

Criminal Transmission of HIV

A guide for legal practitioners in NSW – May 2009

1st Edition
HIV/AIDS Legal Centre Inc and DLA Phillips Fox

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1st Edition, 2009

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This is the first in a series of publications on the criminalisation of HIV exposure/transmission in Australia. Further titles by the National Association of People Living with HIV/AIDS (NAPWA) and the AIDS Council of NSW (ACON) are scheduled for release in 2009.

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Foreword

THE HON. MICHAEL KIRBY AC CMG*

In the mid-1980s, soon after the human immuno-deficiency virus (HIV) had been identified, I attended, and addressed, an international conference on the subject in Paris. I declared that, in addition to HIV, a new virus had been detected that was sweeping the world. It was HIL. Highly ineffective laws. Even the President of the French Republic, who was in the audience, smiled at the remark. However, the rash of criminal laws and prosecutions, designed to punish persons convicted of transmitting HIV to others, is no smiling matter. The adoption of a large number of such laws in the past five years or so, in countries as different as Australia and Zimbabwe, has added a new factor to the HIV epidemic which is attracting a great deal of attention from those who have the responsibility of monitoring and responding to it. These include local health and criminal justice officials, but also international civil servants and experts working in the primary United Nations agencies with responsibilities in this area: UNAIDS (the UN joint program); WHO (the World Health Organisation); and UNDP (the United Nations Development Program).

Early in this epidemic, it was realised that, in the absence of a cure that would expel the virus from the body of those infected and a vaccine that would prevent infection in the first place, the most effective strategy available to combat HIV was, paradoxically, to protect people who were infected, or at risk of infection, so as to promote behaviour modification. The countries that have embraced these strategies, including Australia, have witnessed success by adopting novel initiatives: condom supply, needle exchange, decriminalisation of consensual adult sex work; removal of criminal offences addressed to same-sex activities; anti-discrimination laws and public education. Virtually from the start, and under differing governments, Australia has adopted these strategies. The result has been considerable success in reducing the rates of sero-conversion.

The intervening decades have not produced a cure for, or vaccine against, HIV or AIDS. But two developments stand out. One positive and the other negative. On the positive side, at about the turn of the century, combinations of anti-retroviral drugs were found to control the deadly progression of HIV in most patients. Although available in Australia to reduce bodily levels of HIV virtually to zero, such drugs were not at first available worldwide. The creation of the Global Fund and initiatives of UNAIDS and WHO have led to the spread of availability of these drugs, despite their high cost. The consequence has been dramatic for people under treatment.

The negative developments have included a rising anger in society at the continuance and cost of the epidemic; increases, even in Australia, in sero-conversions amongst people who wrongly think 'the epidemic is over'; and the enactment of specific criminal laws to enhance the punishment of those who intentionally infect others with HIV.

This book is addressed to the last of those and is concerned with the response of criminal law to persons who intentionally infect others with HIV. It addresses to the last-stated development, but its subject can only be fully understood and evaluated, against the background of the history of this epidemic to date and the enormous toll it has taken on populations and individuals in all parts of the world, including Australia.

Civil implications of HIV came before me twice, during my service on the High Court of Australia. In *IW v. City of Perth*¹ and *X v. The Commonwealth*², elements of irrationality were evident in the conduct examined in each matter. The criminal transmission of HIV came before the Court on a special leave application against the conviction entered in the case of the accused in *R v. Reid*³. Special leave was refused.

Reid's case illustrates some of the problems explored in this book. It is all very well to propound global and national strategies for combating the spread of HIV on a macro basis. But where there is a suggestion of wilful, deliberate or completely reckless transmission of HIV to a sexual partner, infection with HIV is such a life-changing event that people get angry at such conduct. They look for retribution and punishment. As this book shows, the criminal law provides a number of general and specific offences that can be deployed, depending on the circumstances.

Unfortunately, a glance at the cases recorded in this book tends to indicate that particular offenders seemed to be singled out disproportionately. Especially foreigners who infect local women. Particularly those who come from different lands and alien cultures. Prosecutors have their own discretions to ensure the principled deployment of the criminal law. But once a case is brought, a court can only apply the law as it is enacted. It cannot stay the proceedings or postpone them simply because it might believe that criminal prosecutions are ineffective or even counter-productive as a public health strategy to promote behaviour modification.

This book is addressed to the law in New South Wales. Criminal and public health laws differ significantly across the several jurisdictions of Australia. In the face of the gradual apparent increase in such prosecutions, it is very useful to have a handy text that identifies the epidemiological background; lists the offences and their ingredients; notes relevant cases; and suggests issues that a lawyer and the client must address.

I congratulate those who have been working in this epidemic since it first arrived in Australia. As this book demonstrates, some of them, for a very long time, have been lawyers. HIV/AIDS is not an ordinary medical condition. It is an extraordinary global pandemic with many social and legal implications, some of which are explored in these pages.

Michael Kirby
Sydney
1 June 2009.

*Formerly Justice of the High Court of Australia (1996-2009).

Footnotes

1. (1998) 191 CLR 1.
2. (199) 200 CLR 1.
3. (2006) 162 ACrimR 377, SLR

AIDS and HIV: General Facts

Introduction

In 1959, scientists isolated what is now believed to be the earliest known case of AIDS (Acquired Immune Deficiency Syndrome). In 1978 there were further reports of gay men in the United States and Sweden, and heterosexuals in Tanzania and Haiti, showing signs which were consistent with AIDS¹. The first reports of the Human Immunodeficiency Virus (HIV), published on July 4, 1981, were of homosexual patients who had contracted rare diseases such as a rare skin cancer, Kaposi's Sarcoma and PCP (Pneumocystis Pneumonia). It quickly became clear that the illnesses were caused by a new infection, which soon spread to other population groups outside the gay community. In 1983, the Human Immunodeficiency Virus Type 1 (HIV-1) was identified as the primary cause of Acquired Immunodeficiency Syndrome². Twenty-seven years later and HIV infection has now changed from being a fatal condition to a long term manageable chronic illness. This is due largely to greater understanding of how to treat the virus and the development of antiretroviral therapy (ART), also called Highly Active Antiretroviral Therapy (HAART) (See page 12).

The Human Immunodeficiency Virus

The immune system is the system of organs and cells through the body, which fight infection and maintain health. AIDS, or Acquired Immune Deficiency Syndrome, is a disorder of the immune system. AIDS is caused by a retro-virus known as the Human Immunodeficiency Virus (HIV). HIV targets and invades certain cells in the body and takes over and reprograms some of the genetic functions of those cells. The main type of cells that are infected are a type of white blood cell called CD4 cells or "T-cells". These cells are a critical part of the human immune system responsible for identifying any infective agent. Once an infective agent has been identified, CD4 cells then trigger other cells that make up the immune system to fight the infection. The virus attacks the CD4 cells from the time of infection, gradually overpowering them and so weakening the immune system. As a result, a person with HIV becomes susceptible to a wide range of life threatening infections, cancers, and other disorders, which in turn may lead to the person's death.

The Progression from HIV to AIDS

Although the terms HIV and AIDS are often used interchangeably, this in fact misrepresents the nature of the disease. Whereas being HIV positive means a person is infected with the virus, a person is only said to have AIDS if they become ill from one of a number of specific clinical conditions, which include opportunistic infections, tumours, neurological disorders, or wasting. Therefore, a person may be HIV positive without having AIDS. It is generally thought that HIV will inevitably lead to the development of AIDS, however, even without treatments, a small but significant number of people have been able to live with HIV for a long time without developing AIDS. This is referred to as being a "long-term non-progressor".

Australia currently uses the system developed by the US Centre for Disease Control (CDC) to classify the categories of HIV infection. The categories are as follows³:

STAGE 1 - Primary Infection (Seroconversion Illness). When a person is newly infected with HIV they may go through what is called a 'seroconversion illness' and show flu-like symptoms that may include fever, swollen glands, sore throat and rashes. Symptoms if they occur will generally present between 2-6 weeks after exposure. Approximately 50% of people who become infected with HIV will experience seroconversion. They may appear to be healthy at this stage when they are in fact infectious. In this stage the viral load is usually high and a person may, in fact, be very contagious.

STAGE 2 - Asymptomatic infection. During this stage a person may remain healthy and show no symptoms. This may continue for a number of years. A person may still transmit HIV at this stage.

STAGE 3 - Symptomatic infection. At this stage people might experience symptoms including diarrhoea, minor skin conditions, minor oral conditions, lack of energy, night sweats and/or persistently swollen glands.

STAGE 4 - Advanced disease (AIDS). At this stage, HIV has affected the immune system to such an extent that the body is unable to cope with illness and infection. Severe symptoms are experienced at this stage and people with AIDS are at risk of opportunistic illnesses. Opportunistic illnesses are re-activation of infections which most people are exposed to at some point in their lives but which are normally suppressed by a healthy immune system. HIV weakens the immune system to such an extent that these infections may become acute or ongoing illnesses. Some opportunistic illnesses can be very serious or fatal. However, the risk from such infections can be reduced with antiretroviral and prophylactic treatments.

The Life Expectancy of Persons with HIV/AIDS

It is difficult to give meaningful statistics on the life expectancy of someone with HIV. Prior to 1995, the average period between infection and the development of an AIDS defining illness was approximately 10 years³. Approximately 50% of people with an AIDS defining illness, diagnosed at that time, would die within 2 years. The widespread introduction of new treatments for people living with HIV began in early 1996. Triple combination antiretroviral therapy (see page 12), has been successful in stopping or slowing disease progression in many people with HIV/AIDS.

Combination therapy has improved the quality and expectancy of life for many people with HIV. However, a small but still significant number of people with HIV have experienced no or only a small benefit from combination therapy if they have advanced disease with developed resistance to the available drugs. In addition, much of the early optimism and hope surrounding the development of combination therapy has been tempered by a realisation that increased longevity has not come without a price. People on combination therapy often have difficulty following the complex drug regimes, are unable to tolerate the often debilitating side effects, or develop other co-morbidities such as diabetes or cardio-vascular disease.

Despite the difficulties associated with treatment, combination therapy can increase the survival of people with HIV to several decades or longer if treatments continue to improve. It is now estimated that if the CD4 count can be maintained above 500, 90% of people will live 35 years after infection, or beyond. Factors which may determine how long an HIV positive person lives may include how well they maintain their physical and emotional health, treatment decisions, genetic factors and if they experience co-infection with other illnesses such as sexually transmitted infections and hepatitis. The age at which the person is infected with HIV may be an important factor. Prior to the widespread use of HAART, older age at time of infection predicted a faster progression to AIDS and death. However, studies have shown that older age patients beginning HAART have better responses to therapy than younger age patients. This may be because of better adherence to therapy in older patients⁴. Finally, the stage of disease progression at the time of diagnosis will also influence longevity.

HIV testing

Diagnosis: anti-body and antigen testing

When a person is infected with HIV, their immune system produces antibodies to fight the infected cells. Antibodies are chemicals that are part of the immune system that recognize invaders like bacteria and viruses and mobilize the body's attempt to fight infection. An HIV antibody test is used to check for the presence of such HIV antibodies (a "footprint" of the virus, rather than the virus itself).

Most people's bodies will produce these antibodies within a few weeks after HIV infection. However, in some cases this may take up to three months. This three month period is called the "window period". This means that if an HIV antibody test result comes back as negative, it does not necessarily indicate that the person is definitely HIV negative. It is only where a person has had a negative test at three months after significant exposure, that they can be assured that they do not have HIV.

Another kind of test is the antigen test, which looks for the HIV virus itself. This test will identify if someone has become HIV positive much sooner after infection than an antibody test. An antigen test may be used when someone has, or may have had a recent exposure to HIV.

Measuring the effect of HIV on the body: CD4 Count and Viral Load Testing

There are two main tests that are used to measure the ongoing effect of HIV on a person, the CD4 test and the viral load test. The CD4 test shows how much damage has already been done to the immune system. The viral load test indicates the level of virus and viral replication in the blood. The first tests of CD4 and viral load are a person's initial "baseline".

The CD4 cell count or the "T-cell count" measures the damage which has already been done to a person's immune system. It measures the number of CD4 cells in one millilitre of blood. A CD4 cell count test is also used to measure how well a person is responding to treatments. A low CD4 count for a person not on treatment (eg <200) means that a person's immune system is very suppressed by the virus and they are at high risk of developing AIDS. A low CD4 count for a person on treatment indicates that the immune system is slow to recover.

A healthy adult will have a T-cell count ranging from 500 to 1350 cells/mm³. A T-cell count of greater than 500 indicates little or no immune system damage has occurred. A T-cell count of between 250 and 500 is indicative of some damage to the immune system, but with a low risk of major opportunistic infections. A T-cell count of less than 250 indicates more serious immune system damage, leaving a person at risk from major opportunistic illnesses³.

The "viral load test" measures the amount of virus present in the blood. This information can then be used to assess how actively the virus is replicating and how actively HIV is attacking the immune system. It measures the number of copies of HIV in one millilitre of blood. CD4 and viral load tests are usually repeated regularly. A rough guide to viral load results is that a viral load of 50,000 copies or more shows that the virus is very active, and that damage to the immune system is likely to occur. 10,000-50,000 viral copies shows that damage is still occurring, but at a less rapid rate. Less than 10,000 viral copies indicates slower damage to the immune system. A viral load below 50 viral copies is termed "undetectable", which means that standard measures cannot detect the amount of activity accurately below this level. A non-detectable viral load means that the virus may still be replicating, but it will be at a very low rate. Although a low or undetectable

viral load may reduce the risk of transmission of the virus, a person with an undetectable viral load can still transmit the virus (see page 11 for a more detailed discussion of this issue). It is recommended that HIV positive patients undergo immune monitoring tests for CD4 count and viral load testing every 3-4 months.

The Transmission of HIV

This section provides general information about the modes of transmission of HIV and the degree of risk of transmission that each carries. Although evidence of the risk of transmission may be highly relevant evidence in a criminal trial, an attempt to calculate the exact risk in a particular factual situation should be avoided. The High Court of Australia has stated that in analysing level of risk or danger, it is not the correct approach to do this by analysis of mathematical probability⁵. The question of the degree of risk associated with a particular act is a question of fact to be decided by the jury. Therefore, although understanding the risks associated with certain behaviour is essential, overemphasis on statistical data based on population studies should be avoided as it is often difficult to prove an accused person was aware of the mathematical calculation of risk (see page 40).

How is HIV transmitted? HIV can only be transmitted through exposure to blood or to some body fluids of a person who is infected with the virus. This can occur in four ways¹³:

- (a) unprotected sexual intercourse with an HIV positive partner;
- (b) injection or transfusion of contaminated blood or blood products (but this is unlikely in Australia since routine screening of all blood products for HIV was introduced in 1985). It is also possible for HIV to be transmitted via artificial insemination, skin grafts or organ transplants;
- (c) sharing injecting equipment that has previously been used by an HIV positive person;
- (d) transmission from mother to child during pregnancy, childbirth and through breast feeding.

HIV cannot be transmitted through;

- (a) casual every day contact;
- (b) mosquitoes
- (c) contact with saliva (non-bloody), tears, vomit, sweat, urine or faeces
- (d) exposure of intact skin to HIV-contaminated body fluids such as blood

This means that HIV cannot be transmitted through kissing, hugging, sneezing, coughing, breathing, touching or the sharing of eating utensils.

High Risk Activity

Unsafe sex is any sexual activity that allows semen, vaginal fluid or blood to pass from one person into the bloodstream of another person. Some forms of sexual contact have been classified as "high risk" with regards to the potential for the transmission of HIV. These include unprotected anal and vaginal intercourse, with receptive anal sex being estimated to produce the highest risk of infection. Infected blood or semen can enter the bloodstream through the lining of the rectum or the vaginal wall. The virus may also pass through tiny cuts or through the opening of the penis. The presence of other sexually transmitted diseases significantly increases the risk of HIV transmission. HIV can also be present in vaginal fluids or blood that enters the penis through tiny

cuts or through the opening of the penis. HIV is also found in pre-ejaculation fluid and withdrawing before ejaculation may not prevent transmission of HIV. Sharing of intravenous injecting equipment is also considered to be a high-risk activity as it may lead to the transmission of infected blood from one user to another⁶.

Low Risk Activity

Other forms of sexual contact are defined as “low risk”. Unprotected oral sex without ejaculation carries a very small risk for transmitting HIV from the penis or the vagina to the mouth of the receptive partner. If blood, semen or vaginal fluid enters the mouth it will increase the risk. This is especially so if there are any cuts or bleeding caused by flossing and teeth brushing, gum disease, ulcers or other throat infections. Protected anal intercourse also carries a low level of risk. Mutual masturbation is generally said to be safe, except where bodily fluids such as semen or blood come into contact with cuts or openings in the skin.

In order to be infected by contact with HIV infected blood, that blood must be able to enter the body. This usually occurs through exposure to an open wound or a needle stick injury. In the past, it also occurred as a result of using HIV infected blood for transfusions or the production of other blood products. This would be highly unlikely to occur following the introduction of comprehensive screening of all donated blood in 1985.

Risk Reduction and Viral Load

It is generally thought that the risk of HIV transmission during unsafe sex is lower if viral load is lower and higher when viral load is higher⁶. However, a number of studies have shown that viral load is not an accurate way of measuring the risk of transmission. Viral load is measured from blood plasma. There is some correlation between viral levels in the blood and genital fluids, including semen and cervical secretions. However, a number of studies have shown that men with an undetectable viral load in their blood nevertheless have detectable HIV in their semen⁷. Similarly, some women who are on ART and have undetectable levels of HIV in their blood have detectable levels of the virus in the genital tract⁸. If a person misses significant doses or ceases HIV medication at any time, then the risk of transmission to a sexual partner will increase.

A number of factors have been shown to influence the relationship between viral load in blood, semen and cervical secretions. These include the presence of sexually transmitted infections; antiretroviral drug concentrations; adherence with antiretroviral therapy and intermittent changes in levels of HIV day to day⁹. This means that an ‘undetectable’ viral load test may not reflect the actual viral load in the genital tract or in semen. In addition, viral load can vary from day to day and breaks in treatment can affect results. Finally, viral load tests measure the “free virus” in the body but HIV is also present in the genetic material of cells in the body. HIV infected cells can exist in blood and semen and can be transmitted during unsafe sex.

In January 2008, a group of Swiss HIV experts issued a report on behalf of the Swiss Federal Commission on HIV/AIDS on the infectiousness of HIV positive individuals¹⁰. The report states that an HIV infected person on optimally effective antiretroviral therapy (ART) cannot transmit HIV through sexual contact if the following conditions are met:

- The person infected with HIV must adhere to the ART consistently, and be regularly evaluated by the treating physician;

- The infected person must have a viral load below the limits of detection (blood plasma level of less than 40 copies/ml) and have been at this level for at least six months;
- The infected person must have no additional sexually transmitted disease present.

In February 2009, the Geneva Court of Justice in Switzerland quashed the 18-month jail sentence of an HIV+ man previously convicted of HIV exposure, after accepting the Swiss study that risk of HIV transmission while on successful treatment is close to zero¹¹. In an earlier case involving a five-member panel of the US Court of Appeals for the Armed Forces where the Swiss study was explored, it was concluded that although the risk of transmission was very low, it could not be considered to be zero.

Much international debate continues as to whether this suggested 'zero risk' is accurate. A recent study suggests that the risk of HIV transmission in heterosexual partnerships during effective treatment is low but non-zero, and that the risk for male homosexual partnerships is high over repeated exposures¹². Whilst the Swiss report recommends a 6 month period of undetectable viral load, other studies still suggest that this timeframe should be extended for at least 2 years⁹.

The Swiss report has not been accepted by the World Health Organisation, UNAIDS or the US Centre for Disease Control. A number of influential Australian HIV/AIDS organisations have stated that further research is required before the Swiss study can be accepted⁹. It appears unlikely that the Swiss report will attain widespread acceptance in Australia until further research confirms its findings. It is therefore unlikely that a person will be able to use the fact that they were on successful and stable ART with an undetectable viral load as a successful defence to a charge of transmission of HIV in Australia.

HIV Treatment and Drug Regimes

Over the past twenty six years, the treatment of HIV has changed as the disease has come to be better understood and managed¹³. Since the advent of Highly Active Anti-Retroviral Treatment (HAART) in 1996, the number of deaths from AIDS have dramatically declined and people living with HIV who are on treatment have a much longer life expectancy.

HAART involves combining a number of different drugs which attack the virus in different ways. This is called combination therapy. Combination therapy aims to reduce a person's viral load and the use of viral load testing allows for the monitoring of the efficacy of such drug combinations. Where a person is on treatment and a test reveals a high viral load this may indicate that a person has not been adhering to the recommended treatment and has built up a resistance to certain drugs or certain drug combinations.

HIV works by replicating itself in the body. Every time a copy is made there is a chance that the virus will mutate slightly. If a person is on a drug and mutation occurs at a specific site relevant to that drug, the virus will become resistant to that drug. Where a person is on two or three drugs, the virus would need to replicate two or three times, making a combination of drugs more effective. However, if a person misses doses regularly or stops taking drugs for a few weeks they increase the chance of mutation, and the development of resistance to drugs³. Drug resistance can be transmitted from person to person if a person is newly infected with HIV by a patient who has developed resistance to one or more antiretroviral drugs.

Although HAART has reduced morbidity rates and the incidence of AIDS considerably, it is not a cure for HIV and it cannot entirely eradicate the virus from the body. Currently, HIV is considered to be a chronic disease which, although incurable, can be controlled with lifelong therapy. The management of antiretroviral therapy is complex and requires a considerable amount of discipline from patients and strict (greater than 95%) adherence to treatment regimes¹⁴.

Side effects to treatments

Many of the drugs prescribed as a part of combination therapy produce side effects in some people, including nausea, diarrhoea, headache, lethargy, insomnia and lipodystrophy, or fat wasting¹⁵. These side effects will often be short term and disappear after weeks or months. In other cases, side effects may be ongoing or recur intermittently and in such cases can often be severe or debilitating.

New Developments in HIV Medicine¹⁴

Legal practitioners should be aware of new developments in HIV Medicine and ensure that legal analysis is based on the most up to date medical information about HIV/AIDS. Since 1996, highly active retroviral therapy (HAART) has been widely used for treating HIV infection. HAART is a combination of at least three antiretrovirals (ARVs) from at least 2 drug classes. The three most commonly prescribed HIV antiretroviral drugs are:

- Nucleoside and nucleoside reverse transcriptase inhibitors (NRTIs, sometimes called nucleoside analogues or “nukes”)
- Non-nucleoside reverse transcriptase inhibitors (NNRTIs, or “non-nukes”)
- Protease inhibitors

Newer classes of antiretroviral drug include:

- Fusion inhibitors and CCR5 entry inhibitors which prevent HIV from entering healthy CD4 cells in the body. They work differently from the first three groups, which are active against HIV after it has infected a CD4 cell
- Integrase inhibitors - this new class of antiretroviral drug irreversibly inhibits the integration of HIV DNA into the DNA of the host cell.

These new classes may offer hope for HIV-positive people who have developed HIV resistance to the earlier drugs.

Post-Exposure Prophylaxis (PEP)

Where a person has been exposed to HIV, they can have post-exposure prophylaxis (PEP) as a way of reducing the risk of infection with HIV. PEP involves treatment with a combination of HIV drugs for one month, which has been shown in some cases to prevent the virus from taking hold in the body. PEP must be sought from a doctor as soon as possible after the exposure and no later than 72 hours after exposure to the virus in order for it to be most effective.

Epidemiological research has shown that a short course of antiretroviral therapy can reduce HIV transmission rates. For example, a study of health care workers with needle stick injuries showed that using PEP after the incident reduced the risk of infection by about 80%¹⁶. Post exposure prophylaxis has been proven to prevent mother to child transmission of HIV. However, the efficacy of PEP in the event of sexual exposure has never been proven by a placebo controlled clinical trial (the “gold standard”) and such trials will never be undertaken.

According to WHO Guidelines, PEP cannot be considered 100% effective, it is therefore important that HIV post-exposure prophylaxis policies reinforce the importance of primary prevention and risk prevention in all settings where HIV could be transmitted. PEP is not a vaccine or a cure for HIV.

Re-infection and Superinfection³

Re-infection refers to a person getting a new or secondary infection from a virus that has already infected them. In the context of HIV, re-infection may also be referred to as superinfection (where someone is infected with more than one type of HIV). The question of whether re-infection with HIV could occur was heavily debated until 2002 when three well documented cases of HIV re-infection were described. Several other cases have been described since this time.

There is still a considerable amount of uncertainty about the implications of superinfection and what impact it may have on disease progression. The presumed risk to an HIV positive person is that reinfection would mean they acquire a drug resistant strain of HIV causing rapid damage to the immune system, limiting treatment options and affecting the success of current treatment. It is also unknown how often re-infection occurs. It is quite hard to identify and prove, so even though it has not been observed frequently, it may actually occur more often. People with HIV may also become reinfected through unsafe sex or injecting with other people with HIV who are infected with a different (or drug resistant) strain of the virus (see page 34).

Safe sex is still advised when both partners are HIV positive. HIV infected individuals are not protected from superinfection with new viral strains; and infections with several different strains are often associated with accelerated progression of the disease.¹⁷

Post-Diagnosis Counselling and the Law

In NSW the *HIV Antibody Testing - Counselling - Guidelines*¹⁸ state that pre-test counselling, now often called "discussion," for HIV should include a brief explanation of the legal issues associated with a positive result. These guidelines are mandatory, however the exact content of such an explanation will clearly vary between different health professionals. When the result is positive, the doctor must give the person information on:

- how to minimise the risk of infecting other people with the virus
- the public health implications of being HIV positive
- the person's legal responsibilities (*Public Health Act (NSW) 1991* s12).

A doctor who fails to do this commits an offence punishable by a fine of up to 50 penalty units.

Where to find the latest medical information

To find up to date medical information on HIV/AIDS or to find an expert witness contact either:

Australasian Society of HIV Medicine (ASHM)

Web: www.ashm.org.au/

AIDS Council of NSW (ACON)

Web: www.acon.org.au/

HIV/AIDS Legal Centre (HALC)

Web: www.halc.org.au/

Footnotes

1. Aegis timeline "So Little time" <http://www.aegis.com/topics/timeline/default.asp>
2. Barre-Sinoussi F, Chermann JC, Rey F, et al. Isolation of a T-lymphotropic retrovirus from a patient at risk for AIDS. *Science* 1983, 220: 868-71. <http://amedeo.com/lit.php?id=6189183> (accessed 2 April 2009)
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Human Rights and HIV/AIDS

International Guidelines on HIV/AIDS

The UNAIDS *International Guidelines on HIV and Human Rights*¹ outline how states can effectively manage the spread of HIV. The guidelines stress that this can only be achieved through the promotion of human rights for those living with the disease;

“States should review and reform criminal laws and correctional systems to ensure that they are consistent with international human rights obligations and are not misused in the context of HIV or targeted against vulnerable groups”².

Criminal lawyers and policy makers alike must recognise that there exists a “paradoxical relationship of mutual interest”³ in promoting human rights for HIV positive people. Ultimately, those who can prevent the spread of the virus are those infected with the virus. Although the guidelines are primarily aimed at governmental action and the drafting of policy, the implementation of the criminal law must be monitored and regulated by the judiciary and legal practitioners so as to prevent the misuse of laws in the context of criminal trials for HIV transmission offences.

Human Rights, HIV/AIDS and the Criminal Law

*“AIDS makes us angry. But in law we must be rational”*³

Criminal trials for the transmission of HIV arouse considerable community interest, which is often manifested in the form of fear, panic and outrage. Overwhelmingly, the community response comes in the form of calls for unmitigated, punitive justice. However, the law must be implemented in such a way that supports public health initiatives and which has the ultimate aim of preventing the spread of HIV.

The objectives of criminalization include incapacitation, rehabilitation, retribution and deterrence. These are fundamentally ill-suited to achieving positive health outcomes. No studies to date have shown that applying the criminal law to HIV transmission has prevented HIV transmission⁴. There is a serious risk that harsh punitive justice will reinforce the HIV/AIDS related stigma, spread misinformation about HIV/AIDS and create a disincentive to HIV testing, as people fear a threat of incurring criminal liability. Furthermore, application of criminal sanctions may in fact hinder access to counselling and support, by discouraging honest disclosure to medical staff and creating a false sense of security that the criminal law can protect a person from contracting HIV⁵.

No one has the right to transmit HIV, but it is only through creating and implementing law that fosters honesty within the HIV positive community, that the spread of HIV can be prevented. With the exception of cases where individuals actually intend to do harm, criminalising HIV transmission does not empower people to avoid HIV infection, and in fact may make it more difficult for them to do so, endangering both public health and human rights. Therefore, the implementation and use of the criminal law in the context of HIV transmission must be done with consideration for human rights and one central objective, to prevent the infection of individuals and the spread of HIV within the community.

The Decision to Prosecute

The Prosecution Guidelines of the NSW Office of the Director of Public Prosecutions outline the proper conduct for a responsible prosecutor in NSW. The guidelines state that in making the decision to prosecute, “the general public interest is the paramount criterion”⁶. In a case of HIV transmission where there is at least some evidence of intent to cause infection, a prosecution will almost certainly be brought in the interest of protecting the public from further infection. Although arguably imprisonment would not in fact reduce this risk of transmission, in the most extreme and worst of the cases, the use of criminal punishment may be necessary to publicly condemn the heinous nature of the crime. Only in the most extreme case, where the conduct of concern is truly criminal in nature, should punishment, as a means of cultural signification of wrongdoing, be employed.

In the United Kingdom, prosecution guidelines specific to different offences have been implemented to guide prosecutors in their decision regarding whether or not to prosecute. The guidance recognises the tension between public health and criminal justice considerations. For offences relating to the intentional or reckless transmission of sexually transmitted diseases, the guidelines outline the factual, scientific and medical evidence on which to base a prosecution⁷. For example, The Crown prosecution guidelines make it clear that only in the rarest of cases could a person who has actively sought to avoid onward transmission of HIV be successfully prosecuted. This guidance is in line with sexual health promotion practice, encouraging the use of safe sex practices to prevent transmission of infection.

Criminal liability should only be attached to acts which in fact cause the transmission of HIV rather than those which merely expose a person to risk of transmission. In *R v Barry* (unreported, Qld CCA, 17 July 1989), a seventeen-year old Aboriginal man, who was HIV positive, was charged with wilful exposure of HIV. This was the result of Barry having rubbed his own excrement into the face of a police officer. For that charge, Barry received a twelve month sentence. His total sentence exceeded his two year life expectancy. Barry later committed suicide in his cell. This is a clear case where prosecutorial discretion should have been exercised, both due to the almost negligible risk of transmission in a case of contact with faeces, and the fact that no actual transmission occurred. The law should not be used in the context of HIV so as to target vulnerable groups. The public interest in preventing such human rights abuses clearly outweighs the public interest in the perceived need to protect the public from the accused.

Currently, there is no offence of wilful exposure in NSW. The recent repeal of section 36 Crimes Act 1900 (NSW) has removed the specific offence of infecting a person with a grievous bodily disease and has included this within the general offence of causing grievous bodily harm under section 35 of the Crimes Act. This is a positive piece of law reform in that it removes the stand-alone section dealing with HIV transmission and incorporates it within a general offence.

Consent and International Law

Transmission of HIV is often caused as a result of consensual activity, such as through sexual activity or intravenous drug use. For example, twenty five percent of transmissions amongst gay men happen within relationships⁸. The issue of whether a person has the legal capacity to consent to having unprotected sex with an HIV positive person is relevant for HIV positive people who have sex with other HIV positive people, also called poz-poz sex (see 34). It is also relevant for homosexual and heterosexual couples who engage in sex where one member of the couple is positive and the other is negative. This is called “sero-discordant” or “poz-neg” sex.

If the law of consent is construed so as to deny a person the legal capacity to consent to expose him or herself to the risk of infection with HIV, then this may represent a serious encroachment into the private lives of HIV positive people and their partners. Such an encroachment may be in violation of Australia's international obligations under the International Covenant on Civil and Political Rights (ICCPR). Article 1 of the ICCPR protects privacy of individuals from arbitrary interference. This is the right to self-determination. Australia is a signatory to the covenant and it was ratified in 1980.

In addition, the Commonwealth Human Rights (Sexual Conduct) Act (1994) section 4 states that sexual conduct involving only consenting adults acting in private is not to be subject, by or under any law of the Commonwealth, a State or a Territory, to any arbitrary interference with privacy within the meaning of Article 17 of the International Covenant on Civil and Political Rights.

It is a reality that HIV positive people do have sex and that they see this as a right. The National Association of People Living with HIV/AIDS (NAPWA) has adopted a *Declaration of the Rights of People with HIV/AIDS* and this includes, "The recognition that HIV positive people have the right to a full and satisfying sex life"⁹. Where the criminal law of consent in NSW is defined in relation to HIV, consideration must be given to the potentially invasive effect that the law may have in terms of denying people a capacity to consent to acts that are within the private domain. Should the law of consent develop in this way, it would reinforce stigmatisation and discrimination against HIV positive people. Alternatively, it could simply result in the creation of ineffective laws that are impossible to police (See discussion of consent and the law, page 32).

Footnotes

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NSW criminal offences and the prosecution case

Who can be held liable for the transmission of HIV?

Any person who transmits HIV or exposes another person to the virus may be held criminally liable where the act falls within the scope of a criminal offence. Transmission of HIV may be prosecuted under a number of different provisions in the *Crimes Act 1900* (NSW). The prosecution should endeavour to ensure that the charges laid fit the nature of the alleged criminal activity, so as not to produce results which may be outside the intended scope of the legislation, or which do not reflect the degree of culpability of the accused.

Legal Analysis in a criminal trial in NSW

In a criminal trial for a transmission offence, legal analysis must consider the implications of HIV specific legal issues within a criminal context. The paucity of cases of transmission offences in NSW means that consideration of case law from other jurisdictions may be useful. However, careful attention to the statutory requirements of the NSW offences is essential. It should be noted that as there has only been one criminal trial for HIV transmission in NSW to date (*Kanengele-Yondjo v Regina*¹, see page 48), many of the issues discussed in this resource are largely hypothetical, as they have not been judicially considered in this state. Cases from overseas jurisdictions are not binding in NSW, however, it is essential to consider judicial trends globally where they may be of relevance to a NSW trial.

Onus and burden of proof

The onus is on the prosecution to prove all elements of the offence beyond a reasonable doubt.

Statutory Offences

Crimes Amendment Act (NSW) 2007:

In 2007 the NSW government introduced a raft of changes to the *Crimes Act 1900* (NSW)². The law was passed in response to a number of incidents involving people throwing or dropping rocks onto moving vehicles. Generally such people are charged with inflicting grievous bodily harm. The amendments increased the maximum penalty for that offence. Item 4, Schedule 1 amends section 33 of the *Crimes Act* so that causing grievous bodily harm with intent now carries a 25 year maximum prison term. Item 7, Schedule 1 amends section 35 of the *Crimes Act* so that where grievous bodily harm is caused recklessly, the maximum sentence has been increased from 7 to 10 years.

The Act also includes a number of other amendments aimed at modernising and simplifying the *Crimes Act 1900* (NSW). This includes the abolition of the stand-alone offence of causing a grievous bodily disease under section 36 (see page 48 for a discussion of the attempted use of section 36 for a prosecution in NSW). Instead, this is incorporated into the grievous bodily harm offence where the definition of grievous bodily harm includes a grievous bodily disease. UNAIDS endorses the use of general criminal laws in the context of HIV transmission and has expressed concerns regarding the use of HIV specific offences³.

The term 'malice' has been replaced by the more specific reference to 'recklessness' or 'intent or recklessness' where necessary.

An accused person will be charged according to the law at the time of the offence. This is important to consider given the changes to the *Crimes Act* outlined above.

With respect to s35, for offences committed before 27 September 2007, the relevant charge will be maliciously inflicting grievous bodily harm, with a maximum penalty of 7 years (or 10 years if committed in company).

The new s33 applies to offences committed on or after 15 February 2008.

Section 36 has been repealed, and even when in force was rarely used to lay charges since it required intent which was often difficult to establish.

The following sections consider all possible charges which may be laid in the context of a criminal trial for transmission of HIV and the implications of the recent amendments to the *Crimes Act* 1900.

Murder

Section 18 of the *Crimes Act* defines the offences of murder and manslaughter:

- (1) (a) Murder shall be taken to have been committed where the act of the accused, or thing by him or her omitted to be done, causing the death charged, was done or omitted with reckless indifference to human life, or with intent to kill or inflict *grievous bodily* harm upon some *person*, or done in an attempt to commit, or during or immediately after the commission, by the accused, or some accomplice with him or her, of a crime punishable by imprisonment for life or for 25 years.
- (b) Every other punishable homicide shall be taken to be manslaughter.
- (2) (a) No act or omission which was not malicious, or for which the accused had lawful cause or excuse, shall be within this section.
- (b) No punishment or forfeiture shall be incurred by any *person* who kills another by misfortune only.

Actus Reus and Causation

There is no precedent in NSW of a person being charged with murder in relation to the transmission of HIV. At common law this was precluded by the rule that the death had to occur within a year and a day of the act or omission which caused it. HIV may lead to the development of an AIDS defining illness and eventually death, but there is almost always a significant delay which can last for many years. This rule has been amended in NSW by section 17A of the *Crimes (Injuries) Amendment Act* 1990. This issue is now left to the jury to determine as a question of fact whether the infection with HIV was the “operating and substantial cause of death” (*R v Hallett*⁴).

Although highly unlikely, in that longevity for HIV positive people is increasing, it is still theoretically possible that a murder charge could be laid for a transmission offence, if a death occurred quickly enough. This may only ever occur in the extremely rare case of superinfection (see page 14). This occurs where an HIV positive person is re-infected with another strain of the virus, leading to an acute infection, which accelerates the onset of AIDS and the progression towards death. In 2004, a New York man was reported to have contracted a multi-drug resistant strain of HIV which led to his death within three months⁵. However, such cases are rare and it is unlikely that a murder charge would be brought in an HIV transmission trial in Australia.

Murder charges have been laid in other jurisdictions. On April 4 2009, Canadian man Johnson Aziga made legal history when the jury in the Ontario Superior Court of Justice found him guilty of two counts of first-degree murder⁶.

Aziga was diagnosed in 1996 and allegedly had unprotected sex with at least thirteen women without disclosing his HIV positive status. He was charged in January 2004. The two female complainants died in December 2003 and May 2004. This is a highly unusual case, and is set to be appealed. It is worrying that non-disclosure of a sexually transmitted disease is being equated with murder. It highlights the need for further discussion and the need for clear guidelines to prosecutors in respect of HIV non-disclosure cases. Although Mr Aziga's double murder trial is unique, the Canadian Supreme Court in *R v Cuerrier*³⁶ earlier held in 1998 that failure to disclose HIV status prior to sexual intercourse is a form of fraud that vitiates consent to sexual intercourse, which means the sexual acts become an assault in the eyes of the law (see page 34).

Mens Rea

Assuming that causation is proven, the prosecution must also prove that the accused possessed the requisite mens rea or mental element for murder. The offence will only be made out where there is intention to kill or inflict grievous bodily harm, or where there is a reckless indifference for life. In the context of HIV, there may be difficulties of proof here as many cases of HIV transmission do not involve an intent to cause actual death, and where there is recklessness or wilful blindness, this is usually in relation to the risks of infection. The difficulty of proving the high level of mental culpability that is required to establish murder, is likely to inhibit such a charge from being laid in NSW.

Attempted Murder

NSW has never had a case where a transmission offence was prosecuted under attempted murder. Other jurisdictions have adopted this approach. In *State of Texas v Weeks*⁷, an HIV positive person was convicted of attempted murder for spitting on a prison guard. In NSW, attempted murder requires proof of an intention to cause death (not just grievous bodily harm). The burden of proving this beyond a reasonable doubt would be difficult to discharge in the absence of clear evidence that there was an intention to cause death, not just infection or the risk of infection.

Constructive Murder (felony murder)

Constructive murder, also known as felony murder, is the exception to the general principle of unlawful homicide that the seriousness of a particular killing be measured according to the accused's mental state. Where a syringe filled with HIV positive blood is used in the commission of a crime, constructive murder may be the applicable charge. In NSW, under s18(1)(a) *Crimes Act*, a crime is committed when the act causing death was 'done in an attempt to commit, or during or immediately after the commission, by the accused, or some accomplice with him, of the crime punishable by imprisonment for life or for 25 years.' This charge may be laid where a blood filled syringe is used as a weapon. The felony murder rule does not require proof of any intention to cause infection. All that is required is the intention to commit the foundational crime, in this case, robbery with wounding.

Manslaughter by criminal negligence

Manslaughter may be the applicable charge where HIV is inadvertently transmitted. For inadvertence to be held criminally culpable, the accused must do an act 'consciously and voluntarily without any intention of causing death or grievous bodily harm but in circumstances which involved such a high risk that death or grievous bodily harm would follow that the doing of the act merited criminal punishment' (*Nydam v The Queen*⁸, approved in *The Queen v Lavender*⁹). In the context of HIV, this would require proof of a high risk that infection would occur as a result of the accused person's act or omission. No case has ever arisen in NSW involving this charge. However, it is conceivable that if it did arise, proof of careful condom usage, safe sex practices and low viral load may negate the proof of this high risk.

This offence employs an objective test which may expose individuals who are inadvertent to liability for a serious offence. Commentators have observed that imposing criminal culpability where there is mere negligence is casting the net of liability too wide¹⁰. In addition, where objective standards are imposed on acts that are commonly seen as being within the realm of the private and domestic, caution should be taken so as not to violate human rights of HIV positive people.

Manslaughter by Unlawful and Dangerous Act

This offence requires that there be an unlawful and dangerous act that causes the death of another (*DPP v Newbury & Jones*¹¹). It does not require an intention to kill or inflict grievous bodily harm, however the unlawful and dangerous act must be an intentional and voluntary one and it must be established that a reasonable person in the position of the accused would have realised that he or she was exposing the victim to an appreciable risk of injury (*Wilson v The Queen*)¹². This is unlikely to arise in most cases of transmission by sexual contact. However, it may be the applicable charge where HIV transmission is caused in the commission of some other criminal activity such as sexual assault or intravenous drug injection.

Assault and Specific Statutory Offences

The offences discussed so far all require that death has occurred in order to satisfy the actus reus of the offences. As discussed above, these charges may be difficult to establish and inappropriate in the context of HIV transmission, as the result of infection with HIV is rarely immediate death. In NSW, transmission of HIV is more likely to be prosecuted under section 33 and 35 of the *Crimes Act 1900 NSW*¹³ since the recent amendments to the *Crimes Act*.

Section 35 - Malicious wounding or infliction of grievous bodily harm

The old section 35 (prior to the Crimes Amendment Act 2007)

- (1) Whosoever *maliciously* by any means:
 - (b) inflicts grievous bodily harm upon any person
- shall be liable to imprisonment for 7 years.

The prosecution had to establish both of the following elements: a) That the accused had inflicted grievous bodily harm upon a person and b) that the act was done maliciously.

The New Section 35

The new section 35, as amended by item 7, Schedule 1 of the Crimes Amendment Act 2007, recasts these offences as a consequence of the omission of the concept of 'malicious' (see item [2] Schedule 1). The offences are separated into those done intentionally, and those done recklessly. Consequently the applicable offences and sentences are as follows:

Section 33 (as amended by item 4, schedule 1):

1. Inflicting grievous bodily harm with intent >> 25 years

Section 35 (as amended by item 7, schedule 1):

1. Recklessly inflicting grievous bodily harm in company >> 14 years (penalty raised from 10 years)
2. Recklessly inflicting grievous bodily harm >> 10 years (penalty raised from 7 years)

Is HIV grievous bodily harm?

Prior to the recent amendments to the *Crimes Act* 1900, grievous bodily harm was defined in section 4 of the *Crimes Act* as including any permanent or serious disfiguring of the person. This was said to refer to bodily injury of a really serious kind (*DPP v Smith*¹⁴). Whether a particular injury constitutes 'grievous bodily harm' is a matter for the jury, but it is highly likely that any reasonable jury would regard infection with HIV as grievous bodily harm.

In Western Australia, in the case of *Houghton v The Queen*¹⁵, the complainant was infected with HIV by the accused, but was not suffering from any adverse symptoms at the time of trial, nor was she receiving any treatment. Despite the apparent health of the complainant at the time of the trial, the disease was described as being "dormant". The eventual development of AIDS was referred to as an inevitable consequence that was likely to cause permanent injury to her health. Causation was seen as being a physical rather than temporal connection.

Psychiatric harm has been held to be a form of actual bodily harm (*R v Chan-Fook*¹⁶). In the New Zealand case of *R v Mwai*¹⁷, two complainants were infected with HIV whilst others were only exposed to the risk of infection. Those who were not infected were nonetheless exposed to severe trauma as they believed they may have been infected. It was held that grievous bodily harm includes really serious psychiatric injury identified as such by appropriate specialist evidence. This principle has been affirmed in NSW in *R v Lardner*¹⁸.

In the case of *R v Stone*¹⁹, a man was charged with malicious wounding with intent to prevent lawful apprehension. The accused had resisted arrest and in doing so threatened a police officer with syringes. He repeatedly said that he had AIDS and would kill the officer. Two needle stick injuries were inflicted but this caused only minimal physical harm and HIV was not transmitted. Despite this, the personal and psychological impact that it had upon the officer was emphasised by the judge. Special regard was given to the frightening "terror of AIDS" and Stone was sentenced to six years and eight months imprisonment. Prosecutors should be wary of following cases like *Stone* and *Mwai* and laying charges for grievous bodily harm where exposure to HIV has caused psychiatric harm, in the absence of transmission of the virus. There is a serious risk that the net of liability will be cast too wide. As the UNAIDS Guidelines emphasise, the aim of the criminal law must always be to prevent the spread of virus itself. To go beyond this creates the risk of over criminalisation and stigmatisation of the HIV positive community.

Schedule 1 of the *Crimes Amendment Act 2007* has now amended the definition of grievous bodily harm (see s4 *Crimes Act* 'definitions'). Grievous bodily harm now explicitly includes (in s4(1)(c)) 'any grievous bodily disease (in which case a reference to the infliction of grievous bodily harm includes a reference to causing a person to contract a grievous bodily disease)'. Whereas previously it was at least arguable that the case of *R v Clarence* (1889) 22 QB 23 (see page 32) was good law in NSW, this makes it clear that infecting a person with a grievous bodily disease will constitute grievous bodily harm. The extension of this general definition has effectively made the section 36 offence redundant and thus the *Crimes Amendment Act 1997* repeals section 36.

Increased Sentences for Grievous Bodily Harm

Although the removal of the charge under section 36 is a positive step towards protecting the rights of people living with HIV, increased sentences under section 35 may have a detrimental effect in certain cases. Where a person has infected another person or persons through truly reckless acts, the increased sentence may be warranted. However, as there is no recognised defence of consent to harm in NSW, there is at least a theoretical risk that in cases where transmission has occurred during consensual sex involving at least one HIV positive person, higher sentences may be unjustified. Increasing sentences in such cases may serve to further stigmatise and criminalise people living with HIV and impinge upon their ability to engage in consensual sex.

Does the increase in longevity for HIV positive people mean that infection with HIV is no longer seen as grievous bodily harm?

Before the recent amendments to the *Crimes Act*, the answer to this question was unclear. The trend in the case law suggested that medical evidence of improvements in HIV treatment, increased quality of life and longevity were not likely to succeed in convincing a court that infection with HIV does not constitute grievous bodily harm. The new definition of grievous bodily harm inserted into the *Crimes Act* seems to make the infection itself the criteria for the harm rather than the nature of the resulting illness. Overwhelmingly, the disease is still seen as being a serious and life-altering form of illness. This may change in the future as medical treatments for HIV/AIDS develop. However, it seems that currently, such evidence would be more effective in proving insignificant risk in relation to the issue of consent or proof of recklessness.

Malice

Under the old section 5 of the *Crimes Act*, malice was defined as an act that is either;

- (a) done of malice
- (b) done without malice but with indifference to human life or suffering; or
- (c) with intent to injure some person or persons and in any such case without lawful cause or excuse; or
- (d) done recklessly or wantonly

Malice is defined in the Butterworth's Concise Australian Legal Dictionary as "The motive of an action: spite, ill-will, desire to injure" (*Mraz v R20; Trobridge v Hardy*²¹). Generally, malice is seen as being the requisite mental element for the offence. That includes intent or recklessness which are compendiously referred to as "malice aforethought". Malice can also refer to the volition of the act as well as the motive.

However, the old section 5 gave very little direction as to what constituted an act of malice. In 1955, the Honourable Mr Justice Fullagar of the High Court in *Mraz v R*²⁰ described the definition of malice in the *Crimes Act* as a 'mere question-begging definition'. This confusion has been rectified by Item 2 of Schedule 1 of the *Crimes Amendment Act 2007* which deletes the term 'maliciously' and replaces it with either 'recklessly' or 'recklessly and intentionally' as required.

Intention to injure

Under the old section 35, where intent was used to prove the element of malice, section 35 required proof of intent to cause some physical injury and not an intent to inflict grievous bodily harm (*R v Stokes and Difford*²²). This offence is now found in section 33. Where HIV is transmitted through sexual contact, it may be difficult to prove an actual intention to cause injury as the very nature of sexual relations is that they are conducted in private. This means that intention can often only be proven through witness testimony in the absence of any direct evidence. Proof of intent may largely rely on the credibility of witness testimony in a scenario where it is one witness's credibility being assessed against another's. In *R v Reid*²³, evidence that the appellant had publicly taunted the complainant with the fact that he had been diagnosed as HIV positive as a result of sexual contact with the appellant, was held to be evidence of intention. Even in the absence of clear evidence of intention, the offence may be made out where there is evidence of recklessness.

The test for recklessness

The degree of recklessness that is required to establish malice is a realisation of the particular kind of harm done, but not necessarily the exact degree of harm caused (*R v Coleman*²⁴; *R v Stokes and Difford*²² at 40). The prosecution must prove that the accused was aware of the risk of HIV infection, but not necessarily the exact nature of how the illness may in fact lead to the development of AIDS and eventually death.

The degree of foresight required for this offence has been compared with the tests for recklessness used to establish the offence of murder (*Crabbe v R*²⁵ and *Royall v R*²⁶). The prosecution must prove beyond a reasonable doubt that the accused person foresaw that grievous bodily harm (here infection with HIV) would be the *probable* result of the accused person's acts. Probability is a higher test to establish than mere possibility. Where it is merely possible (but not likely) that HIV infection will occur as a result of the act, the offence will not be established. The High Court's reasoning in *Crabbe* was applied in both *R v Reid*²³ at 7-11 and in *Mutemeri v Cheesman*²⁷ at 400.

Although no case has been heard in NSW in which recklessness was a central issue, it is possible that evidence of the use of a condom or safe sex practices may be used to negate the requisite *mens rea*. Although it is more unlikely, theoretically it is possible that evidence that a person was undertaking treatment and had a low viral load could be another relevant factor in negating the mental element of an offence (see page 11, Risk Reduction and Viral Load).

Knowledge of the Accused

The degree of knowledge that the accused has as to their serostatus will be relevant to the determination of the mental element and the test of recklessness. This is an element of the prosecution case and is therefore distinct from the defences of consent and disclosure.

Recklessness will be made out where it is proved that a person knew they were HIV positive but decided to engage in high-risk unprotected intercourse and in doing so “run the risk”. Although recklessness was not in issue in the English case of *R v Dica*²⁸, it was acknowledged that where a person knows of their HIV positive status and decides to put others at risk, not intentionally but due to a lack of care, recklessness will be established.

A person cannot be held liable for a transmission offence if they were unaware, at the time of the alleged act which caused another person to become infected, that they were HIV positive. This was at issue in the case of *Mwale* (unreported, see page 52).

Wilful Blindness

A more difficult case would be one where the accused was not aware of their HIV positive status, not having been tested, but the nature of the circumstances suggests that they should have been aware of the likelihood that they are HIV positive. In *He Kaw Teh v The Queen*²⁹, the High Court accepted that wilful blindness may be treated as the equivalent of knowledge. This decision is certainly persuasive, however it may be distinguishable on the facts since it was a case involving drug charges.

In *R v Adaye*³⁰, Adaye was aware that his wife was HIV positive and was warned by a doctor that if he was not already HIV positive then he soon would be. Adaye did not undergo testing. He went on to infect another woman, the complainant in the case. The defendant pleaded guilty to a charge of recklessly inflicting grievous bodily harm. Although he was not actually aware of his serostatus, this was a case where the circumstances indicated that he probably was on notice of the likelihood that he was infected and he was wilfully blind to that fact.

In *R v Williams*³¹, the Supreme Court of Canada held that where a person was aware of the risk of HIV positive status and persists in unprotected sex, this will be sufficient knowledge to establish recklessness.

Recklessness is ultimately a question of fact. If a person is unaware of their serostatus and they engage in unprotected sex, awareness of the general risk of HIV infection will not be reckless unless there is some factual circumstance which suggests that the person should have realised there was an unjustifiable risk of infection. Such circumstances may include where a person is experiencing HIV-related symptoms and has been advised to undergo an HIV test, or if the person has engaged in high-risk unprotected sex with another person who is known to be HIV positive.

Section 36: Causing a Grievous Bodily Disease

NOTE: This section has been repealed by the *Crimes Amendments Act* (NSW) 2007. It is included here as important historical background information. It should also be noted that an accused person will be charged according to the law at the time of the offence.

A person:

- (a) who maliciously by any means causes another person to contract a grievous bodily disease,
or
- (b) who attempts maliciously by any means to cause another person to contract a grievous bodily disease,

with the intent in any such case of causing the other person to contract a grievous bodily disease, is liable to imprisonment for 25 years.

In order to prove a charge under s 36, the prosecution must establish;

- that the accused caused another person to contract a grievous bodily disease;
- that the act was done maliciously;
- and that they intended to cause the transmission of the disease.

Causation

Phylogenetic analysis is used in criminal investigations to determine the source of infection (see page 39). However, this kind of analysis cannot by itself prove that transmission occurred directly between two individuals. Whilst it is certainly persuasive evidence it must be supplemented with other forms of evidence.

The prosecution must prove, beyond a reasonable doubt, that the complainant was HIV-negative before the relevant contact with the accused person. Medical evidence of past HIV tests may be adduced, as well as witness testimony from recent previous partners who are also HIV negative. Witness credibility may also be important here, especially in a situation where a person has multiple sexual partners and the source of infection is less than clear.

Grievous Bodily Disease

This is not defined in the legislation and is given its ordinary and natural meaning. *The Oxford English Dictionary* defines 'disease' as 'a condition of the body, or of some part or organ of the body, in which its functions are disturbed or deranged; a morbid physical condition; a departure from the state of health, especially when caused by structural change...' Section 36 was specifically intended to cover the transmission of HIV, as the history of the section demonstrates.

Intention

The offence under section 36 was first introduced in 1990 in response to a spate of attacks with HIV positive blood filled syringes. At that time, the case of *R v Clarence*³², established the principle that causing a person to contract a life-threatening disease was neither an assault or grievous bodily harm. Section 36 aimed to address this problem by creating a specific offence referring to such an act. However, there were some ambiguities in the definition of the offence. Although the section specifically stated that intention was an element of the offence, malice was also an element. Malice is a term of legal art and includes acts which are intentional, reckless or done with indifference to human life and suffering. This created some confusion regarding the mens rea of the offence. It has been suggested that "the better view is that intention to cause infection with a grievous bodily disease is required. This is consistent with the principle of statutory interpretation that penal provisions are construed narrowly in favour of the defendant."³³ This charge has never been judicially considered in the context of HIV in NSW. In the case of *Kanengele-Yondjo*¹, the accused was initially charged with the higher offence under section 36 but this was reduced to the lesser charge under section 35 after a charge bargain. In future cases, evidence that the accused person was aware of their HIV status but, nevertheless, engaged in unprotected sex, would be enough to prove intention to cause another person to contract a grievous bodily disease.

Section 39: Using poison etc to endanger life

Using poison etc so as to endanger life

Whosoever maliciously administers to, or causes to be administered to, or taken by, any person, any poison or other destructive or noxious thing, so as to endanger the life of such person, or so as to inflict upon such person grievous bodily harm, shall be liable to imprisonment for ten years.

Although it may appear to be an abuse of language to suggest that HIV is a “poison”. In 1990, a prisoner in NSW attacked a guard with an HIV-infected syringe and was charged with administering a poison under section 39. However, the case never went to trial as the defendant died shortly after committal. In a later case involving a syringe attack in 1995¹⁹, the defendant was charged under section 35. It is highly unlikely that a person would now be charged under section 39.

Section 54: Causing grievous bodily harm by a negligent act or omission

Causing grievous bodily harm

Whosoever by any unlawful or negligent act, or omission, causes grievous bodily harm to any person, shall be liable to imprisonment for two years.

Causing grievous bodily harm by criminal negligence

An individual could hypothetically be charged under Section 54 where HIV is transmitted inadvertently. This might be used where the standard of ‘recklessness’ in Section 35 is not met. In this context, the standard of negligence applicable is the same as that applied in the case of manslaughter as a result of a negligent act or omission³⁴. Thus, inadvertence is held criminally culpable when there is ‘such a great falling short of the standard of care which a reasonable man would have exercised and which involved such a high risk that death or grievous bodily harm would follow that the doing of the act merited criminal punishment’³⁵.

One type of negligent act might be for example where a person was unaware that they were HIV positive and transmitted HIV to another, but had engaged in risky behaviours that should have alerted them to the risk that they might be HIV positive. It is possible that a sex worker who does not get tested and who transmits HIV might fall into this category. In 2008, a Swiss court ruled that a person who was unaware that he was HIV positive, but was aware that a previous partner was HIV positive was guilty of negligent transmission of HIV for having unprotected sex with a later partner³⁵. The question is whether a reasonable person in that position would have suspected that they might be HIV positive and been tested and/or practiced safe sex.

Causing grievous bodily harm by unlawful act or omission

Where HIV is transmitted by an unlawful act, Section 54 may be applicable. There is little case law that indicates what constitutes an ‘unlawful’ act pursuant to Section 54. However, cases on liability under unlawful and dangerous act manslaughter may provide some guidance.

It seems unlikely that an offence under the *Public Health Act* 1991 (NSW) Section 13 would constitute an ‘unlawful act’ for the purposes of Section 54 as it is not an offence punishable by imprisonment.

We are unaware of any person being charged under this section for transmission of HIV. If such a charge were to be laid, it is likely that evidence of careful condom usage, safe sex practices and low viral load would be a valid defence.

Section 61I: Sexual assault

Sexual assault

Any person who has sexual intercourse with another person without the consent of the other person and who knows that the other person does not consent to the sexual intercourse is liable to imprisonment for 14 years.

The main issue with sexual assault is whether there is a distinction between consenting to sexual intercourse, and consenting to sexual intercourse with an HIV positive person.

The *Crimes Amendment (Consent - Sexual Assault Offences) Act 2007* provides a new statutory definition of consent, and sets out the circumstances in which consent may be negated.

The new definition of consent in the *Crimes Act 1900* NSW section 61HA (5)(c) states that:

A person who consents to sexual intercourse with another person... under a mistaken belief that the sexual intercourse is for medical or hygienic purposes (or under any other mistaken belief about the nature of the act induced by fraudulent means), ...Does not consent to the sexual intercourse.

This subsection specifically refers to the case where, for example, someone poses as a doctor and has intercourse with another having persuaded them that it is a form of medical treatment, that is, where the complainant is deceived about the nature of the act itself. However, could this section also be applied to having sex with someone who asserts they are HIV-negative when they are in fact HIV-positive? It would depend on whether lying about HIV status could be counted as a mistaken belief as to the nature of the act induced by fraudulent means. In a prosecution for the offence of sexual intercourse without consent the prosecution must prove that the accused knew the complainant did not consent, or was recklessly indifferent as to whether there was consent, or had no reasonable grounds to believe that the complainant consented.

The Canadian Supreme Court held in *Cuerrier*³⁶ and in *Williams*³⁷ that an HIV positive person has a duty to disclose their HIV status before engaging in any activity that poses a 'significant risk' of transmission of the virus (for example unprotected sexual intercourse). Non-disclosure or lying about HIV-positive status is considered to be a fraud that vitiates consent to sexual intercourse, and so the sexual intercourse becomes a sexual assault.

Canadian man Johnson Aziga was in April 2009 found guilty of 2 counts of first-degree murder (see page 21), ten counts of aggravated sexual assault and one of attempted aggravated assault for failing to disclose his HIV status to the women prior to having unprotected sexual intercourse.

An undesirable and inaccurate result of charges and/or convictions for sexual assault in these circumstances is that the convicted individuals are subjected to the added stigma of being classed as 'sex offenders' as a result of having 'consensual' sex but not disclosing their HIV status.

HIV as an aggravating factor in sexual assault cases

Can an HIV positive person charged with sexual assault have the fact that he was HIV positive taken into account in sentencing under s21A Crimes (Sentencing Procedure) Act 1999? This would depend on whether the accused knew of his HIV status and whether HIV was in fact transmitted, and possibly also depend on whether the victim knew the accused was HIV positive at the time of the offence. If the accused is unaware of his status, then it cannot be used as an aggravating factor.

If HIV was transmitted, then section 61J of the Crimes Act 1900 may be the more appropriate charge (sexual intercourse without consent in circumstances of aggravation) circumstances of aggravation include 'reckless or intentional infliction of actual bodily harm'. Aggravating factors cannot be taken into account in sentencing if they form the basis of a more serious charge such as aggravated sexual assault.

If HIV was not transmitted, could the accused's HIV positive status nevertheless be considered an aggravating factor in sentencing? If the victim was unaware of the accused's HIV positive status then probably not. However, if the accused used any kind of threat in relation to his HIV status, it could be argued that this falls within s21A(ca) of the listed aggravating factors in s21A of the Crimes (Sentencing and Procedure Act) 1999, 'the offence involved the actual or threatened use of explosives or a chemical or biological agent' if HIV can be classed as a biological agent. This may also cover instances where a crime is committed and the accused threatens the offender with a syringe containing HIV infected blood.

Offences in Relation to Blood and Tissue Donation

A more appropriate charge for a case of donation of infected blood or tissue would be a public health offence. Where a person intentionally or recklessly donates blood or tissue which is infected with HIV, this act will constitute the common law offence of public nuisance. In NSW, under the *Human Tissue Act* 1983 (NSW) section 20D, a person who donates blood or semen is required to sign a certificate and the signature must be witnessed by a prescribed witness under the Act. This makes it an offence to provide false or misleading information. The maximum penalty for breach of this section is 100 penalty points of \$1100.

Footnotes

1. *Kanengele-Yodjo v Regina* [2006] NSWCCA 354
2. The Crimes Amendment Bill 2007 was assented to on the 27/09/2007. For the text of the bill and the 2nd reading speech see Parliament of NSW 'Bills' <http://www.parliament.nsw.gov.au/prod/parlment/nswbills.nsf/7bd7da67ee5a02c5ca256e67000c8755f08ef5ba36acfc8f6ca257361001fe792!OpenDocument>
3. Criminal Law, Public Health and HIV Transmission: Policy Options Paper, UNAIDS 2002 page 32 http://data.unaids.org/publications/IRC-pub02/JC733-CriminalLaw_en.pdf
4. *R v Hallett* [1969] S.A.S.R 141
5. BETA "News Briefs," Summer 2005 <http://www.sfaf.org/beta/2005_sum/news_briefs.html>
6. "Guilty verdict in first ever murder trial for sexual HIV transmission" <http://www.aidsmap.com/en/news/779517F3-B26C-473F-B809-58C1548E4A91.asp?type=preview>
7. *State of Texas v Weeks* (Texas Dist Ct, Walker City, 4 November 1989)
8. *Nydam v The Queen* (1977) VR 430 per Young CJ, McInerney J and Crockett JJ at 445
9. *R v Lavender* (2005) 222 CLR 67 at [136]
10. Bronitt, Simon H, "Criminal Liability for the transmission of HIV/AIDS", *Criminal Law Journal* 16 (2) 1992, p 88
11. *DPP v Newbury & Jones* [1977] AC 500
12. *Wilson v The Queen* (1992) 174 CLR 313 at 333
13. Kanengele-Yodjo was originally charged under section 36 but this was reduced to the lesser charge under section 35 as a result of a guilty plea and a charge bargain
14. *DPP v Smith* [1960] 3 All ER 161
15. *Houghton v The Queen* [2004] WASC 20
16. *R v Chan-Fook* [1994] 2 All ER 552
17. *R v Mwai* [1995] 3 NZLR 149

18. *R v Lardner* (unreported), NSWCCA, 10 September 1998
19. *R v Stone* (1995) 85 ACrimR 218
20. *Mraz v R* (1955) 93 CLR 493
21. *Trobridge v Hardy* (1955) 94 CLR 147
22. *R v Stokes and Difford* (1990) 51 A Crim R 25
23. *R v Reid* [2006] QCA 202
24. *R v Coleman* (1990) 19 NSLWR 467 at 475
25. *Crabbe v R* (1985) 156 CLR 464
26. *Royall v R* (1991) 172 CLR 378
27. *Mutemeri v Cheesman* (1998) 100 AcrimR 397 at 400
29. *He Kaw Teh v The Queen* (1985) 157 CLR 523
30. Crown Court, Liverpool, reported in the Guardian Newspaper January 2004 <http://www.guardian.co.uk/uk/2004/jan/13/southafrica.aids>
31. *R v Williams* (2003) 176 CCC (3d) 449
32. *R v Clarence* (1889) 22 QB 23
33. Simon Bronitt, *Crimnet*, "Assault and related non-fatal offences" p9 <<<http://law.anu.edu.au/criminet/tassault.html> >>
34. *R v D* [1984] 3 NSWLR 29
35. Court rules in HIV case: <http://criminalhivtransmission.blogspot.com/2008/07/switzerland-federal-court-rules-that.html>
36. *R v Cuerrier* [1998] 2 SCR 371
37. *R v Williams* [2003] 2 SCR 134

The Defence Case

Consent

Criminal prosecutions for the transmission of HIV most commonly involve acts to which the parties have consented, usually consensual sex or injecting drug use. Consent may become a central issue in an HIV trial, as it may be relevant to negating an element of the prosecution case or as a defence in and of itself.

Impediments to the doctrine of informed consent

Historically, the common law said that where two parties were engaged in consensual sexual intercourse, and one party knowingly caused the infection of the other with a sexually transmitted disease, the fact that the complainant had consented to the sex itself was enough to establish the defence of consent. It was irrelevant that the person had not consented to the harm itself.

In the case of *R v Clarence*¹, a man had sexual intercourse with his wife, knowingly infecting her with gonorrhoea. The case was controversial as it established the principle that a wife could not withhold consent to sex within marriage. It was held that, notwithstanding the fact that she would not have had sex with him had she known of his condition, her consent to the sexual intercourse was real. The act did not constitute fraud because Mrs Clarence was not deceived as to the nature of the act itself or the identity of the participant, so as to vitiate consent.

The High Court of Australia, affirmed this decision in *Papadimitropoulos v The Queen*². In this case a couple entered into a “sham” marriage. The complainant was unaware of this and engaged in sexual intercourse with her “husband”, under the mistaken belief that they were married. The court held that the woman’s consent was real and actual because she was not deceived as to the nature of the act itself or the identity of the accused. Any other circumstances surrounding the act were deemed to be irrelevant. The decision represented a very narrow construction of the type of fraud which will have the effect of vitiating consent. It suggests that where there is consent to the actual sexual activity itself, the quality of the activity and any risk it carries are irrelevant. Note that the recent amendments to the *Crimes Act 1900* in section 61HA ‘Consent in relation to sexual assault offences’ now clearly states that if consent is given under a mistaken belief that the other person is married to the person, then the consent is not valid consent (section 61HA (5)(b)).

R v Clarence and the “direct and intentional violence” requirement

Clarence was also a controversial authority as it was held in that case that the charges of unlawfully and maliciously inflicting grievous bodily harm and assault occasioning actual bodily harm required there to have been an application of direct and intentional violence. There needed to be an immediate connection between the violent act and the consequent injury. The majority reasoned that the transmission of disease had delayed and uncertain effects and was not direct and immediate. This principle has been undermined in subsequent cases. It is now a well established principle that “an injury can be caused to someone by injuring their health; an assault may have the consequence of infecting the victim with a disease or causing the victim to become ill. The injury may be internal and may not be accompanied by any external injury...”³

In NSW, the gap created by *Clarence*, in that infliction of a disease was not seen as constituting bodily harm, was addressed through the creation of the offence of maliciously causing (or attempting to cause) another person to contract ‘a grievous bodily disease’ (s36 *Crimes Act*). This legislation was enacted in response to several attacks with blood-filled syringes. The element of malice was expressly provided for in the legislation (see page 24).

Section 36 has been repealed and the offence recast in sections 33 and 35 of the *Crimes Act*. Is consent a relevant defence under these sections? Where there is evidence of informed consent to the risk of infection, it seems unlikely that the prosecution will be able to make out the element of intention for the purposes of s33. Where this cannot be established, but there is evidence of recklessness, the lesser charge under section 35 may be pursued. However, this inevitably raises the important question of whether a person can in fact consent to the infliction of grievous bodily harm.

Is it possible to consent to unsafe sex with an HIV positive person?

In *R v Brown*⁴, the House of Lords held that it was not in the public interest for a person to wound or cause actual bodily harm to another without cause. This case involved a group of sado-masochistic men who engaged in violent acts against one another for sexual pleasure. Exceptions such as rough horseplay, properly conducted games and sports, reasonable surgery, tattooing and male circumcision were recognised.

In *Brown*, the risk of HIV infection (one of the parties was HIV positive) was noted as a further reason to prohibit the recognition of consent to such activities. These statements seemed to also rule out consent to acts not intended to cause harm but involving *risks* of harm. This created uncertainty as to whether a sexual partner's informed consent to run the risk of HIV infection would afford a good defence where infection occurred.

Consent in the United Kingdom

The English Court of Appeal clarified the role of consent in negating liability for transmission of HIV in *R v Dica*⁵ and *R v Konzani*⁶. If there is evidence that the defendant infected the complainant and the complainant was aware of the risk of transmission, it could be possible to raise the defence of consent. In *R v Dica*, the court said it would be a defence to conviction if the complainant had consented to the risk of transmission. Further, in *R v Konzani*, the court clarified the position by saying that only a 'conscious' or 'willing' consent to unprotected sex would be effective. These decisions mean that informed consent to unprotected sex which carries the risk of transmission will afford a defence to an HIV positive person charged with recklessly causing grievous bodily harm.

In the trial of *Dica*, it was held that whether or not the complainants knew he was HIV positive was irrelevant because *R v Brown* deprived them of any "legal capacity to consent to such serious harm"⁷. As a result consent was not left to the jury at trial. However, this was overturned on appeal. It was held that *R v Brown* was wrong in law and was to be confined to violent conduct involving the deliberate infliction of bodily harm. It would have no application where the parties engaged in consensual sexual intercourse and they were not intending to actually spread the disease but rather are knowingly prepared to run the risk of infection. Here the distinction between consent to being infected with a sexually transmitted disease and consent to run the risk of infection were seen as distinct. A re-trial was ordered.

Consent in Canada and New Zealand

In *R v Cuerrier*⁸, *R v Clarence* was rejected by the Supreme Court of Canada. In the context of exposure to HIV infection during unprotected sexual intercourse, the majority held that a person cannot truly consent to the risk of infection if their partner does not disclose their HIV positive status beforehand. Non-disclosure or lying about HIV-positive status is considered to be a fraud that vitiates consent to sexual intercourse, and so the sexual intercourse becomes a sexual assault. This recognised the application of the doctrine of informed consent. The same principle was affirmed in New Zealand in *R v Mwaia*⁹.

Degree of Risk

The degree of risk will be important in determining whether the defence of consent is available. In *R v Emmett*¹⁰ a man set fire to his partner's breasts which led to her almost being asphyxiated. This was done within the context of a consensual sexual relationship but it was held that the degree of risk went beyond what could be consented to. By contrast, in *R v Wilson*, where a husband branded his wife's buttocks with his initials, the defence of consent succeeded due to the lower degree of risk. Theoretically, it is conceivable that the use of a condom and other safe sex practices may lead to the lowering of risk to such an "acceptable" level. In the Canadian case of *Cuerrier*, it was held that an HIV positive person engaging in anal or vaginal sex without a condom posed a 'significant risk' of HIV transmission. However, there is no authority in NSW to support this.

It is also clear that the law of consent, and the question of what is deemed to be socially acceptable violence, is driven by considerations of public policy. This involves the judicial enforcement of perceived notions of public morality. "Why violence perpetrated for sport, horseplay, or ornamentation has an acceptability denied to sexual fulfilment lies beyond reason. All that can be done is to note and memorise the decisions of the court as and when they arise."¹¹

Such legal enforcement of moral standards may create difficulties for HIV positive people wanting to engage in consensual sex, as sexual activity which is deemed to be unacceptably risky, from an "objective" standard, may be prohibited. "Poz-poz serosorting" is one such example. This involves HIV positive people selecting partners who are infected with the same strain of HIV in order to manage the risk of infection. The implicit assumption is that this practice allows HIV positive couples to engage in unprotected sex, whilst managing the risk of infection. However, there is still the risk of the transmission of other sexually transmitted infections, which can produce severe symptoms in HIV positive people. A more disturbing prospect is that this practice can lead to HIV superinfection. This occurs where an already HIV positive person becomes reinfected with a new, possibly drug-resistant strain of HIV which can severely weaken the immune system (see page 14). Two HIV positive people engaging in unprotected sex may cause cross-infection of each other. NSW has not seen such a case of re-infection or superinfection in the context of a criminal prosecution, but theoretically it poses difficult questions about the notion of informed consent and socially acceptable forms of harm. Although cases of superinfection are rare, a NSW court may see the possibility of a drug-resistant form of HIV developing as a significant threat to public health. This may take such sexual activity beyond the limit of the kind of harm to which a person may consent. Alternatively, it is possible that serosorting could be recognised as a valid form of risk management which could establish a defence of informed consent. It is unclear how the law in NSW will develop so as to regulate such private activities.

Can you consent to sexual intercourse with an HIV positive person?

Does this mean that couples engaging in consensual “pos-pos sex” or “pos-neg sex” are breaching the criminal law by exposing themselves to HIV? Is sex with an HIV positive person a criminal act, even where there is consent to the sex and no actual transmission of the virus? This is an important question for many couples with one or more HIV positive partners.

Other Australian states have specific exposure offences such as the offence of endangering life under section 29(1) of the *Criminal Law Consolidation Act 1935* (SA), and recklessly engaging in conduct placing another in danger of death, without lawful excuse, pursuant to section 22 of the *Crimes Act 1958* (VIC). NSW does not have a specific exposure offence.

It is unclear if a NSW court would follow the suggestion in *R v Brown* that a person cannot consent to such “exposure” to harm. There still remains in the *Crimes Act* in NSW the offence of attempting to commit any offence in the Act, for example attempting to cause grievous bodily harm (section 344A of the Act).

Use of a condom and safe sex practices

Will the use of a condom or other safe sex practices act as a defence? There has been no case in NSW which has directly considered this point. However, courts in other jurisdictions have accepted that the use of a condom during sex may be an available defence, even where an HIV positive person has not disclosed their sero-status.

In *R v Cuerrier*⁸, the Supreme Court of Canada accepted that use of a condom might be used to negate liability even in the absence of disclosure. The majority acknowledged that although completely safe sex with an HIV positive person would be impossible, correct use of condoms may reduce the risk of infection so that it was no longer ‘significant’.

In *R v Mwai*⁹, in reference to the offence of criminal nuisance under s 145 of the *Crimes Act 1961* (NZ), the NZ Court of Appeal thought it was ‘certainly arguable’ that an HIV positive person would not be subject to a legal duty to use a condom if he disclosed his condition to a sexual partner who then consented to run the risk of infection.

In *Police v Dalley*¹², the defendant was acquitted of charges of criminal nuisance, under s 145 of the *Crimes Act 1961* (NZ), because neither vaginal sex with a condom, nor oral sex without a condom carried a sufficiently high risk. It was held that disclosure of HIV status in this case was not necessary. However, it should be noted that this case did not involve actual infection with HIV but rather exposure to a risk of infection. The defence as it exists in New Zealand is largely related to the language of s 145 which imposes a duty to take reasonable precautions upon people in charge of dangerous things.

The use of a condom has not been recognised as a defence in NSW. No case has considered this question to date. A NSW court may be reluctant to recognise a stand-alone defence where there is actual infection without disclosure but the use of a condom. However, the use of the condom may go to negating mens rea where the charge requires proof of intent or recklessness.

It is possible that the defence may be run in future cases and the success may also depend on factual circumstances such as if the condom was used correctly, if a condom was used during all sexual encounters, whether the condom was used within the expiration date and whether it was used with correct lubricant (that is water based lubricant). Failure to use a condom properly may lead to non-recognition of the defence. It may also be detrimental to the defendant's case if the complainant, and not the defendant, was in fact the person who insisted that a condom be used.

Is there a duty to disclose HIV positive status?

Under the *Public Health Act* 1991, section 13, a person who knows that he or she suffers from a sexually transmissible medical condition is guilty of an offence if he or she has *sexual intercourse* with another person unless, before the intercourse takes place, the other person has been informed of the risk of contracting a sexually transmissible medical condition from the person with whom intercourse is proposed, and has voluntarily agreed to accept the risk. The maximum penalty is 50 penalty units or a \$5500 fine.

There is no explicit statutory duty to disclose HIV status under the *Crimes Act*. Nothing in s33 or s35 (or even the now repealed s36) imposes or imposed a duty of disclosure upon an HIV positive person before having sex. However, failure to disclose may go to proving an element of one of the applicable offences such as intent or recklessness. Since the demise of *Clarence* as an authority it is clear that at common law, consent to the act of having sex will not be a defence where there is no informed consent to the quality of the act and the risk of infection. Therefore, a failure to disclose HIV status may be a critical factor in establishing liability for transmission offences in NSW.

The new definition of consent in the *Crimes Act* 1900 NSW section 61HA applies to the offences of sexual assault and aggravated sexual assault. Section 61HA (5)(c) states that:

A person who consents to sexual intercourse with another person... under a mistaken belief that the sexual intercourse is for medical or hygienic purposes (*or under any other mistaken belief about the nature of the act induced by fraudulent means*)...Does not consent to the sexual intercourse.

Could this section, which mainly deals with mistaken belief that the reason for sexual intercourse is for medical purposes also be applied to having sex with someone who asserts they are HIV-negative when they are in fact HIV-positive? It is conceivable that where a person consents to sexual intercourse and the other person knew that they were HIV positive but did not disclose this fact, such non-disclosure could be held to vitiate the consent given, resulting in a potential charge of sexual assault (see page 28).

Honest Mistake of Fact

HIV screening checks test for antibodies against HIV which are produced naturally by the body. However, in most cases the immune system will take one to three months, and in some rare cases up to six months, to develop these antibodies. This process is called seroconversion (see page 7). This means that there is a "window-period" during which a person may test negative for HIV when they are in fact carrying the virus and are able to pass it on to others.

The defence of honest mistake of fact may arise where an accused person mistakenly believes in the existence of a certain fact (that they are HIV negative). The mistake must render the accused person's act innocent (*Proudman v Dayman*¹³). The defence is not available where there is a mistake of law, such as a belief that wilful transmission of HIV is not unlawful. Where there is evidence of complete ignorance as to serostatus it is unlikely that a charge under either s33 or s35 will be made out, as proof of intention and recklessness requires some degree of knowledge of foresight of harm. However, honest belief will not be made out where there is mere ignorance or inadvertence (*State Rail Authority (NSW) v Hunter Water Board*¹⁴). Where a person is wilfully blind to the possibility that they are HIV positive, they will not be able to claim this defence (see page 26).

The accused has the evidential burden of proving the mistake and the prosecution has the legal burden of disproving the mistake. (*He Kaw Teh v The Queen*¹⁵).

Footnotes

1. *R v Clarence* (1889) 22 QB 23
2. *Papadimitropoulos v The Queen* 1957 98 CLR 249
3. *R v Chan-Fook* [1994] 2 All ER 552, per Hobhouse LJ at p 151
4. *R v Brown* [1993] 2 All ER 75
5. *R v Dica* [2004] QB 1257
6. *R v Konzani* [2005] 2 Cr App R 14
7. *R v Dica* [2004] QB 1257 at 1262
8. *R v Cuerrier* [1998] 2 SCR 371
9. *R v Mwai* [1995] 3 NZLR 149
10. *R v Emmett* (unreported, 18th June 1999)
11. Simester, A.P. "Criminal law: theory and doctrine" 2000, cited in, Brown, D, Farrier, D, Egger, S & McNamara, L (2001) *Criminal Laws* 3rd Ed. Federation Press, Sydney. 843-4.
12. *Police v Dalley* [2005] NZAR 682
13. *Proudman v Dayman* (1941) 67 CLR 536
14. *State Rail Authority (NSW) v Hunter Water Board* (1992) 28 NSWLR 721
15. *He Kaw Teh v The Queen* (1985) 157 CLR 523

Evidence

Best Available Evidence

UNAIDS has outlined the guidelines for the use of medical evidence in creating policy regarding HIV and the criminal law. The same approach should be adopted when adducing medical evidence in criminal trials.

“The best available scientific evidence regarding modes of HIV transmission and levels of risk must be the basis for rationally determining if, and when, conduct should attract criminal liability”¹

It is essential to ensure that conduct does not attract criminal liability purely because of a “perceived” threat, in the absence of medical evidence that a particular form of transmission does in fact carry an actual risk of transmission. The criminal law must always have, as its central policy imperative, the aim of preventing the spread of HIV. In this respect, the law must make every effort to keep abreast of current medical and scientific information about the disease.

What medical evidence is required in a criminal trial for HIV transmission? This will depend largely on the legal issues relevant in the trial.

Expert Evidence

The rules of evidence prevent a witness from giving evidence of their opinion, with the recognised exception of expert witnesses². Before a person may give expert opinion evidence ‘the judge must be satisfied that the witness possesses the necessary qualifications, whether those qualifications be acquired by study or experience or both’ (*R v Bonython*³).

In order to establish that the person has the relevant expertise and experience for them to be regarded as an expert, the following criteria must be satisfied:

Evidence must not be a matter of common sense

The information contained in the evidence must relate to something about which the court requires assistance. If the court can rely on their own experience or common sense then the evidence will be inadmissible.

Evidence must relate to an area of expertise

The evidence must relate to the witness’s area of expertise. This means that the claimed knowledge and expertise must be sufficiently recognised as credible by others within that profession or field of work who are able to evaluate the theoretical and practical value of the evidence.

Evidence must not relate to the “Ultimate Issue”

The ultimate issue rule has been abolished: section 80 *Evidence Act* 1995. This does not however allow expert opinion on the ultimate legal issue (*Allstate v ANZ (No 33)*⁴). Generally, an expert may only give evidence so as to assist the court. They are not to supplant the role of the tribunal of fact and, thus, may not give an opinion as to the ultimate issue in the trial. Evidence of this nature will be rejected.

Evidence must not be based on extraneous material

The expert’s opinion must be based upon matters that are directly within the expert’s own observations. Reliance on material that cannot be directly evaluated by the court is not admissible.⁵

In *R v Parenzee*⁶, evidence from a Perth Group was considered by Sullan J, as part of an application to appeal. At trial, Parenzee was convicted of three counts of endangering life. It was the prosecution case that Mr Parenzee knew that the act or acts were likely to endanger the life of each of the women and that he was recklessly indifferent as to whether their lives were endangered. Two members of the Perth group sought to appear as expert witnesses. Their testimony asserted that there is no scientific evidence that HIV has been isolated and that its existence has not been proven. They also asserted that there is no cogent scientific evidence that AIDS is caused by HIV or evidence that proves that HIV is sexually transmitted.

The evidence of both witnesses was held to be inadmissible. This was because neither of the applicant's witnesses had any practical experience or qualifications in any of the disciplines to which their evidence pertained. Although they claimed to have done "wide reading" on the subjects that they gave evidence in relation to, neither witness had in fact been involved in actual work with HIV patients or in any clinical trials in relation to HIV.

One of the so-called expert witnesses was said to be evasive and failed to explain complex scientific concepts with any ease or clarity. In addition, the witnesses failed to provide an alternative theory for the cause of AIDS. Their work was based solely on the critique of other scientific theories in the absence of any practical research to form the basis of their work. As a result the evidence was held to be outside the scientific mainstream and not accepted by the general scientific community. In addition, Sullan J found that the experts were not partial and objective and that they were largely motivated by a desire to assert the validity of their own theories over those of the mainstream scientific community.

Parenzee is a clear example of why care must be taken to adduce credible expert evidence that is based on well-founded scientific research. Although there is scope for adducing more "progressive" medical evidence, it is essential to ensure that it is not so questionable so as to be inadmissible.

You may find a medical specialist to give evidence by contacting the medical practitioners HIV specialist body, the Australasian Society for HIV Medicine (see page 14).

Phylogenetic Analysis as evidence

In order to establish liability for a transmission offence, the prosecution must establish that the accused person caused the infection of the complainant. In some cases the accused may accept that they were responsible for infection but claim that there was consent or disclosure beforehand. In other cases they may claim that they were not responsible at all.

Phylogenetic analysis is a complex scientific process undertaken by HIV virologists, whereby they examine the genetic distance between different strains of HIV. This kind of evidence is potentially very persuasive as it appears to be a way of scientifically proving the source of infection. However, this evidence cannot be used alone to prove conclusively that one person is the source of HIV infection. Phylogenetic analysis can only determine the degree of relatedness of two samples of HIV. It cannot create a definitive 'match'. This is because HIV is not unique to an individual, unlike DNA or fingerprints⁷.

It is essential to recognise that phylogenetic analysis does not prove in what direction transmission flowed. Even where there appears to be a match in HIV strains there are several possibilities, including that the defendant was actually infected by the complainant; that the complainant was infected by a third party with a similar viral strain; that both the complainant and the defendant were infected by one or more third parties with similar viral strains; that the complainant was already HIV-positive and was re-infected with another strain of HIV, either by the defendant, or by a third party. This means that the building of a phylogenetic “tree” requires consideration of a certain degree of approximation and error.

Phylogenetic evidence should never be used as the starting point of a criminal investigation. Where this kind of evidence is used in a criminal trial, it is vitally important that expert witnesses acknowledge the limitations of this kind of testing. Where the source of infection is at issue, other evidence will need to be adduced, including evidence of the complainant’s sexual history. Witness testimony from previous partners who are HIV negative may go to establishing that the complainant was HIV negative before sexual contact with the accused occurred.

One situation where phylogenetic testing may be of use is in establishing the timing of infection. This may be relevant to the establishment of intention in that it may be relevant to proving that the accused person either knew of their serostatus or perhaps that they were reckless to the fact. If transmission occurred during a “window-period” when the accused person was unaware of their status (having received a flawed negative result whilst being actually positive); the proof of timing of infection could be a crucial element of a defence.

Finally, although phylogenetic testing cannot conclusively prove transmission it may be used to exclude transmission. Such evidence has been used to disprove that an accused person was the source of transmission in the UK in 2006⁸.

Evidence of Level of Risk

There are multiple and variable factors which contribute to the degree of risk of HIV transmission associated with any given instance of infection. If a person is on a treatment program of combination therapy their viral load may be very low and their CD4 count high. Similarly, using a condom can further reduce risk. The mode of transmission will also determine how “risky” a particular activity is.

Generally, where there is no intention to infect and the risk is low, reason suggests that liability should not be attached to the act or that the penalty should be reduced. How does the law measure risk taking behaviour?

In *Boughey v The Queen*⁹, the High Court held that it is not the correct approach to analyse level of risk or danger in terms of mathematical probability. This was seen to be an artificial process as an accused person would not undertake such a mathematical calculation before doing the act. Although the large body of research on HIV transmission based on population studies allows for such mathematical precision, such epidemiological calculations are inherently limited in that they are very general in nature. They cannot possibly take into account the many variables which contribute to risk in any given situation. They can by no means offer a conclusive and definite calculation of the exact risk associated with any particular situation. Thus, as suggested in *Boughey*, the jury may consider the risk by referring to the facts as a whole.

The trend in Australian courts has shown a reluctance to accept that evidence suggesting that the risk of infection is low can negate liability for transmission. However, one case where such evidence was successfully used to negate the elements of the prosecution case is *R v B*¹⁰. In this case, the defendant was charged under section 22 of the *Crimes Act (Vic)*: 'A person who without lawful excuse recklessly engages in conduct that places or may place another person in *danger of death* is guilty of an indictable offence.' The central issue in the case was whether the defendant had engaged in conduct that placed another person in danger of death and this involved an assessment of risk. Teague J held that there must be an "appreciable" risk and that this would not be made out where there was only a remote possibility of death or a mere possibility that the conduct might cause death.

Teague J stated that: 'The evidence of Dr Mijch is clear. The possibility that an uninfected person could contract HIV infection from an isolated act of unprotected intercourse is one in 200 or less than one in 200. In the context of an assessment of conduct which may or may not involve criminality, that level of possibility has to be seen as a remote possibility. In those circumstances I cannot accept that a jury, faced with the evidence before it, could find that there was an appreciable danger of death. Accordingly, I am satisfied that there is no case to answer'¹⁰.

Although a mathematical calculation of risk is not the accepted approach, evidence of the mode of transmission should still be adduced to prove the degree of risk posed (see page 10 regarding modes of transmission of HIV). This is especially important where the risk is virtually negligible. In *R v Barry*¹¹, the defendant was convicted of assault after he exposed a police officer to faeces. He was charged with wilful exposure and sentenced to twelve months imprisonment. In sentencing, the judge emphasised the risk to the police officers, despite the fact that there was no evidence submitted to suggest that they were at any risk at all. Clearly evidence of the almost negligible risk of transmission of HIV (through exposure to faeces) should have been adduced.

Subpoena of Medical Information

The source of an HIV infection may be put at issue in a criminal trial. Similarly, where the issue of recklessness or intent is raised, evidence of the kind of counselling a patient received post diagnosis may be relevant. This means that the prosecution may seek to gain access to the medical records of the accused. In the Michael Neal case in Victoria, health professionals and Department of Health staff were subpoenaed and required to disclose ordinarily confidential medical records¹². Equally worrying, as a result of this warrant, the police were incorrectly supplied with not only Neal's records, but also the records of 16 other HIV positive people about whom the health department had concerns. The disclosure of ordinarily confidential health records can undermine public health efforts and deter people from seeking testing, counselling and being fully honest with health care providers through fear of prosecution.

The *Criminal Procedure Act 1986 (NSW)* is the principal piece of legislation that regulates the issuing of subpoenas in NSW.

What kind of subpoenas may be issued?

Under section 221, a subpoena may be issued for different purposes including; to direct a person to give oral evidence in court, to direct that a person or organisation produces a document, or to direct that a person attend court to give oral evidence and produce documents.

How is a subpoena issued?

Under section 222, any party to the proceeding may request a registrar to issue a subpoena. The subpoena must be addressed to an individual person. This will usually be the treating doctor or health professional.

When must the subpoena be returned?

The party who requests the issue of the subpoena may also request that it be returnable on any day on which the proceedings are listed before a court. This must not be more than 21 days before any such day. Alternatively, the party who requests the issue may request that it be returnable on any other day with the leave of the court.

Limits on obligations under subpoenas

Under section 225, the person named is not required to produce any document or thing if it is not specified or sufficiently described in the subpoena or if the person would not be required to produce the document or thing on a subpoena for production in the Supreme Court.

This means that the medical records being sought must be sufficiently specified. This may not be very difficult where the request is for "all documents" within a patient's file.

Setting aside a subpoena

A court may, on application by the person named in a subpoena, set aside the subpoena wholly or in part. This application will be made by the time listed for return of the subpoena, and an argument will be heard before a Local Court Magistrate who will decide whether it should be set aside. A subpoena may be set aside on the following grounds;

- The subpoena is an abuse of process. This may occur where it has not been served for the purpose of obtaining relevant evidence and is, therefore, not bona fide (*R v Baines*¹³). There may also be an abuse of process where it is not issued for the purpose of a pending trial, hearing or application (*Botany Bay Instrumentation & Control Pty Ltd v Stewart*¹⁴).
- The subpoena is oppressive. A subpoena may be seen as 'oppressive' where it is too wide in its terms or where it is issued against a non-party and requires them to determine what are the relevant facts in issue (*Commissioner for Railways v Small*¹⁵). This is not likely to arise where the request is for a medical file, which would usually consist of a single file containing a relatively small number of documents.
- The subpoena constitutes 'fishing'. The fundamental principle expressed in section 225 is that the subpoena must be identify the document to be produced with reasonable particularity (*Spencer Motor Pty Ltd v LNC Industries Ltd*¹⁶). Where the subpoena is deemed to be merely 'fishing' for evidence, this will not be permitted and the subpoena will be set aside.

Objecting to a subpoena to produce documents

Where the subpoena is not set aside, the named person must produce the documents to the court. However, it is possible for the person to argue that the documents should not be inspected or copied but remain sealed. The party named on the subpoena will usually have legal representation at this point. An objection to a subpoena to produce may be made on the following grounds;

- *No legitimate forensic purpose*

The court must be satisfied that the evidence sought will materially assist the case of the defence or prosecution. It must be more than a 'mere fishing expedition' (*R v Young*¹⁷).

- *Legal professional privilege*

This privilege only attaches to documents created for the dominant purpose of legal advice or for use in legal proceedings (*Esso Australia Resources Ltd v Federal Commissioner of Taxation*¹⁸). This privilege will generally not attach to the medical records of an accused person in a criminal trial for an HIV transmission offence.

- *Professional confidential relationship privilege (ss126A-F Evidence Act 1995)*

A 'protected confidence' is a communication by a person in confidence to a 'confidant' who is acting in a professional capacity when the confidant is under an express or implied obligation not to divulge its contents (section 126A Evidence Act). This would presumably include doctor/patient relationships and psychiatrist/patient relationships, but the precise ambit of this section is very unclear.

- *Sexual assault communications privilege*

Information disclosed during counselling and other confidences to or about a victim or alleged victim of sexual assault are protected. This will generally not apply in a case where the medical information sought was regarding treatment for HIV. See sections 295-306 *Criminal Procedure Act 1986*.

- *Public interest immunity*

A document will be protected from compulsory disclosure where it is determined, through a balancing process, that the public interest in disclosing information or documents is outweighed by the public interest in preserving its secrecy or confidentiality where the disclosure would harm the public interest (*Sankey v Whitlam*¹⁹).

- *Does the public interest immunity apply to medical records?*

Although medical records and patient/physician communications are generally understood to be confidential, at common law they are not recognised as a category which attracts the public interest immunity (*R v Young*²⁰).

Although the categories of confidences which will attract the immunity are not closed, and new ones may be recognised, it is unlikely that medical documents including information about the treatment of a patient with HIV will be recognised in the future. In *Sum Mok v NSW Crime Commission & Anor*²¹, despite arguments that the disclosure of prison medical records would undermine the therapeutic and protective regime established by the Mental Health Act 1986, it was held that records held by prison medical authorities were not protected on grounds of public interest immunity.

Footnotes

1. UNAIDS, "Criminal Law, Public Health and HIV Transmission: A Policy Options Paper" 2002, page 5
2. Evidence Act 1995 (Cth) s79
3. *R v Bonython* (1984) 38 SASR 45, 46
4. *Allstate v ANZ* (No 33) (1996) 137 ALR 138 at 143
5. Points are summarised from Freckleton and Selby, *Expert Evidence: Law, Practice, Procedure and Advocacy* 2nd ed, 2002, Sydney, page 2
6. *R v Parenzee* [2006] SASC 127
7. Bernard J, Asad Y, Vandamme A, Wait M, Geretti A. The use of phylogenetic analysis as evidence in criminal investigation of HIV transmission 2007, NAM London
8. Michael Carter, "Prosecution for reckless transmission in England ends with not guilty," *AIDS MAP*, August 9 2006 <<http://www.aidsmap.com/en/news/9770EEA6-020F-440A-9224-D7BAD7784A69.asp>>
9. *Bouhey v The Queen* (1986) 161 CLR 10
10. *R v B* (unreported, Teague J, Vic Sup Ct, 3 July 1995) at 183
11. *R v Barry* (unreported Qld CCA; noted in (1991) 2 (49) *Aboriginal Law Bulletin* 20)
12. AFAO, 'Workshop on Criminalisation of HIV Transmission: Report' 2006
13. *R v Baines* [1909] 1 KB 258
14. *Botany Bay Instrumentation & Control Pty Ltd v Stewart* [1978] 1 NSWLR 372 at 382
15. *Commissioner for Railways v Small* (1938) 38 SR (NSW) 564
16. *Spencer Motor Pty Ltd v LNC Industries Ltd* [1982] 2 NSWLR 921
17. *R v Young* (1999) 46 NSWLR 681 per Beazley JA at 129
18. *Esso Australia Resources Ltd v Federal Commissioner of Taxation* (1999) 201 CLR 49
19. *Sankey v Whitlam* (1978) 142 CLR 1 per Gibbs J at 38
20. *R v Young* (1999) 46 NSWLR 681²⁰, per Spigelman CJ at 89 and 143
21. *Sum Mok v NSW Crime Commission & Anor* [2002] NSWCA 53

Criminal Trials and the Media

Sub Judice Contempt

Criminal trials for the transmission of HIV almost always arouse considerable media interest. Reporting is often sensationalised and designed to engender fear and panic in the reader. Investigating police, prosecution and defence counsel must be aware of the possibility that media reporting may interfere with, or lead to a miscarriage of justice in a criminal trial for an HIV transmission offence.

Before a person has in fact been charged and arrested, the media are under no legal obligation to limit news reports. They may report the name of the suspect, police allegations, or a picture of the suspect. This, of course, is subject to the law of defamation. However, once the proceedings are “imminent”; a matter is said to be sub judice. This means there are proceedings that are to be or are being heard before a judge (*James v Robinson*¹). Once a matter is sub judice the kind of material which can be published will be more restricted.

Sub judice contempt will be committed where the media publish a matter which has the tendency to interfere with the administration of justice in the trial. This will be proven where the publication has a real or substantial, as opposed to a trivial, risk of prejudice (*Hinch v Attorney - General*²). If the interference with the trial is merely incidental, such as where the report is broader in scope than a report of the trial itself and the interference with justice is coincidental and trivial, then there will be no contempt (*Bread Manufacturers Ltd, Ex parte; Re Truth & Sportsman Ltd*³).

Media outlets or journalists will have a defence to contempt where they can show there is a public interest in the open discussion of the matter. In the case of an HIV transmission trial, the media would most likely argue that this is a matter of great social importance and that the public has a right to be informed about crime in society. Furthermore, there would be an argument that the public should be made aware of any person/s who pose a risk to the public at large. This conflict between open justice and protection of the administration of justice would be weighed up by a judge to determine whether or not the matter published is contemptuous. Where contempt is made out, separate proceedings against the contemnor will be instituted, and there may be grounds for an appeal or re-trial.

Suppression Orders

An accused person has a right to a fair trial and to the proper administration of justice (*Dietrich v The Queen*⁴). Defence counsel should be aware that an accused is entitled to be ‘protected from an unacceptable and significant risk that the effect of prejudicial pre-trial publicity will prejudice a fair trial’ (*Advertiser Newspapers Pty Ltd v SA Health Commission*⁵). The prosecution should also be aware of this so as to avoid the case being sent for a re-trial or a police investigation being undermined.

However, where there is no legislative authority, it is unclear whether courts have the power to make non-publication orders which are binding on people outside the court.⁶ Assuming that courts do have this power, the restriction is only justified where necessary for the proper administration of justice in the proceedings at hand (*Ex parte Queensland Law Society Incorporated*⁷). The order must be specific and not go further than what is necessary in the circumstances. It must also be based on material before the court which allows for the conclusion that the order is necessary (*John Fairfax & Sons Ltd v Police Tribunal of New South Wales*⁸).

In criminal trials for the transmission of HIV, a court will often issue a suppression order regarding the identities of the complaint/s. In addition, where the police are undergoing investigations into an alleged transmission offence but no charges have been laid, the police may apply for a suppression order to prevent the publication of information about the identity of the accused person. This is to ensure that future witnesses or complainants are not exposed to material which may prejudice any evidence they may give. Similarly, future jurors may be prejudiced by suggestive reporting.

In *Advertiser Newspapers Pty Ltd v SA Health Commission*⁹, the Advertiser Newspapers appealed against orders of a magistrate suppressing them from publishing information concerning a South Australian man (McDonald) who is currently awaiting trial for intentional transmission of HIV. McDonald was being detained under s32(1) of the *Public Health Act (Vic)*.

The magistrate made an order, pursuant to s69A of the *Evidence Act 1929*, suppressing from publication the image of Mr McDonald and the names and content of the affidavit of one of the victims referring to the use and sale of drugs. The appellant sought an order revoking the previous orders and substituting them for an order suppressing only the names and any material which might identify the six alleged victims.

Although it is alleged that all eleven victims were infected by the same genotype of HIV as that with which McDonald is infected, that does not conclusively prove that they contracted the virus from him. Therefore, one potential issue at trial will be whether the alleged victims will be able to identify McDonald. Identification evidence is seen as being 'inherently fragile' (*Alexander v The Queen*¹⁰). This is because the human memory is generally defective. Most importantly, in this case, identification evidence is capable of being influenced by suggestion¹¹. In order to prevent a miscarriage of justice, as a result of wrongful identification, Debell J, refused to lift the suppression order of McDonald's image.

The appellant also sought to publish material containing unsubstantiated allegations of drug offences. These allegations were untested and highly prejudicial. Furthermore, they were held to be irrelevant to any charge of endangering life which might be made. As a result the suppression order was not lifted in regard to this material.

Restrictions on publication under the *Public Health Act 1991*

A public health order may be made under Division 6 of the *Public Health Act 1991*. Under section 35, where proceedings in a court are considering the issue of a public health order, that court may make orders which may restrict the publication of matters relating to those proceedings, the identity of the person in respect of whom proceedings are being instituted, and any information from which their identity may be deduced. This does not apply to a genuine volume of a law report where the person in respect of whom the proceedings were instituted is not named. The penalty for contravention of this section is \$1100 for a corporation or \$550 or 6 months imprisonment or both. Section 35 does not preclude punishment for contempt, but there cannot be a double punishment for both contempt and the above offence.

Footnotes

1. *James v Robinson* (1963) 109 CLR 593
2. *Hinch v Attorney- General* (1987) 164 CLR at 28 per Mason CJ
3. *Bread Manufacturers Ltd, Ex parte; Re Truth & Sportsman Ltd* [1937] SR (NSW) 242
4. *Dietrich v The Queen* (1992) 177 CLR 292
5. *Advertiser Newspapers Pty Ltd v SA Health Commission*, [2007] SASC 158, per Debell J at 23
6. For a discussion of the debate about the power to make a non-publication order see, Butler & Rodrick, *Australian Media Law* 2nd Edition, Thomson Lawbook Co, 2004, 4.90-4.95
7. *Ex parte Queensland Law Society Incorporated* [1984] 1 Qd R 166 at 170 per McPherson J
8. *John Fairfax & Sons Ltd v Police Tribunal of New South Wales* (1986) 5 NSWLR 465 AT 477
9. *Advertiser Newspapers Pty Ltd v SA Health Commission*, [2007] SASC 158
10. *Alexander v The Queen* (1981) 145 CLR 395 at 426
11. Heydon, John Dyson, *Cross on Evidence* at 1355, Sydney; Butterworths, 1996

Case Summaries

Summary

This resource focuses on the law in NSW and the legal issues that may arise in future trials for the prosecution of HIV transmission offences in this state. The only completed case for such an offence in NSW is that of *Kanengele-Yondjo v Regina*¹. A further case is ongoing in NSW. The Kanengele-Yondjo judgment does not offer any discussion of the substantive issues of law that have been discussed in other jurisdictions and which are considered in this resource because there was in fact no trial, only a charge bargain and an appeal as to the sentence. In this respect, cases from other jurisdictions may be of use. However, the differences between criminal law in different jurisdictions may limit the usefulness of such cases.

It is estimated that there have been 20 prosecutions involving HIV exposure or transmission in Australia since 1991². Not all of these are included below since many are still ongoing, and/or yet to go to appeal level. Many are unreported and it has proven to be difficult to obtain detailed information about the cases. A selection of cases that highlight particular issues are summarised below.

New South Wales

Kanengele-Yondjo v Regina [2006] NSWCCA 354

Kanengele-Yondjo was charged with two counts of malicious wounding or infliction of grievous bodily harm under section 35 *Crimes Act* 1900 (NSW). Originally, the Crown Prosecutor had wanted to charge him under section 36, which carries a 25 year maximum sentence. However, prosecutors decided it would be too difficult to prove that the defendant had intended to infect the women. The defendant entered a guilty plea and a charge bargain led to the lesser charge being laid.

It is interesting that the defendant was not charged under section 36 (which has now been repealed), but under the generic charge of grievous bodily harm in section 35. Section 36 was introduced into the Crimes Act in 1990, as an HIV-specific offence. The HIV sector argued that it was unnecessary and stigmatised HIV positive people as potential offenders. UNAIDS has also endorsed the use of general criminal laws in the context of HIV transmission and has expressed concern regarding the use of HIV specific offences³. The Kanengele-Yondjo case raised the question of how feasible it would be to successfully prosecute a person under the old section 36, that is to show that the defendant's actions were done maliciously. This requirement would have been too onerous, particularly given that he had had sex with other women who did not contract the virus.

The defendant was sentenced to a fixed term of six years prison on the first count and a sentence of six years for the second count with a three year non-parole period. The sentences were to be served cumulatively, amounting to 12 years in total, with a non-parole period of nine years. An appeal was made to the NSW Court of Appeal on several grounds regarding the sentence.

The accused was diagnosed with HIV on 5 February 1999. He underwent counselling and was informed of his civil and criminal duty not to infect others with the virus. He was told that he must use a condom and disclose his status to future partners. His treating doctor in fact gave him additional counselling as a female partner of his had already presented at the same clinic and had been diagnosed as HIV positive. He was reluctant to provide names of previous sexual partners for tracing purposes.

Between January - March 2003, the accused had vaginal sexual intercourse with two women. No condom was used with the first woman (A). The accused said to A "I would never hurt you, I don't have anything." He then told her that because he went back to the Congo frequently, he got tests for "everything." A subsequently became HIV positive.

The accused also had a sexual relationship with the second complainant (B). A condom was used on one occasion with B, but on a subsequent occasion the accused took off the condom during sex. When B expressed concern and asked why he had done that, he responded by saying "You shouldn't be worried, I have private health insurance and I have to do an HIV test once a year." He also told her he had given seminars about sexually transmitted diseases and indicated that he was not HIV positive. B subsequently became HIV positive.

Kanengele-Yondjo told police that he had had sexual intercourse with both women and that he had not disclosed his serostatus to either of them but that he had worn a condom with both women.

The grounds of appeal were as follows:

(a) His Honour erred in finding that the case was in the worst class of case

The applicant submitted that, given the basis of the applicant's guilt was recklessness, rather than intent the case did not fall into the worst class of case. The court held that the basis of this submission was misconceived because, if the foundation of the applicant's guilt had involved intent, he would have been charged under section 36 and the maximum sentence would be 25 years not seven years.

The trial judge was seen to have been correct in emphasizing the heinous nature of the crime "carried out with indifference to human life or suffering"; the fact that the offender concealed his condition; and the further risk of the spread of HIV generally. These were all aggravating factors that put this case in the worst case category.

(b) His honour erred in not giving sufficient discount for the plea of guilty

The court held that although, where a defendant enters a plea of guilty, it is to be taken into account as a mitigating factor in the determination of sentence, it is a matter left to the discretion of the sentencing judge. There is no presumption or entitlement to a discount.

(c) His Honour erred in failing to give adequate or any reasons for only giving a discount of 15% for the guilty plea (despite the fact that the plea was entered at the earliest opportunity)

The trial judge considered the reason for the reduction of a sentence. Discount should be given where the defendant shows contrition as there is utilitarian value in reducing penalties and sparing victims the pain of a long trial. However, this was outweighed by the reluctance of the applicant to co-operate, demonstrated by his initial denial of unprotected sex. The Court of Appeal found these reasons to be sufficient.

(d) *His Honour erred in not giving sufficient weight to the applicant's subjective circumstances*

The factors that were considered included some exhibited remorse and contrition, that incarceration would involve hardship and that the applicant had been diagnosed with HIV and his life expectancy was thereby reduced. The applicant submitted that the nine year non-parole to twelve year head sentence would maintain the statutory proportion and said that the defendant's subjective circumstances should have led to a favourable variation in the proportion. The court of appeal held that this was a discretionary matter and that the subjective circumstances had in fact been considered.

(e) *His Honour erred in not giving reasons for failing to fix a non-parole period for count one*

It was held that there was a failure to do this. However, this failure did not result in any miscarriage of justice so as to invalidate the sentence.

(f) *His Honour erred in not taking into account the principle of totality*

The Court of Appeal held that no error had been made in coming to the conclusion that cumulative sentences were appropriate.

(g) *The sentences were individually and collectively manifestly excessive*

The Court of Appeal held that neither the individual or collective sentences were manifestly excessive.

All grounds of appeal were rejected and Kanengele-Yondjo was imprisoned for twelve years.

Victoria

Mutemeri v Cheesman (1998) 100 A Crim R 397

This case is one of the most disturbing from a human rights perspective, as it considers the possibility that liability for a transmission may be imposed for mere recklessness, in the absence of actual infection.

The defendant was convicted of twelve charges of recklessly engaging in conduct placing another in danger of death, without lawful excuse, pursuant to section 22 of the *Crimes Act 1958 (VIC)*. All charges related to incidents in which the defendant had had unprotected sexual intercourse with "AB" whilst being HIV positive.

Section 22 of the *Crimes Act 1958 (VIC)* states that a person who, without lawful excuse, recklessly engages in conduct that places or may place another person in danger of death is guilty of an indictable offence. The maximum penalty is ten years imprisonment.

An appeal was heard in the Supreme Court of Victoria. The questions of law that were raised included;

(a) *Was there evidence upon which it was open for the magistrate to find that the appellant's conduct carried with it an appreciable risk of the death of Ms AB in respect of each charge?*

This was a case that did not involve actual infection of the complainant with HIV. The issue was in regards to whether or not she had been exposed to an appreciable risk. An expert witness testified that the risk of transmission of the HIV virus in the case of unprotected vaginal sex was between 1 in 667 and 1 in 2000 as based on published epidemiological studies. Reduction in the risk depended on a number of possible variables such as that there is a chance of outright survival or that there will be a period of prolonged survival. Other factors may include the possibility of the development of a cure or life-prolonging treatment and the chance of dying as a result of some unrelated cause or event. The Supreme Court held that it was not open to the magistrate without some such evidence, to be satisfied that the appellant's conduct had placed Ms AB in danger of death. A re-trial was ordered on this count.

(b) *Did the magistrate apply the correct test in determining if the conduct was capable of being reckless?*

The appellant claimed the correct test was that the appellant "foresaw that a probable consequence of that conduct would be the death of Ms AB". The trial judge rejected this and formulated the test as "foresaw that a probable consequence of that conduct would be to place Ms AB in danger of death". The trial judge's direction was affirmed as the correct test on appeal.

(c) *Did the learned magistrate err in taking judicial notice that contracting HIV is a life endangering situation?*

It was held that this was justified as it is "a fact made notorious by wide publicity in Australia over a number of years."

(d) *Were the sentences imposed manifestly excessive?*

This did not need to be decided as the appeal succeeded on ground a). However, the court held that the sentence would have been appropriate if the conviction had stood.

The convictions, sentences and orders of the Magistrates' Court were set aside and all charges were dismissed.

Kuoth 2007

The defendant was charged with two counts of reckless conduct endangering life under section 22 of the *Crimes Act 1958*. Kuoth was diagnosed HIV positive shortly after he arrived in Australia from the Sudan in 2006. The defendant did not infect the woman to whom the charges relate, but infected his current partner, with whom he had a child. Kuoth was served with a public health order by the health department requiring him to use condoms, disclose his HIV status to sexual partners and to attend counselling, but he did not do so. He was detained in a psychiatric hospital after a psychiatric report concluded he had 'a high risk of infecting others with HIV'. He was also reported to be suffering from post traumatic stress disorder having witnessed the deaths of his family in war-torn Sudan.

In sentencing Kuoth, the judge initially considered that a non-custodial sentence would be too lenient, but after reading the report from the Department of Human Services regarding Kuoth's psychiatric treatment, Judge Lacava agreed that Kuoth should be given a suspended two-year jail term. This demonstrates that custodial sentences are not always appropriate for HIV transmission cases and discretionary sentencing is important to consider. It also raises important issues regarding how best to 'house' people who are a danger to public health, and how co-morbidities such as post-traumatic stress disorder can affect an individual's capacity to understand and manage their HIV status.

Kuoth's case was identified when a public servant mistakenly handed over his file along with a number of others as a result of the police department's warrant for the file of Michael Neal (see section below).

Neal 2008

In May 2006 Neal was arrested and charged with 35 offences including attempting to infect others with HIV, and deliberately infecting others with HIV. He was found guilty of deliberately trying to spread HIV in July 2008. He was found not guilty of intentionally infecting two men with the virus. He was sentenced to 18 years and nine months jail with a non-parole period of 13 years. In passing sentence, Judge Parsons noted "this is the first prosecution of its type in Victoria and there's no doubt a very clear message has to be sent to the community in relation to this type of offending."

Neal's case is significant in that it highlighted the gaps between public health and criminal laws in Victoria. The case underlined the lack of appropriate communication and procedures between health officials and police. For example, when the police issued a warrant to obtain Neal's medical records, they were incorrectly supplied with not only Neal's records, but the records of 16 other HIV positive people about whom the health department had concerns. As a result of this, Kuoth (see above) was charged with reckless conduct endangering life for not disclosing his HIV status to two sexual partners. The disclosure of ordinarily confidential health records can undermine public health efforts and deter people from seeking testing, counselling and being fully honest with health care providers through fear of prosecution.

It is also noteworthy that the Neal case generated a significant amount of sensationalist media reports and headlines, with extensive reporting of the less mainstream sexual practices engaged in by the accused, suggesting that the general population should be shocked and disgusted by such practices, when in fact many people find these practices perfectly normal. The media generalised the behaviour that resulted in a criminal investigation to all people living with HIV. Such media coverage has the potential to be detrimental to the work achieved in decreasing stigmatisation, stereotyping and discrimination directed towards the gay and HIV positive communities.

Mwale 2008

Mwale's case, like Kuoth's, was identified when his health department file was mistakenly given to the police as part of their warrant for the file of Neal.

Mwale was charged with reckless conduct causing serious injury under s23 *Crimes Act* 1958. He was charged with transmitting HIV to a woman with whom he had been having a sexual relationship.

The accused was acquitted after Hampel J directed the jury that the Crown had failed to prove one of the five necessary points of law to enable the jury to bring about a conviction. Mwale was diagnosed HIV positive on 9 December 2003. The complainant was diagnosed HIV positive on 17 November 2004. The judge found that Mwale had engaged in unprotected sex with the complainant for three years prior to his diagnosis. He was at the time of the diagnosis counselled and advised of his obligations not to engage in unprotected sex with a person without disclosing his HIV status. The relationship ended on 14 February 2004, but the accused and complainant continued to have infrequent unprotected sexual intercourse between February 2004 and November 2004 according to the complainant.

Hampel J held that the main issue was whether the complainant was placed at risk of serious injury by transmission of HIV through unprotected sexual intercourse if she was already HIV positive. The Crown would have to exclude the reasonable possibility that the complainant was already HIV positive before the accused was diagnosed. Her Honour concluded that on the evidence, it was not possible to exclude the reasonable possibility that the complainant was already HIV positive by 9 December 2003. It was not known when Mwale contracted HIV, and there was therefore a real risk that he may have infected the complainant before he was diagnosed, in which case he could not be found to have knowingly put her at risk of infection.

An interesting aspect of the ruling is that Justice Hampel refers to the illogicality of applying s23 to such circumstances and the anomaly that can result. Her Honour compares two situations. Firstly, assume that the complainant was HIV negative, but there was evidence that unprotected sex occurred after the accused's diagnosis with HIV and counselling. The complainant was thus exposed to a risk of serious injury by transmission of HIV, but a risk that did not materialise. In this situation, there would be a case capable of supporting a conviction. In the second situation, as in the case heard, the complainant was HIV positive, and the possibility that she became positive before the accused was diagnosed could not be excluded and so a conviction could not be supported.

Hampel J concludes by noting that "if the gravamen of the conduct which is sought to be characterised as criminal is the engaging in unprotected sexual intercourse without disclosure of HIV positive status, once that is known and the person has been counselled, then a prosecution should not stand or fall on an event external to that, namely the victim's HIV status... this is not a matter for me or for a court, but maybe it is something which parliament should consider."

Name unknown 2008⁴

A 39 year old man from Melbourne pleaded guilty to one count of reckless conduct endangering life. He was sentenced by County Court Judge Thomas Wodak to five years in prison. The man began a sexual relationship with the female complainant in January 1996 and had unprotected sex on many occasions. In March 1996 the complainant tested positive for HIV. The accused, who was haemophilic, had been HIV positive since 1984 when he contracted HIV from a contaminated blood transfusion.

The man told his partner the truth in 1997. They subsequently married five years after her diagnosis in 2001, but the marriage ended in 2007. The complainant only made a complaint to police after the relationship ended, around 12 years after the alleged incident occurred. This case highlights the fact that HIV-positive individuals could face criminal charges many years after any alleged act of transmission takes place. However, it should be noted that proving that one person infected another becomes more difficult the longer the time that has elapsed since the alleged incident.

Western Australia

Houghton v The Queen [2004] WASC 20

Houghton, the applicant, was charged under s 297 of the Western Australian *Criminal Code* with unlawfully inflicting grievous bodily harm upon the complainant. The maximum imprisonment for this offence is 10 years.

The applicant was diagnosed with HIV in 1990. He was convicted in October 2002 with having infected a woman with HIV through vaginal and anal sex. The appellant was aware of his HIV positive status. He was counselled by medical practitioners and others about safe sex practices. He claimed that the counselling led him to believe that it was safe to have unprotected sex if he did not ejaculate semen into the sexual partner. He did not disclose his HIV positive status to the complainant and said he did not want to “scare her off”.

The prosecution led evidence from the complainant that they had engaged in unprotected anal sex and that the applicant had ejaculated inside her. The applicant denied having ejaculated inside her and having had anal sex at all.

The main questions of law were:

(a) *Is infection with HIV grievous bodily harm?*

The major issue at the trial was whether the complainant had suffered grievous bodily harm in being infected with HIV. Under the Criminal Code section 1(1), grievous bodily harm is defined as any bodily injury of such a nature as to endanger, or be likely to endanger life, or to cause, or be likely to cause, permanent injury to health;

Expert evidence was given showing that the complainant was a “long-term non-progressor”. This meant she had not begun to show any signs of illness and was not on any treatment at the time of the trial. The disease was essentially dormant in her body. On appeal it was held that infection with HIV does constitute grievous bodily harm as the injury she sustained “was likely in that way to cause permanent injury to her health.”

(b) *What does “unlawfully” mean?*

In relation to the term “unlawfully”, the applicant submitted that the prosecution had to prove that the act causing the harm, that is the sexual intercourse itself, was unlawful. In doing this it was submitted that the prosecution had to negate an honest and reasonable but mistaken belief that the act would cause transmission. On appeal, the majority of Steytler and Wheeler J held that the term “unlawful” should be given its ordinary and natural meaning. They looked at s266 which imposes a duty on persons in charge of dangerous things. They considered *R v Mwai* (see section 36.1) and held that it was strongly arguable that the act was unlawful because it was done in breach of the duty imposed under s266. However, it was held that this issue should have been left to the jury and as it was not, the trial had substantially miscarried. The appeal was allowed on this ground.

(c) The omission of a direction in Terms of s 23

The appellant asserted that the judge erred in failing to give a direction, pursuant to section 23, that the prosecution needed to prove that the defendant's act was willed, and not accidental, or alternatively to give the jury a direction on criminal negligence. On appeal Murray J held that this issue did not arise at trial and even if it had, there was no evidence to prove that a reasonable person in the position of the plaintiff would not have foreseen the consequences.

(d) Direction about the relevant act or acts

The appellant claimed the trial judge erred in failing to instruct the jury that the Crown must prove the precise act by which the HIV virus was transmitted by the applicant to the complainant, whether it be by vaginal or anal sex, and that the prosecution had to exclude infection by other means or by somebody else. On appeal it was held that there was no other evidence of other modes of transmission, so there was no error in the direction.

(e) Mistake of fact

The applicant contended that the trial judge erred in that he directed the jury that, when considering section 24, they should consider the honest belief of an ordinary person in the accused's position. The appellant contends that the jury should have been directed to consider the question of whether the applicant honestly believed that by having unprotected sex, without ejaculating in the vagina or anus of the complainant, he would prevent transmission of HIV. On appeal the direction was held to have been adequate.

(f) The comment on the Expert Evidence

The appellant submitted that the comment impermissibly indicated to the jury how they should approach the evidence of the witness and how they may reason towards the guilt of the applicant. This ground was rejected on appeal.

(g) The Direction as to Drawing Inferences

The trial judge gave a direction that the jury would have to make an inference as to whether the virus would cause grievous bodily harm because there was no direct evidence of that. This was held to have been unnecessary but not to have led to any miscarriage of justice.

(h) Direction as to "lies"

The Crown Prosecutor had asserted that the applicant had fabricated a letter from a medical authority saying he was HIV negative. The appellant submitted that the trial judge should have given an instruction as to how the jury could use the conclusion that the applicant had deliberately lied.

In *Edwards v The Queen*⁵ in the judgement of Deane, Dawson and Gaudron JJ at 210-1, it was held that a lie can only be used where it relates to a material issue. The lie should be identified precisely, as should the circumstances and events that are said to indicate that it constitutes an admission against interest.

Steytler and Wheeler JJ in the majority held that the trial judge should have identified each lie, as well as the surrounding circumstances that were said to indicate that it constituted an admission. It was held that the lies did not, in fact reflect on guilt. Therefore, the trial judge should have directed the jury that if they found it to be a lie, it should not be treated as reflecting a consciousness of guilt on the part of the appellant. The appeal was allowed on this ground.

The appeal was granted, the conviction was quashed and a retrial was ordered.

Queensland

***R v Reid* [2006] QCA 202**

Reid was charged under s 317(b) of the *Criminal Code* 1899 (Qld) with one count of unlawfully transmitting a serious disease with intent and, in the alternative, with one count of grievous bodily harm under section 320. The former carries a maximum life sentence, whereas the lesser charge carries a maximum of fourteen years imprisonment. The prosecution case was that the appellant had transmitted the HIV virus to the complainant with intent to do so or, in the alternative, with unlawfully doing grievous bodily harm to the complainant. Section 320 does not have an element of intention but the prosecution must prove the element of unlawfulness. Much of the evidence came down to the credibility of different versions of conversations that occurred in the bedroom and in private, and whether the choice to have unprotected sex was really a choice or not. The court found that Reid had lied about his HIV status, and he was found guilty on count one. The jury therefore did not need to decide count two. He was sentenced in the District court of Brisbane to ten years and six months imprisonment.

The facts of the case were that from the 16 January 2003 the appellant had anal sexual intercourse with the complainant at a frequency of three to four times a week. Condoms were not used on any of these occasions as both had agreed that they preferred not to use them. The plaintiff testified that, before doing so, he had asked the appellant and was assured by him that he was not HIV positive. This was in fact false and the appellant was aware of his positive serostatus as he had been diagnosed in November 1987. Mcpherson JA notes that the appellant had not taken any medication to prevent the development of the disease (at 3). The evidence showed that certainly by the 4 March 2007 the complainant had been infected, although he was probably infected as early as 20 February, at a much earlier stage in the relationship.

The appeal to the Supreme Court of Qld was dismissed. The grounds were as follows:

1. *The verdict is unreasonable and cannot be supported having regard to the evidence*

In order to find a verdict of guilty, the jury had to be satisfied beyond a reasonable doubt that the appellant intended to transmit the virus. The appellant contended that medical evidence adduced at trial showed that the risk of infection was less than 1%. The infection was earlier in the relationship, when the risk was lower. As the number of instances of unprotected sex increases, the risk increases according to probability. The appellant contended, that as the risk at the start of the relationship, when infection occurred, was low, there was no intention to infect the complainant.

Keane J rejected this, as it attributes the evidence of Dr McCarthy to the applicant when there was no evidence to justify such attribution. There was no evidence to suggest that the 1% risk reflected what the appellant actually knew at the time of infection. The test for intention is a subjective one and can not be replaced by an objective inquiry into what the actual likelihood of infection was.

Keane J noted that the appellant understood that unprotected sex with the complainant was likely to infect him with HIV. He also considered the possibility that the appellant had a mental state that was mere “selfish recklessness”; but concluded that it was open to the jury to find there was intent because of the taunting of the complainant by the appellant after the complainant was diagnosed. Keane J also noted the appellant’s knowledge of post-exposure prophylaxis and the fact that he did not alert the complainant to the need for such urgent treatment.

The first ground of appeal failed.

- 2. The learned trial Judge erred in the directions he gave to the jury as to the manner in which they should approach the issue of intent*

McPherson JA held that the trial judge fell into error in failing to direct the jury “that they must, before convicting, be satisfied that the appellant knew that, by having unprotected anal sex with the complainant, it was ‘probable’ or ‘likely’ that the disease would be passed on to him.” (per McPherson JA at 13). However, McPherson was in the minority. Keane J held that the trial judge was not under an obligation to outline a dichotomy between recklessness and intent and that the trial judge’s direction was adequate direction to the jury. Chesterman J agreed and the ground of appeal was dismissed.

The applicant also asserted that the trial judge should have made closer reference to the police interview and comments made by the appellant which would go to suggesting mere recklessness (that he was “completely irresponsible” and “stupid in the extreme”). Keane J stated that the police interview was so adverse to the appellant that this was not prejudicial.

- 3. The learned trial Judge erred in failing to direct the jury in relation to the absence of motive.*

It was held on appeal that motive is not relevant to proving intention and no direction was needed.

South Australia

***R v Parenzee* [2006] SASC 127**

Parenzee was convicted of three counts of endangering life under section 29(1) of the *Criminal Law Consolidation Act 1935* (SA). This was the first Australian prosecution and conviction for exposure without resulting transmission. It was alleged that Parenzee had unprotected vaginal sexual intercourse with his wife and two other women when he knew he was HIV positive, despite been advised of the risk of transmission through unprotected sexual intercourse. The prosecution asserted that the defendant knew that the act or acts were likely to endanger the life of each of the women and that he was recklessly indifferent as to whether their lives were endangered.

It was alleged that Parenzee had told all three women that he was dying of cancer. Between 1998 and 2000, the accused attended Flinders Medical Centre and always arranged appointments so that his wife could not accompany him. His wife did not contract the virus, however, the accused then went on to infect a second woman, SMC. The accused's wife did not discover the truth about his serostatus until 2003. She spoke to him about it, and it was alleged that the accused said, in reference to Ms SMC's infection, that he "could not give a shit". The accused also had unprotected sex with a third complainant, Ms JB, but she did not become HIV positive. Ms JB later confronted the accused regarding his serostatus and he denied that he was HIV positive.

At trial an application was made for the separation of count 1 from count 2 and 3. This was rejected as Sullan J held there was "evidence of an underlying unity or system in misleading Ms SMC and Ms KC about his condition, and later when confronted by Ms JB, denying that he suffered from HIV." (at 32).

Application for permission to appeal was made to the Supreme Court of South Australia on the ground that new expert evidence had become available. The evidence led was from a Perth Group who claimed that there is no scientific evidence to prove that HIV exists, that it causes AIDS or that it is sexually transmissible. If this evidence was found to be cogent it would have to lead to an acquittal.

Justice Sullan held that the defence witnesses who were called to lead the above evidence were not in fact experts and the evidence they gave was not expert evidence. The application to appeal was dismissed. (see page 39)

McDonald 2009

McDonald is accused of 'recklessly' infecting eight men with HIV between January 2001 and January 2006. His trial has been delayed until at least May 2009 and so we currently have little information about the case. He has pleaded not guilty to eight charges of having unprotected sex with the men while knowing he was HIV positive, and knowing the acts were likely to endanger their lives and intending or being recklessly indifferent to endangering their lives.

McDonald's case raises the issue of appropriate housing and detention of those posing a threat to public health. McDonald is the first person in South Australia to be detained without charge under the South Australia *Public and Environmental Health Act*. He was placed in a psychiatric ward after a report from a health department psychiatrist concluded that McDonald didn't accept the need for restrictions on his sexual behaviour.

New Zealand

***R v Mwai* [1995] 3 NZLR 149**

Mwai was accused of having unprotected sexual intercourse with several women, two of whom became infected with the virus.

Mwai was charged under section 201 of the *Crimes Act 1961* (NZ). The section states that everyone is liable to imprisonment for a term not exceeding 14 years who, wilfully and without lawful justification or excuse, causes or produces in any other person any disease or sickness. However, he was discharged on this count by the judge, pursuant to section 347.

He was also charged under s188 (2). The section states that every one is liable to imprisonment for a term not exceeding 14 years who, with intent to cause grievous bodily harm to any one, wounds, maims, disfigures, or causes grievous bodily harm to any person. Where there is only an intent to injure, but not cause grievous bodily harm, the maximum imprisonment is a term not exceeding 7 years.

A final charge was laid under s145. This section states that every one commits criminal nuisance who does any unlawful act or omits to discharge any legal duty, such act or omission being one which he knew would endanger the lives, safety, or health of the public, or the life, safety or health of any individual.. The maximum sentence is imprisonment for one year.

An appeal was dismissed on all grounds. The following issues were raised;

- (a) Whether infecting a person with HIV could constitute grievous bodily harm? Whether psychological harm caused by exposure to HIV would constitute grievous bodily harm?

Infecting someone with HIV was held to constitute grievous bodily harm. The applicant submitted that s188 only applied to immediate harm not prospective harm. This was rejected as the court held that “the link between cause and effect is a physical one, not one of time”⁶

It was also held that psychiatric injury caused by exposure to HIV can constitute grievous bodily harm, where the injury is properly defined by expert medical evidence. Here the court applied the decision in *R v Chan-Fook*⁷ .

- (b) Could the causal connection between intercourse and infection be proved to the necessary criminal standard, considering (as the appellant submitted) that factors leading to actual infection are beyond the control of the carrier.

The court held that it was only necessary to prove the appellant’s act was the substantial cause of the infection and that had been proven.

- (c) In relation to the third charge, was there an omission to discharge any legal duty which the accused knew would endanger the life, safety or health of any individual (failure to disclose or use a condom?)

The appellant submitted that as he had no control over the virus and that he had not omitted to discharge any legal duty in respect of it. It was held that, for the purposes of s 156, the term “anything whatever,” meaning the dangerous substance, was in fact the semen and not the virus itself. Therefore, the accused was under a duty to wear a condom. Here it was acknowledged that wearing a condom in this respect could constitute a defence to the charge.

Dalley 2005

Dalley was charged under sections 145 and 156 for exposing a woman to HIV by failing to inform her of his HIV positive status⁸. This case focussed on condom use as a defence to an HIV exposure charge.

The first charge related to oral sex without the use of a condom, and the second charge to vaginal intercourse with a condom. The judge found, on the basis of expert evidence, that the risk of transmission of the virus during unprotected oral sex was so low that it could not be regarded as a risk. This was despite the acknowledgment that the risk was not zero.

The judge noted in relation to the second charge, that the risk of HIV transmission from an HIV positive man to a negative woman during vaginal intercourse is relatively low based on comprehensive expert evidence. The judge also found that condoms significantly reduced the risk of HIV transmission during vaginal intercourse. It was held that the defendant had taken reasonable precautions and was not guilty of a criminal nuisance.

The case established that disclosure of HIV positive status to sexual partners is not required if a condom is used properly. Disclosure prior to oral sex is not required due to the low risk of transmission of the virus during oral sex.

United Kingdom

***R v Dica* [2004] QB 1257**

Dica was convicted of two counts of causing grievous bodily harm, contrary to section 20 of the *Offences Against the Person Act* 1861. Section 20 states that whosoever shall unlawfully and maliciously wound or inflict any grievous bodily harm upon any other person, either with or without any weapon or instrument, shall be guilty of a misdemeanour, and being convicted thereof shall be liable to be kept in penal servitude. Dica was sentenced to 8 years imprisonment including consecutive sentences of three years and six months and four years and six months.

Dica was diagnosed as HIV positive in 1995 and began treatment on medication. He was alleged to have had unprotected sex with two women, both of whom contracted HIV. The prosecution case was not that he had deliberately set out to infect the women, but rather that he was reckless in his actions.

However, the central issue at trial was not recklessness but the issue of consent. This case was decided when *R v Clarence* (1889) 22 QB 23 was considered to be the law in England. This meant that where a person consents to having sexual intercourse, they can not withhold the consent, where the sexual intercourse then causes them to become infected with a disease. *Clarence* is also authority for the proposition that transmission of a disease does not constitute grievous bodily harm. The defence case was that, although both women had willingly consented to sexual intercourse, neither would have done so if they had been informed about the defendant's HIV positive status. This argument would have been rejected if the court followed *Clarence*.

The trial judge held that *Clarence* had been undermined as an authority and therefore it was open to the jury to convict the appellant. However, he then went on to conclude that, in applying *R v Brown & Ors* [1994] 1 AC 212, even if the complainants had been aware of Dica's condition, their consent was irrelevant, because they did not in fact have the legal capacity to consent to such serious harm. The appellant elected not to give evidence as a result of this ruling and the issue of consent was not left to the jury.

On appeal, counsel for the appellant contended that both of these findings were wrong in law. The assertion was that *Clarence* was still good law and therefore, transmission of a disease could not be seen as grievous bodily harm. Furthermore, consent to sexual intercourse could not be revoked even where it led to the transmission of a disease. Therefore, the accused should have had a full defence of consent.

On appeal, in reference to the trial judge's first finding it was held that *Clarence* had no continuing application. Therefore, it followed that grievous bodily harm could be caused where there was no assault, including where a bodily disease is transmitted. In addition, consent to the act of sexual intercourse would be vitiated where there was no consent to the risk of HIV infection. In reference to the trial judge's second finding, it was held that the court could not say that a person has no legal capacity to consent to the risk of infection with HIV, as this would be "interference... with personal autonomy, and its level and extent may only be made by Parliament"⁹. The decision reflects the reality of sexual relationships in contemporary society and the judgment considered;

"the complexity of bedroom and sex negotiations, and the lack of realism if the law were to expect people to be paragons of sexual behaviour at such a time, or to set about informing each other in advance of the risks or to counsel the use of condoms. It is also suggested that there are significant negative consequences of disclosure of HIV, and that the imposition of criminal liability could have an adverse impact on public health because those who ought to take advice, might be discouraged from doing so. If the criminal law was to become involved at all, this should be confined to cases where the offender deliberately inflicted others with a serious disease."¹⁰

This clearly reflects Lord Mustill's comments in *Brown* that "the criminal law does not concern itself with these activities, provided they do not go too far. It also seems plain that ... the general social appreciation of the proper role of the state in regulating the lives of individuals changes with the passage of time."¹¹

The appeal was allowed on the grounds that the issue of consent should have been left to the jury. A retrial was ordered.

***R v Konzani* [2005] 2 Cr App R 14**

Konzani was convicted on three counts of inflicting grievous bodily harm on three women, contrary to s 20 of the *Offences Against the Persons Act* 1861. He was sentenced to ten years, four years and three years for each count respectively. The sentences were to run consecutively and in total amounted to seventeen years imprisonment.

The appellant was diagnosed with HIV in November 2000. At that time he was informed of the risk of infection and the need to practice safe sex. In all three cases, the accused had unprotected sexual intercourse with the complainants. Each of them contracted the HIV virus. Konzani did not tell any of them that he was HIV positive.

It was admitted that the accused had infected the women and thereby caused them grievous bodily harm. However, the defence submitted that by consenting to unprotected sexual intercourse, each complainant had consented to all the risks associated with unprotected sex, including the risk of contracting HIV. Therefore, the defence argued, the accused had a defence and should be acquitted.

This case was decided a year after *Dica* and it clarified the issue of informed consent in English law. The main grounds of appeal were that the judge wrongly declined to leave to the jury the issue whether the appellant may have had an honest, even if unreasonable belief, that the complainant was consenting to the risk of contracting the HIV virus.

The court of appeal found that the defence of informed consent, as raised in *Dica*, was limited in that it was based on conflicting public policy considerations. The court noted the interest in preventing the spread of HIV through the denial of legal capacity to consent to the risk of infection. This had to be balanced against the recognition of personal autonomy in the context of consensual non-violent sexual relationships. However, in so far as *Dica* recognised that *Brown* did not deny a person legal capacity to consent to the risk of contracting HIV, the court in *Konzani* noted that this must be informed consent. Allowing a person to recklessly infect another and then claim that they had a defence, in that they held an honest yet mistaken belief that that person had given their informed consent to run the risk of infection, would also deny personal autonomy.

This means that where a person has an honest, yet mistaken belief, that the other person has given their informed consent to run the risk of infection, this defence will only be made out if there is actual evidence of informed consent. Honest belief will not be a defence alone. In *Konzani*, the court of appeal held that, even though there may be some situations where such an honest belief in the informed consent of the other party may exist, there was no evidence at all to suggest that was the case here, “the honest truth was that the appellant deceived them.”¹². The appeal against conviction was dismissed.

Canada

***R v Cuerrier*, [1998] 2 S.C.R. 371**

The accused was charged with two counts of aggravated assault pursuant to s268 of the *Criminal Code* in respect to unprotected sexual intercourse with two complainants. Both complainants had consented to the unprotected sexual intercourse but they testified that they would not have given consent if they had been informed of the accused’s HIV positive status. At the time of the trial, neither complainant had tested positive for HIV. The accused was acquitted on both counts.

On appeal this was overturned and a retrial was ordered. The Supreme Court of Canada held that not disclosing one’s HIV -positive status before unprotected (vaginal or anal) sex amounts to fraud which effectively vitiates the sexual partner’s consent to sex . Therefore, the physical sexual contact amounts to an assault. In this respect the court moved away from the position in *R v Clarence* and held that parliament had, through reform of the legislation, demonstrated an intention to provide a more flexible concept of fraud in assault cases.

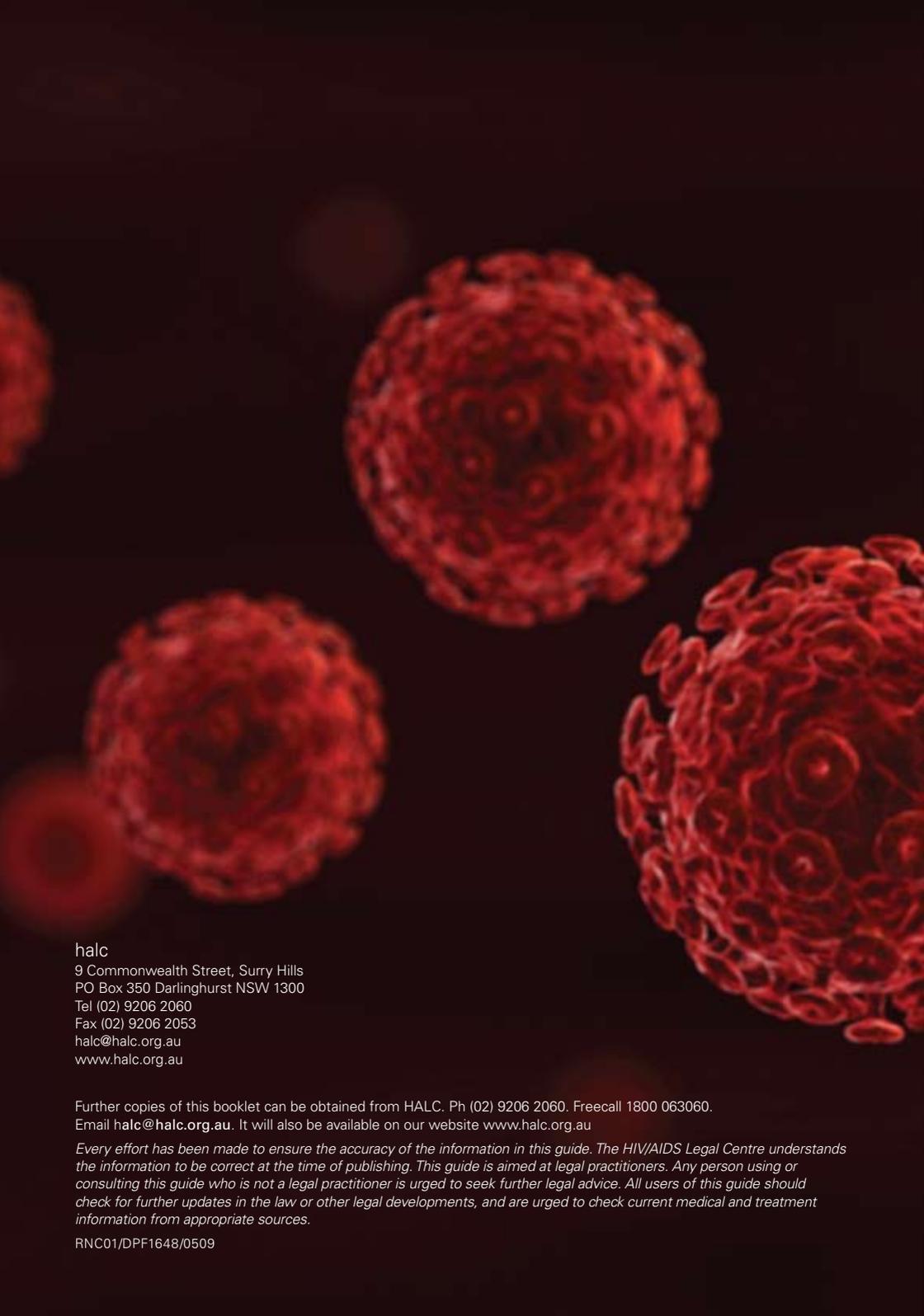
The court held that there was a duty placed upon HIV positive people to disclose their serostatus before engaging in activity that posed a “significant risk” of transmission. However, the court failed to provide any clear definition of what would constitute such risky behaviour. The court said that the nature and extent of the duty to disclose, if any, will always have to be considered in the context of the particular facts presented. Particularly, the court did not consider if low risk sex would still require disclosure, for example, where a condom is used. The court acknowledges that safe sex will reduce such risks;

“To have intercourse with a person who is HIV-positive will always present risks. Absolutely safe sex may be impossible. Yet the careful use of condoms might be found to so reduce the risk of harm that it could no longer be considered significant so that there might not be either [harm or risk of harm].”

Despite this, there is no unequivocal statement that the duty to disclose will be discharged where there is safe sex or low risk sexual acts. The judgment suggests that disclosing HIV-positive status before sex in the case of either “high” or “low” risk activity is the only way of preventing a criminal charge.

Footnotes

1. *Kanengele-Yondjo v Regina* [2006] NSWCCA 354
2. Groves A, Cameron S ‘Criminal prosecution of HIV transmission: the policy agenda’ AFAO Discussion Paper May 2009
3. Criminal Law, Public Health and HIV Transmission: Policy Options Paper, UNAIDS 2002 page 32
http://data.unaids.org/publications/IRC-pub02/JC733-CriminalLaw_en.pdf
4. “Jilted wife accuses husband of criminal HIV transmission twelve years after alleged event” Bernard EJ.
<http://criminalhivtransmission.blogspot.com/2008/03/australia-jilted-wife-accuses-husband.html>
5. *Edwards v The Queen* (1993) 178 CLR 193
6. *R v Mwai* [1995] 3 NZLR 149 at 153
7. *R v Chan-Fook* [1994] 1 WLR 689
8. *New Zealand Police v Dalley*, District Court of Wellington, Court File No. CRI-2004-085-009168 Oct 2005
9. *R v Dica* [2004] EWCA Crim 1103
10. See note 2, at 54
11. *R v Dica* [2004] EWCA Crim 1103
12. *R v Konzani* [2005] 2 Cr App R 14at 45



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