sydney, NAPWA.
- 63 Other cases that have involved consideration of 'intent' have used a definition of 'intent' which might be best described in lay terms as cognisance of the real possibility, probability or likelihood of HIV infection resulting from their actions: an idea that might arguably be better described as reckless in lay, but not legal, terms.
- 64 County Court of Victoria, July 2008 (unreported).
- 65 UNAIDS and UNDP. (2008). *Policy Brief: Criminalization of HIV transmission*. Geneva.
- 66 NCHECR. (2009). *HIV/AIDS, Viral Hepatitis & sexually Transmissible Infections in Australia Annual Surveillance Report*, Sydney, NCHECR.
- 67 Lazzarini, Z., et al. (2002). Evaluating the Impact of Criminal Laws on HIV Risk Behavior. *Journal of Law, Medicine and Ethics*, 30.
- 68 Grierson, J., et al. Op. cit.
- 69 Burris, S., et al. (2007). Do criminal laws influence HIV risk behavior? An empirical trial, *Arizona State Law Journal*, 3.
- 70 UNAIDS. (2002). *Criminal law, public health and HIV transmission: a policy options paper*. Geneva.
- 71 Australian Government. (2010). *Sixth National HIV Strategy: 2010-2013*, Department of Health and Ageing, Canberra.
- 72 Grover, A. (2010). *Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health*, UN Human Rights Council (in accordance with resolution 6/29).
- 73 Truss, J., File No: 3298 of 2008 Judgement, District Court of NSW, 8 April 2010.
- 74 For example, seeking removal of section 13 (proposed section 76) from the *Public Health Act*, or guidelines for police and/or prosecutors about defining limits to impact pursuit of HIV-related criminal law offences.
- 75 Case first scheduled for mention in August 2010.
- 76 UNAIDS & UNDP. (2008). *Policy Brief: Criminalization of HIV Transmission*, Geneva.
- 77 Ibid.
- 78 Terrence Higgins Trust. (2009). Media Release: Policing Transmission. Available at: <http://www.tht.org.uk/mediacentre/pressreleases/2009/january/january27.htm> (accessed 14 February 2011). London.
- 79 The Crown Prosecution Service. Policy for prosecuting cases involving the intentional or reckless sexual transmission of infection. Available at: <http://www.cps.gov.uk/publications/prosecution/sti.html> (accessed 14 February 2011).
- 80 Available at www.afao.org.au