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HIV/AIDS Legal Centre Incorporated (NSW) ABN 39 045 530 926

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By Email: Gemma.Broderick@health.nsw.gov.au

Dear Ms Broderick,

Re: Submissions on Proposed Mandatory Disease Testing Bill 2020

We refer to your correspondence of 11 May 2020 inviting the HIV/AIDS Legal Centre to provide comments/submissions on the proposed Mandatory Disease Testing Bill 2020 (the Bill).

About the HIV/AIDS Legal Centre

The HIV/AIDS Legal Centre (HALC) is a not-for-profit specialist community legal centre in NSW. HALC provides free and comprehensive legal assistance to people in NSW with HIV or Hepatitis-related legal matters, undertakes Community Legal Education and Law Reform activity in areas relating to HIV and Hepatitis, provides legal training, education and experience to employees and volunteers and liaises and works in partnerships with other organisations to achieve these objectives.

Comments in relation to the Bill

While HALC has enormous respect for and acknowledges the work of emergency service workers, and notes that they are entitled to feel safe and protected in their work environments, we strenuously opposes a law that would allow for the mandatory testing for blood borne viruses (BBVs) in any form.

It is an enshrined principle of public health laws across all States and territories that testing for BBVs (besides in exceptional circumstances) should only be conducted with a person's consent. Testing without consent is known to reduce the best public health outcomes, as it not only increases the stigma and the irrational fear associated with BBVs, but also decreases engagement with health services and treatment.

The Bill appears to be punitive rather than trying to achieve the goal of protection for the 'prescribed worker' ('worker'). The focus on the 'deliberate' action of a 3rd Party begs the questions that if the focus is on peace of mind and protection of the worker then why are only "deliberate" acts included.

Additionally, HALC submits that the Bill in its current form cannot achieve the outcomes it seeks to achieve. For example, it is not possible to both receive test results within the 72 hour

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window needed to assess the necessity of PEP or other treatment preventative treatment, and to also allow for fair, medically-guided, and accountable decision-making.

Furthermore, the Bill gives additional powers to the Police which draws a concern that these powers create a real or perceived risk of abuse, particularly where such powers are not subject to scrutiny by the Courts.

Finally we note the "Violence against emergency services personnel" Report (the Report) of the Committee on Law and Safety, August 2017 made a finding that any such legislative scheme for mandatory testing should only be able to be enlivened in circumstances where there is a risk of transmission of listed diseases and that the factual circumstances should be clearly defined, based on up to date medical evidence, as to when there is such a risk. It is submitted that The Bill in its current form does not follow these findings.

Should the proposed the Bill be enacted we propose the following:

- 'Senior Officers' who decide on grant of a Mandatory Disease Testing Order ('Order') must be Medical Doctors, with particular knowledge of infection risk and BBV transmission.
- Only blood or semen be considered relevant bodily fluids, and only contact with a wound, abrasion, orifice (e.g. eyes or mouth) or mucous membrane be a relevant form of contact as this is the only way BBVs can be transmitted. All relevant diseases must be clearly defined in the Act. It is submitted that only diseases that can be transferred through blood, and are chronic or potentially terminal be included.
- While, we continue to oppose mandatory testing as a whole, if the Bill is passed, whether or not the act was 'deliberate' must be a relevant consideration for both the Senior Officer, Chief Health Officer (CHO) and Local Court in the deciding grant of an Order.
- Every single 3rd Party (or their responsible person), regardless of age, must be informed of an application for an Order, advised to seek legal advice and how to provide submissions, be informed of the review and decision-making process and timeframe, receive medical counselling regarding the risk, and how to nominate a doctor to receive test results, 10 business days prior to a Senior Officer making a decision.
- A "vulnerable person" should be automatically provided with legal representation (e.g. Legal Aid) at Local Court like in the case of Orders under the Mental Health Act. An Order should not be able to be made if the vulnerable person does not have legal representation.
- The current definition of 'workers' is too broad. Firstly, the Report did not conclude that any such legislation would provide protection to workers against BBVs. Further, there is no statistical or anecdotal evidence to support the inclusion of Correctional Officers, Juvenile Justice Officers, Fire Service Officers, SES Workers, non-emergency health service staff, and Sheriff Office staff in the definition of workers. While there was some evidence of violence against Ambulance Officers, Police and other Emergency Health responders, there was no evidence of the risk to these workers of BBV transmission as a result of this violence. It is submitted that the Regulations should not allow for an expansion of the definition of 'workers' in the future without further evidence of risk.

- Real and informed consent before testing should be a non-negotiable principle in the application of all health policy, and this proposed Bill in particular.
- The Bill should seek to reduce opportunities for the Worker to know the 3rd Party's health status – they only need to be advised on risk and treatment plan.
    - E.g. – if 3rd Party tests HIV positive, but maintains an undetectable viral load, then the Worker only needs to be informed that there is low/no transmission risk, not of the 3rd party's HIV status.
- The Bill should include dedicated allocation of funding for specialist health services available to Workers for counselling after an incident, general training (particularly for Police) on BBV presentation and transmission, risk and stigma, and community education campaigns regarding BBV transmission, risk and stigma.

The purpose of this law as stated is for addressing the fear and stress that emergency service workers face when they are conducting six months of BBV testing following an incident in the course of their work. Understandably, that fear is formidable. However Mandatory Testing for BBVs is not an appropriate vehicle to alleviate that fear or stress.

If a worker has an incident (e.g. spit onto clothing), and their doctor within 24 hours, advises them that the risk of transmission is incredibly low, and no treatment is advised, nothing changes in regards to the next steps that they would take (not taking treatment, follow up testing, etc.) from knowing a third party's test results, a week later. If it turned out the 3rd Party did have HIV that was transmissible, by then it is too late to start a course of Post exposure Prophylaxis (PeP), and most importantly, the ***risk of transmission remains the same***¸ An Order in these circumstances would not assist with a Worker's feeling of stress or anxiety.

If a worker has an incident at work (e.g. is bitten, drawing blood), and their doctor within 24 hours, advises them that the risk of transmission is high and that treatment is advised, nothing changes in regards to the next steps that they would take (start a course of PEP, follow-up testing, etc.) from knowing the third party's test results, a week later. If it turned out that the 3rd Party did have HIV that was transmissible, it would not matter because emergency PEP must be initiated within 72 hours of the incident, based on the transmission risk.

Comments on other specific sections of the Bill

Section 5(4) – In its current form, the Bill allows for the issuing of Regulations which could expand the definition of 'workers' to all workers. HALC's concern is that potential for infringement on civil liberties would be disproportionate to the harm that this Bill is trying to remedy. There is no evidence that all workers (as currently defined in the Bill) are at a high risk of BBVs.

Definition of 'workers'

The Personnel Report did not identify SES or Fire Brigade, Sheriffs or Correctional or Juvenile Justice Staff to be at particular risk of BBV transmission during work. Therefore, these types of workers should be excluded.

The Report found that mental health patients or people who were stressed, confused or disorientated in the course of seeking emergency medical care were more likely to be violent (1.35). However, none of the referenced reports concluded that mental health care workers

who were subject to high incidents of violence or injury and were at higher risk of BBV transmission at work. The Report largely focussed on emergency services and as such, the inclusion of mental health workers in the Bill is not based on evidence and on the contrary could subject already vulnerable mental health patients to an invasive and further traumatising experience.

It is submitted that the Bills should cover emergency health workers (paramedics, ambulance officers and those who work in hospital Emergency Departments, such as security) only. It is not appropriate to include health practitioners who were not identified as high risk, such staff at a business hours podiatry clinics or those with minimal patient contact, etc.

Additionally, in relation to the Police, the report did not conclude that there was any link between violence against police officers, including biting and spitting that lead to those police officers contracting a BBV. The Report also made no findings on whether a "deliberate" act of a third party, lead to a police officer contracting a BBV.

Given the above and the actual and perceived risk of Police using these provisions as a form of extra-judicial punishment, HALC vehemently opposes the exclusion of Police in this Bill.

We note that the Police Association of NSW's (PANSW) response to the HIV Sector's concerns regarding the potential disproportionate impact of a Mandatory Disease Testing Bill on key populations (that are already stigmatised or discriminated against), was that the Bill would be carefully drafted to ensure no groups were unfairly targeted (4.101). In our submission this indicates a serious lack of insight into the impact of BBV stigma and systematic discrimination, and the unequal impact that neutrally drafted laws have on minority and vulnerable populations.

If the Police are to be included in the definition of Workers in the proposed Bill, then several additional safeguards must be included to address the potential for rights violations.

First, *funding for an independent and BBV-specific GP* to be contacted within 24 hours, by a Police Officer who has come into contact with a 3rd Party's bodily fluid, for confidential advice and counselling.

Secondly, 'Senior Officers' should be allocated who are *completely independent* from the Police Force, such as the CHO or other independent Medical Officer, rather than an Inspector.

Thirdly, should the Police Officer still hold carriage of a criminal matter in relation to the 3rd Party, or the 3rd Party be detained by Police, the *matter should be reallocated* to a different Local Area Command.

Lastly, *extensive* further training is needed to both quell disproportionate fears and stressors that police officers have in regards to getting BBVs on the job, and as to professional conduct in dealing with the public – such as an ethical and professional responsibility to maintain confidentiality of 3rd Parties' HIV status, and the impact of stigma and discrimination.

Anecdotally, HALC is aware of instances where people with HIV have voluntarily disclosed their HIV status to the police as a gesture of good will following injury and the police, in clear breach of professional standards and community expectations, have then disclosed the person's HIV status to third parties as well as the media instead of keeping that information

confidential. In these instances, here was no risk of HIV transmission and the person with HIV was in fact that the victim in the incident.

Section 5(1) –whether or not an incident is eligible for request of an Order is contingent on if in the *opinion* of the Worker the action was 'deliberate'.

The term 'deliberate' echoes the *mens rea* (intention) element of a criminal offence, yet no scrutiny of whether or not the act was 'deliberate' is afforded in the current version of the Bill.

That a *mens rea* type element is included strongly infers that this Order can be sought as a kind of extra-judicial punishment for 3rd parties. HALC strongly opposes an extra judicial form of punishment, administered as a public health measure, that has limited oversight from the judiciary or even the Senior Officers in regards to the 'deliberateness' aspect of this incident/offence.

Section 6 – HALC strongly recommends that the "Senior Officer" must be a medical doctor and be independent from the institution of the Worker and be employed by an S100 provider.

To avoid the perception of bias or perception of influence (e.g. a junior police officer making a request, and their immediate senior making the decision), a direct or indirect supervisor of the Worker should not be making the decision.

The 3rd Party should not be in the care or custody of the person ultimately making the decision (such as persons in custody, detention, or detainment).

Section 7 – It is highly unlikely that a properly specialised Health Practitioner will determine that a mandatory test order be made where it is not required to protect the Worker. As such, to avoid 'rubber stamping', either only practitioners from s100 providers or, those that have training in prescribing PEP or other necessary treatments should be made responsible for making the decision.

Section 8 – HALC proposes that written advice from the doctor consulted in the 24 hours after the incident *must* be included in any application for an Order.

As the results of the Order are really only useful in the first few days after an incident, the Worker must request an Order within 2 days on the incident, not 5 days. (This also achieves a balance were the 3rd Party can be afforded more time to respond).

The Worker should not be compelled to consent to their Senior Officer (especially if that person is their manager or employer) accessing their medical history. They should be able to choose to disclose this information if helpful (e.g. any co-morbidities, or health complications).

Section 9 – After the Senior Officer informs the 3rd Party, they should then be given 10 business days to respond, before the Senior Officer makes a decision.

Even 10 days is a very short amount of time for a likely disadvantaged person to respond to a legal Order. It would be difficult for a person to receive specialist advice from Community Legal Centres, Legal Aid and even private solicitors in 5 days.

Subsection (4) must be omitted, as the person must be given an opportunity to understand the Order proposed, and to seek legal advice and respond appropriately. Further this section is inconsistent with Section 12(1) which stipulates that an Order must be refused anyway if the person cannot be located.

If a 3rd Party has come into contact with a relevant worker, it is highly likely that the 3rd Party have been involved in an emergency or traumatic situation. If they have sought medical care from a Hospital Emergency Department, called the Fire Brigade, a Paramedic or Police it is highly likely that they will need further time to be able to respond to a request for an Order (e.g. have been arrested, seriously injured or have been involved in another serious incident).

The Personnel Report indicated that an increase in violence towards emergency workers was associated with drug and alcohol use (particularly methamphetamines), confused, disoriented or mentally ill patients, and the broader stress factors in seeking emergency medical care (1.35). People who have problematic use of drugs and alcohol, or are mentally ill require further safeguards to ensure they receive, understand and are supported to respond appropriately to a notification about an Order.

Further safeguards are required for people in custody (especially when those in charge of their welfare are seeking or deciding on the Order).

This Section requires the Senior Officer to seek consent from the 3rd party before making an order. If the 3rd Party is in the care of a Hospital, is in custody or detention or detained by Police, it is not ethical or appropriate for a Senior Officer *of that institution* to seek 'real and informed consent' from that person.

Further, if Section 27 means that non-compliance with etiquette, ethics or professional standards is possible, it leaves a high risk of 3rd Parties not being provided an opportunity to provide real and informed consent.

In the Bill as it currently stands, in the same conversation as requesting consent for a test, the Senior Officer is also required to notify them that a request for an Order has been made, for which a breach could see them go to prison for 12 months or pay 100 p.u. for non-compliance. Obtaining real, informed consent, in line with the high standards and ethics of medical practitioners is not possible in such circumstances.

Section 10 – As the Bill currently stands, an application for an Order against a vulnerable person whose guardian is the Secretary of Communities and Justice and where the Worker is an employee of the Department of Communities and Justice (DCJ) must either be decided by the Secretary or their delegate. This creates and inherent conflict for the Secretary or their delegate and such HALC proposes the power to grant the Order should be delegated to the CHO instead.

Section 11 – (1)(a) As previously submitted, a Senior Officer should only be given a power to make an order to test a 3rd party, where there is a risk of contracting a condition and not merely for the purposes of releasing the stress of a Worker. Furtherm the Order should only allow for testing for the specific condition for which a risk of transmission exists.

As an example quoting the Australasian Society of HIV/Hepatitis Medicine (ASHM) Fact Sheet in the "Mandatory Disease Testing: Options Paper", Department of Justice, Sept 2018 – should blood make contact with a Worker's mouth, there is a moderate risk of Hepatitis B

transmission, and only a low risk of HIV and Hepatitis C transmission. In that case, it might be appropriate to order testing for Hepatitis B but not HIV or Hepatitis C.

All 3rd Parties (not just those between the ages of 16 – 18) must be advised to seek legal advice and receive medical counselling regarding the transmission risk.

Section 12 – (5)(a) must be omitted. There is minimal medical utility in granting an Order 3 months after an incident has occurred. By that time the risk would have been realised or not. This section can only serve as an extra-judicial punishment, with an individual having a potential Order sitting over them, months after the incident.

At most, the Senior Officer should be able to continue to deal with decision 7 days after it has been 'deemed' [s12(3)] refused. (This gives the Worker an extra 5 days to contact the Senior Officer if they missed the deadline to appeal to the CHO).

Section 13 – As an Order cannot be made if the 3rd Party cannot be located (s12), than personal service and notification of the Order on the 3rd Party must be condition precedent to a validly made Order. This notification must also occur within 2 days of the Order being granted.
The Worker should not be informed of the name, address or other details of the 3rd Party.

Section 14 – Instead of a prescribed place for a blood sample to be taken, any suitably equipped medical centre should be able to be used within the prescribed period of time.

This will alleviate some obstacles of attending to the 3rd Party (such as travel, cost, unfamiliarity, culturally sensitive services, if there's an AVO, parole conditions, in custody, remotely located etc.).

The 3rd party must be given 5 business days to attend the place for testing.

The Worker's nominated doctor must not receive the name, contact details etc. of the 3rd Party, just the results in association with the Order.

The Order must include information about how to appeal the Order, and the time in which to do this.

The Order must be *personally served* within 2 days, not 5 days. This will speed up the process, so that the Worker can receive the test results in a timelier manner.

If the 3rd Party is not fluent in English, is not literate, have been in a car accident, house fire or been recently arrested etc. it can be exceedingly difficult to receive, understand or act on a notification. Interpreter must be provided where necessary.

Additionally a maximum penalty of 12 months and/or a fine of 100 penalty units is disproportionate to the intrusion of a person's liberty by way of an intrusive medical procedure.

Section 19 – There is no utility in providing the 3rd Party's test results to the CHO, if the 3rd Party has opted to not nominate a doctor.

The Worker's nominated GP should not be notified of the 3rd Party's personal particulars, just the test results. The GP should be instructed to not unnecessarily inform the Worker of the 3rd Party's health status – they only need to be advised on risk and treatment plan.

For example, if the 3rd Party tests HIV positive, but maintains an undetectable viral load, then the Worker only needs to be informed that there is low/no transmission risk, not of the 3rd party's HIV status.

Section 20 – Considering the short time frame, request for an appeal should not have to be in a prescribed form or in writing.

A vulnerable person, independent of their responsible person, should be empowered to request an appeal of an Order.

Section 22 –Both the Worker and 3rd Party should be given 7 business days after they have been notified of a request for an appeal to provide submissions, before the CHO makes a decision.

Section 25 – This section must be omitted. The role of Senior Officer should not be delegated – especially to someone who works with the Worker. The Senior Officer must only be a Specialist Medical Officer.

Section 26 – Costs incurred seeking legal advice must also be covered.

Section 27 – Real and informed consent is a clear issue in this Bill. This Section alarmingly removes liability for non-compliance of professional etiquette, ethics and professional standards, including of health practitioners in the course of enacting an Order of this Bill.

While no personal liability for actions taken to enforce an Order etc., may be appropriate. It is not appropriate to excuse a worker, especially a health care worker from ordinary professional etiquette, ethics and professional standards.

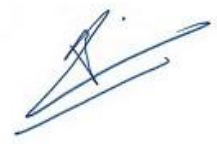
For instance, a health care worker should not breach professional standards in the way they execute a blood test, counsel a patient regarding their test results, etc. while acting on an Order.

Should this Bill be enacted as is, there must still be an expectation that health and other workers act, in enforcement of this Bill, in a way consistent with professional etiquette, ethics and professional standards.

Section 31 – The Bill must specify the kind of data that must be collected and reviewed. A review must be conducted after 12 months, and tabled before Parliament with 18 months.

We thank you for seeking our comments in relation the proposed changes. Please feel free to contact us if you have any questions.

Yours faithfully



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