

TRANSMISSION OF HIV AND THE CRIMINAL LAW: EXAMINING THE IMPACT OF PRE-EXPOSURE PROPHYLAXIS AND TREATMENT-AS- PREVENTION

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In its engagement with HIV, the criminal law has long attracted controversy, prompting protest, critique and calls for law reform. This article examines the impact of two major advances in the prevention of HIV transmission on criminal offences that apply to HIV transmission-related events: namely, treatment-as-prevention ('TasP') and pre-exposure prophylaxis ('PrEP'). The use of these two biomedical technologies and their associated practices has the potential to radically reduce, even eliminate, the incidence of HIV transmission. If these benefits are made widely available, these advances will — by reframing current understandings of causation, risk and the seriousness of harm at the foundation of HIV transmission-related criminal offences — potentially bring about shifts in the ways that HIV has been received by the criminal law. This article examines the likely impacts of these new practices and technologies. It argues that, where used, these new forms of HIV transmission prevention should radically reduce, and potentially eliminate, the incidence of HIV transmission-related criminal prosecutions for unintentional transmission. However, it also concludes that these effects will likely be uneven due to the misalignment between those populations who are taking up these new prevention

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options and those who have been historically prosecuted for HIV transmission-related criminal offences.

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I INTRODUCTION

The history of the ‘criminalisation of HIV’¹ extends to the identification of the virus.² Non-disclosure of HIV-positive status, engaging in behaviours that heighten the risk of transmission, and occasions of transmission itself have all been accepted as the basis of various criminal offences across at least 72 nations,³ including common law jurisdictions such as Australia, Canada, the United States, and England and Wales.⁴ Prosecution of those offences does not occur in large numbers; however, it does still occur regularly.⁵ Further, those living with HIV remain subject to additional obligations created by public health law. Non-compliance with these obligations brings criminal liability

¹ The narrative that emerges from the literature in relation to HIV-related criminal law is one marked by an establishment of a binary between criminal law and public health, of incompatibility between these two elements, and generally includes the call for the swift expulsion of the criminal law from the scene of HIV transmission: see Scott Burris et al, ‘Do Criminal Laws Influence HIV Risk Behavior? An Empirical Trial’ (2007) 39(2) *Arizona State Law Journal* 467, 516, who write in this regard:

The criminalization of HIV has been a strange, pointless exercise in the long fight to control HIV. It has done no good; if it has done even a little harm the price has been too high. Until the day comes when the stigma of HIV, unconventional sexuality and drug use are gone, the best course for criminal law is to follow the old Hippocratic maxim, ‘first, do no harm’.

² See, eg, the emergence of HIV disclosure laws in NSW, known in the health bureaucracy as ‘Sharleen’s Law’: Tom Morton, “Dirty Little Secret”: Journalism, Privacy and the Case of Sharleen Spiteri’ (2012) 18(1) *Pacific Journalism Review* 46. For more commentary on the case of Sharleen, see especially ‘Shutting Down Sharleen’, *Hindsight* (ABC Radio National, 21 March 2010) <<https://www.abc.net.au/radionational/programs/archived/hindsight/shutting-down-sharleen/3115028>>, archived at <<https://perma.cc/8HQD-RVF5>>; Tom Morton and Eurydice Aroney, ‘Journalism, Moral Panic and the Public Interest: The Case of Sharleen Spiteri’ (2016) 10(1) *Journalism Practice* 18.

³ As Bernard and Cameron’s global survey on behalf of the HIV Justice Network and the Global Network of People Living with HIV reports, this includes 105 separate criminal jurisdictions if separate criminal jurisdictions are counted, such as individual US states and Australian states and territories: Edwin J Bernard and Sally Cameron, *Advancing HIV Justice 2: Building Momentum in Global Advocacy against HIV Criminalisation* (Report, April 2016) 10–11.

⁴ *Ibid* 11.

⁵ See Sally Cameron, ‘Guide to Australian HIV Laws and Policies for Healthcare Professionals: Criminal Law’, ASHM (Web Page, 2019) <<https://hivlegal.ashm.org.au/criminal-law>>, archived at <<https://perma.cc/LZ4X-U8XM>>; ‘Global HIV Criminalisation Database: Cases’, *HIV Justice Network* <<https://www.hivjustice.net/site/cases/>> (‘Global HIV Criminalisation Database’).

and exposure to the criminal justice system through a referral and escalation process embedded in public health procedures.⁶

At least three decades of law reform has now firmly established a trend away from HIV-specific criminal offences and towards offences of general application that capture HIV transmission as a particular form of a more general class of harm. At the same time, public health efforts combined with advances in clinical treatment and prevention has, for those with access to these advances, seen the experience of living with HIV change radically. Onward transmission rates are now stable in places such as Australia,⁷ and, when properly managed, HIV is a chronic condition with greatly increased life expectancy.⁸

Recently, two new transmission prevention practices have entered this relatively well-settled criminal legal context, marking a new era of HIV prevention: ‘treatment-as-prevention’ (‘TasP’) and ‘pre-exposure prophylaxis’ (‘PrEP’). TasP relies on viral suppression by use of antiretroviral therapy (‘ART’) to the point where the virus is said to be ‘undetectable’.⁹ Medical consensus is that for those living with HIV, achieving and maintaining an ‘undetectable viral load’ (‘UVL’) means that risk of onward transmission of the

⁶ As to those additional obligations, see generally David J Carter, ‘HIV Transmission, Public Health Detention and the Recalcitrant Subject of Discipline: *Kuoth, Lam v R* and the Co-Constitution of Public Health and Criminal Law’ (2016) 25(2) *Griffith Law Review* 172.

⁷ See Kirby Institute, *HIV, Viral Hepatitis and Sexually Transmissible Infections in Australia: Annual Surveillance Report 2017* (Report, 2017) 5.

⁸ Although ‘there is considerable variability between subgroups of patients’: Antiretroviral Therapy Cohort Collaboration, ‘Life Expectancy of Individuals on Combination Antiretroviral Therapy in High-Income Countries: A Collaborative Analysis of 14 Cohort Studies’ (2008) 372(9635) *Lancet* 293, 293. But see Ingrid T Katz and Brendan Maughan-Brown, ‘Improved Life Expectancy of People Living with HIV: Who Is Left Behind?’ (2017) 4(8) *Lancet HIV* e324.

⁹ Testing availability and lower limits of detection vary throughout different parts of the world. Lower limits of detection tend to range from 20 to 400 viral copies/mL. In Australia, the limit is currently defined as less than 200 copies/mL, which meets the definition in ‘Risk of Sexual Transmission of HIV from a Person Living with HIV Who Has an Undetectable Viral Load: Messaging Primer & Consensus Statement’ (Statement, Prevention Access Campaign, 21 July 2016) <<https://www.preventionaccess.org/consensus>>, archived at <<https://perma.cc/T5TR-X7CR>> (‘U=U Consensus Statement’). Note that an ‘undetectable viral load’ (or ‘UVL’) is reduction of a person’s viral load to a point where it is so low that it cannot be detected by measurement. This is usually 40 copies/mL. However, ‘viral suppression’ (where ART suppresses the viral load to less than 200 copies/mL) is the point at which the virus cannot be transmitted, and so the U=U campaign and statement chooses to utilise the term ‘undetectable’ synonymously with ‘virally suppressed’.

virus is reduced so significantly that it is ‘negligible’¹⁰ and ‘effectively zero’.¹¹ PrEP, on the other hand, is a biomedical prevention practice focused on those who are at risk of HIV transmission. Those utilising PrEP take a preventative regimen of ART that has thus far proven to effectively protect against HIV transmission.¹² Where utilised, each approach reduces the risk of transmission to a level described by the Australian medical consensus statement on ‘Sexual Transmission of HIV and the Law’ (Australian Medical Consensus Statement)¹³ as a ‘negligible possibility’,¹⁴ and by the international ‘Expert Consensus Statement on the Science of HIV in the Context of Criminal Law’ (‘International Expert Consensus Statement’)¹⁵ on the science of HIV in the context of criminal law as ‘suggesting that it is likely that PrEP is more than 95% effective’.¹⁶ Together, these two technologies have introduced greatly more effective methods for preventing the transmission of HIV, thus bringing with them the potential to reshape criminal legal engagement with the virus and its transmission.

In this article, I show that the practices of TasP, PrEP and the general gains in quality of life and life expectancy for those living with HIV present the potential to radically reduce, even eliminate, the incidence of HIV transmis-

¹⁰ Ibid. This is the position of the Australian Medical Consensus Statement on the question: see Mark Boyd et al, ‘Sexual Transmission of HIV and the Law: An Australian Medical Consensus Statement’ (2016) 205(9) *Medical Journal of Australia* 409, 410. The most recent analysis (from 2013) is reported as having found ‘no transmission where viral load fell below a threshold of between 50 and 500 copies/mL’: Françoise Barré-Sinoussi et al, ‘Expert Consensus Statement on the Science of HIV in the Context of Criminal Law’ (2018) 21(7) *Journal of the International AIDS Society* e25161:1–12, 4, citing Mona R Loutfy et al, ‘Systematic Review of HIV Transmission between Heterosexual Serodiscordant Couples where the HIV-Positive Partner Is Fully Suppressed on Antiretroviral Therapy’ (2013) 8(2) *PLoS ONE* e55747:1–12. The International Expert Consensus Statement reproduces this work in its statement supporting the efficacy of TaSP: Barré-Sinoussi et al (n 10) 4.

¹¹ ‘U=U Consensus Statement’ (n 9). More recent public health messaging efforts have shifted from the more restrained language typical of medical consensus statements that, like the Australian Medical Consensus Statement’s language, use phrases like ‘a negligible possibility’ towards a ‘zero risk’ messaging. See, eg, Prevention Access Campaign, *How Do You Say U=U?* (Guide, 2019): ‘Use definitive and easy to understand phrases such as “can’t pass it on” “cannot transmit,” and “no risk.” You can even say “zero risk”’.

¹² Okwundu CI, Uthman OA and Okoromah CAN, ‘Antiretroviral Pre-Exposure Prophylaxis (PrEP) for Preventing HIV in High-Risk Individuals (Review)’ [2012] (7) *Cochrane Database of Systematic Reviews* CD007189:i–41.

¹³ Boyd et al (n 10).

¹⁴ Note the overlap and mirroring of language as between legal and medical statements: see ibid 409–10.

¹⁵ Barré-Sinoussi et al (n 10).

¹⁶ Ibid 4.

sion-related criminal prosecutions. I also demonstrate how engagement in PrEP and TasP should figure in assessment of the potential prosecution and in the conduct of criminal trials. Finally, I draw attention to some barriers to achieving this reduction in prosecutions, brought about by the misalignment between those populations taking up these new biomedical treatment and prevention practices, and those who have been historically prosecuted for HIV transmission-related criminal offences in Australia. This misalignment renders it unlikely that a radical downward shift in criminal prosecutions for HIV transmission-related offences will be achieved.

To make these arguments, I engage with recent advances in HIV treatment and control practices, including TasP and PrEP, dwelling particularly on the judicial consideration and role they have played in Australian and foreign legal processes. Drawing on that work, I then discuss the major ramifications of TasP and PrEP for criminal prosecution. To begin, however, I provide an overview of applicable criminal offences and recent prosecutorial experience in Australia and elsewhere of the key HIV transmission-related offences — namely assault, endangerment, and criminal offences that emanate from public health law.

II HIV TRANSMISSION-RELATED CRIMINAL OFFENCES: ASSAULTS, ENDANGERMENT AND HIV-SPECIFIC STATUTORY OFFENCES

Criminal legal responses to infectious disease and its transmission have varied across time and have significantly influenced the reception of, and engagement with, transmissible infection.¹⁷ In the common law world, significant moments of legal engagement include *R v Clarence* ('Clarence')¹⁸ and the 19th century Contagious Diseases Acts,¹⁹ both of which radically shaped the

¹⁷ For a particularly Australian view of public health and its legal and state practice aspects, see the wonderful and wide-ranging work of Bashford: Alison Bashford, *Imperial Hygiene: A Critical History of Colonialism, Nationalism and Public Health* (Palgrave Macmillan, 2004). See also the classic work by Porter: Dorothy Porter, *Health, Civilization and the State: A History of Public Health from Ancient to Modern Times* (Routledge, 1999). In relation to criminal law specifically, see James Chalmers, 'Disease Transmission, Liability and Criminal Law' in AM Viens, John Coggon and Anthony S Kessel (eds), *Criminal Law, Philosophy and Public Health Practice* (Cambridge University Press, 2013) 124.

¹⁸ *R v Clarence* (1888) 22 QBD 23 ('Clarence').

¹⁹ The Contagious Diseases Acts refer to: *Contagious Diseases Prevention Act 1864*, 27 & 28 Vict, c 85; *Contagious Diseases Act 1866*, 29 & 30 Vict, c 35; *Contagious Diseases Act 1869*, 32 & 33 Vict, c 96. See Margaret Hamilton, 'Opposition to the Contagious Diseases Acts, 1864–1886' (1978) 10(1) *Albion* 14, 14.

construction and response to infectious disease, including HIV, in law and medicine.²⁰

Australian HIV-related criminal provisions were influenced by the tradition of legal engagement with infectious disease stemming from *Clarence*; however, they were established by statute rather than through the evolution of the common law as was the case in England and Wales.²¹ Today, HIV-related criminal offences are present in Australian jurisdictions across three general classes of offence: assault offences, endangerment offences, and HIV-specific statutory offences that emanate from public health law.²² Prosecution of assault and endangerment offences is thought to have occurred in all eight of Australia's criminal jurisdictions,²³ leading to a total of over 30 prosecutions.²⁴ No data on the prosecution of criminal offences created by public health law is publicly accessible.

A Assault

Assaults form the core of contemporary HIV transmission-related criminal offences. These offences rely on HIV transmission having occurred, and on the event of transmission being regarded at law as a harm sufficient to be regarded as an assault. Two forms of assault apply to HIV transmission: the first category is HIV-specific assault charges; the second is assault offences of general application where HIV transmission is regarded as a relevant form of harm. I expand on each in the paragraphs that follow.

Early in the history of criminalisation, a series of criminal offences was constructed by legislatures to target HIV transmission directly. This was achieved by enacting criminal offences that explicitly identified HIV transmission — and only HIV transmission — as an *actus reus* element of an

²⁰ Hamilton (n 19).

²¹ As to the United Kingdom, see especially Matthew Weait, *Intimacy and Responsibility: The Criminalization of HIV Transmission* (Routledge-Cavendish, 2007) 90–8 ('*Intimacy and Responsibility*').

²² *Crimes Act 1900* (ACT) ss 19–20, 25 ('*ACT Crimes Act*'); *Crimes Act 1900* (NSW) ss 33, 35, 54 ('*NSW Crimes Act*'); *Criminal Code Act 1983* (NT) ss 174E, 177, 181, 186 ('*NT Criminal Code*'); *Criminal Code Act 1899* (Qld) ss 317(1)(b), 320, 328 ('*Qld Criminal Code*'); *Criminal Law Consolidation Act 1935* (SA) ss 23, 29(1)–(2) ('*SA Criminal Law Act*'); *Criminal Code Act 1924* (Tas) ss 170, 172; *Crimes Act 1958* (Vic) ss 16–17, 22–3 ('*Vic Crimes Act*'); *Criminal Code Act Compilation Act 1913* (WA) ss 294, 297 ('*WA Criminal Code*').

²³ Cameron (n 5).

²⁴ The most recent collation of data ending at 2013, with the proviso that the data is not of the highest quality: *ibid*.

offence. In New South Wales, for example, the offence of ‘causing a grievous bodily disease’²⁵ was enacted in 1990.²⁶ This offence brought with it a maximum penalty of 25 years’ imprisonment for a person who maliciously caused another person to contract a grievous bodily disease or who attempted to do so.²⁷ HIV transmission-specific offences existed in other jurisdictions, including Victoria. Like the offence in New South Wales, the Victorian HIV transmission-specific offence of ‘intentionally causing a very serious disease’ carried with it a maximum penalty of 25 years’ imprisonment and specifically targeted HIV transmission, this time by narrowly and explicitly defining HIV as the only ‘very serious disease’ to which this offence applied in the text of the statute itself.²⁸

From their enactment, opposition to these HIV-specific criminal offences was widespread. Central to this opposition were concerns that HIV-specific offences created and sustained stigma surrounding HIV, reduced the effectiveness of mutual responsibility for sexual health, created significant disincentives for those with HIV to be open with health practitioners and other service providers in relation to their sexual practices and, finally, that HIV itself did not represent a form of harm sufficient or suitable to justify an assault charge.²⁹

Over time, arguments for the abolition of HIV-specific criminal offences were broadly successful. Successive Australian jurisdictions pursued law reform that removed or modified HIV-specific criminal offences.³⁰ The Victorian offence of ‘intentionally causing a very serious disease’ was the last HIV-specific criminal offence in Australia, repealed mid-2015.³¹

²⁵ NSW Crimes Act (n 22) s 36, as repealed by *Crimes Amendment Act 2007* (NSW) sch 1 item 9.

²⁶ *Crimes (Injuries) Amendment Act 1990* (NSW) sch 2, inserting NSW Crimes Act (n 22) s 36.

²⁷ See above n 25.

²⁸ Vic Crimes Act (n 22) s 19A, as repealed by *Crimes Amendment (Repeal of Section 19A) Act 2015* (Vic).

²⁹ I engage in depth with this question of harm in Part IV(C) below. For an account of this thinking, see Peter D Rush, ‘HIV Transmission and the Jurisdiction of Criminal Law’ in Sally Cameron and John Rule (eds), *The Criminalisation of HIV Transmission in Australia: Legality, Morality and Reality* (National Association of People Living with HIV/AIDS, 2009) 74; Matthew Weait, ‘HIV and the Meaning of Harm’ in Catherine Stanton and Hannah Quirk (eds), *Criminalising Contagion: Legal and Ethical Challenges of Disease Transmission and the Criminal Law* (Cambridge University Press, 2016) 18.

³⁰ See generally Jennifer Power, *Movement, Knowledge, Emotion: Gay Activism and HIV/AIDS in Australia* (ANU E Press, 2011).

³¹ See above n 28 and accompanying text.

The reform of HIV-specific criminal offences was not the end of potential or actual criminal legal engagement with HIV transmission. Rather, the approach now taken by all jurisdictions is to utilise an assault offence of general application, by characterising HIV as a bodily disease, the transmission of which is said to constitute a sufficient basis for assault.³² This is said to reflect current 'best practice' in this area.³³ This leaves HIV transmission as the basis for a range of assault offences perpetrated on either an intentional, reckless, negligent or unlawful basis. There are different offences in each jurisdiction. Known by titles that include infliction of grievous bodily harm,³⁴ or causing serious injury,³⁵ these are now the forms of assault offence that apply to instances of HIV transmission. Each of these offences relies on HIV transmission having occurred, and for the defendant being found to have caused that transmission.

A number of high-profile prosecutions have been made for both HIV-specific offences and those of general application. These high-profile cases include those of *Kanengele-Yondjo v The Queen* ('Kanengele-Yondjo'),³⁶ where the accused in 2005 pleaded guilty to two counts of causing grievous bodily harm and was sentenced to six years' imprisonment; *Neal v The Queen* ('Neal'),³⁷ where the accused was sentenced to 12 years' imprisonment for multiple offences, including two counts of attempted intentional transmission of HIV;³⁸ *Aubrey v The Queen* ('Aubrey'),³⁹ where the accused was convicted of maliciously inflicting grievous bodily harm; and, finally, *Zaburoni v The Queen* ('Zaburoni'),⁴⁰ where the conviction of the accused for intentionally

³² See NSW Crimes Act (n 22) s 4 (definition of 'grievous bodily harm').

³³ See J Stan Lehman et al, 'Prevalence and Public Health Implications of State Laws That Criminalize Potential HIV Exposure in the United States' (2014) 18(6) *AIDS and Behavior* 997; Civil Rights Division, US Department of Justice, *Best Practices Guide to Reform HIV-Specific Criminal Laws to Align with Scientifically-Supported Factors* (Guide, 15 July 2014).

³⁴ See, eg, ACT Crimes Act (n 22) ss 19 (intentionally inflicting grievous bodily harm), 20 (recklessly inflicting grievous bodily harm), 25 (causing grievous bodily harm).

³⁵ As is the case in Victoria: Vic Crimes Act (n 22) ss 16 (causing serious injury intentionally), 17 (causing serious injury recklessly).

³⁶ [2006] NSWCCA 354 ('Kanengele-Yondjo').

³⁷ (2011) 32 VR 454 ('Neal').

³⁸ Neal was initially charged with two counts of intentional transmission and 14 counts of attempted intentional transmission: *ibid* 456–7 [1] (Nettle and Redlich JJA and Kyrou AJA). The Victorian Court of Appeal re-sentenced Neal at 484–5 [111].

³⁹ (2017) 260 CLR 305 ('Aubrey'). See also *R v Aubrey* (2012) 82 NSWLR 748 ('Aubrey (Appeal)'); *Aubrey v The Queen* [2015] NSWCCA 323.

⁴⁰ (2016) 256 CLR 482 ('Zaburoni'). See also *R v Zaburoni* (2014) 239 A Crim R 505 (Supreme Court of New South Wales) ('Zaburoni (Supreme Court)'); *Zaburoni v Minister for Immigra-*

transmitting a serious disease to his former partner was quashed and downgraded to unlawfully (recklessly) causing grievous bodily harm,⁴¹ an offence to which Mr Zaburoni had earlier pleaded guilty.⁴²

On appeal, *Neal*, *Aubrey* and *Zaburoni* have led to significant reshaping of the criminal law's application to HIV transmission. *Aubrey's* and *Zaburoni's* cases were both appealed to the High Court of Australia.⁴³ In relation to *Aubrey*, the Court was asked to consider the meaning of 'inflicts' or 'infliction' as required by the assault offence. In deciding that it included non-violent and non-immediate transmission of a disease, the Court overturned the longstanding authority of *Clarence*⁴⁴ on that question, which had held otherwise.⁴⁵ In *Zaburoni*, the High Court was asked to consider questions regarding 'intent' in the context of HIV transmission, an area that I deal with in Part V below.

B *Endangerment*

A second class of criminal offence applies to the potential, but not actual, transmission of HIV. These 'endangerment' offences criminalise dangerous activities that create a risk of harm where evidence of actual injury or harm is not required. General 'endangerment' offences — that is, offences that criminalise 'any act' that causes danger — exist in four Australian

tion and Border Protection (2017) 256 FCR 197; *Zaburoni v Minister for Immigration and Border Protection [No 2] [2017] FCAFC 209.*

⁴¹ As to the intentional transmission offence under Queensland law, see *Qld Criminal Code* (n 22) s 317(1)(b).

⁴² See also case notes on the appeal: Jordan Wei Peng Teng and Rebecca Mahony, 'Zaburoni v The Queen (2016) 256 CLR 482' (2016) 37(2) *Adelaide Law Review* 553; Thomas Faunce and Brendan Siles, 'High Court of Australia and HIV/AIDS Disease Criminalisation: Aubrey v The Queen and Zaburoni v The Queen' (2017) 25(1) *Journal of Law and Medicine* 52.

⁴³ *Aubrey* (n 39); *Zaburoni* (n 40).

⁴⁴ *Clarence* (n 18).

⁴⁵ *Aubrey* (n 39) 318 [16] (Kiefel CJ, Keane, Nettle and Edelman JJ, Bell J dissenting at 338 [73]).

jurisdictions,⁴⁶ while the remaining jurisdictions criminalise only specific dangerous acts.⁴⁷

The first HIV transmission endangerment case known to have proceeded through a committal hearing was that of a man charged with reckless endangerment for having unprotected sex with a woman without disclosing his HIV status in 1993.⁴⁸ The accused was ordered to stand trial but died from an HIV-related illness before the trial commenced. The first decision relating to HIV exposure risk was the Victorian case of *R v B*,⁴⁹ concluded in 1995. Research by Annette Houlihan reports that this case related to consensual sexual intercourse within the Victorian prison system.⁵⁰ The first decision on HIV transmission was made in 1998 in *Director of Public Prosecutions (Vic) v F*.⁵¹ The defendant had earlier had 80 counts of the Victorian HIV transmission-specific offence of 'intentionally causing a very serious disease'⁵² dropped,⁵³ but was subsequently found guilty of 10 counts of reckless endangerment.⁵⁴

When prosecuted, such endangerment offences are the cause of significant tension. The recent case of Mr Gallagher provides a straightforward example.⁵⁵ Mr Gallagher was alleged to have spat on a security guard in Brisbane and was reported to have been made subject to endangerment charges as a result. The security guard in question had allegedly refused to allow Mr Gallagher to leave a venue carrying a drink. Mr Gallagher's assault charge was reported to have been upgraded to assault occasioning bodily harm 'after the

⁴⁶ These are the Northern Territory, South Australia, Victoria and Western Australia: *NT Criminal Code* (n 22) ss 174C–174D; *SA Criminal Law Act* (n 22) s 29; *Vic Crimes Act* (n 22) ss 22–3; *WA Criminal Code* (n 22) s 304. See also Parliamentary Counsel's Committee, *Model Criminal Code* (28 May 2009) cl 5.1.28–5.1.29.

⁴⁷ That is, the Australian Capital Territory, New South Wales, Queensland and Tasmania: see CMV Clarkson, 'General Endangerment Offences: The Way Forward?' (2005) 32(2) *University of Western Australia Law Review* 131.

⁴⁸ See generally Chris Ward, 'HIV-Positive Man Charged with "Reckless Conduct" after Unprotected Sex' (1994) 5(2) *HIV/AIDS Legal Link* 4.

⁴⁹ *R v B* (Supreme Court of Victoria, Teague J, 3 July 1995), cited in Annette Houlihan, 'Risky (Legal) Business: HIV and Criminal Culpability in Victoria' (2011) 4(4) *International Journal of Liability and Scientific Enquiry* 305, 313.

⁵⁰ Houlihan (n 49) 313.

⁵¹ *Ibid* 315, citing *DPP (Vic) v F* (County Court of Victoria, McInerney J, 6 March 1998).

⁵² See above n 28 and accompanying text.

⁵³ Houlihan (n 49) 310.

⁵⁴ This was under *Vic Crimes Act* (n 22) s 22.

⁵⁵ 'Pub Spitter in HIV Threat', *Courier-Mail* (Brisbane, 5 August 2018) 13.

court heard the man had claimed he was HIV positive.⁵⁶ Mr Gallagher's lawyer denied that his client was HIV-positive and, most importantly, argued that HIV is unable to be transmitted through spitting.⁵⁷ Whilst spitting is a particularly egregious basis for an endangerment charge, particularly given the lack of actual risk to the person spat upon, longstanding critique of endangerment offences includes questions regarding the ability of courts and other criminal justice actors to properly understand and interpret measures of risk.

Despite these longstanding tensions, the opportunity for a superior court to consider and clarify aspects of endangerment offences has been limited. However, the appeal relating to Mr Neal's conviction in Victoria provided one such opportunity for the question of consent and endangerment to be more comprehensively dealt with by a superior court in Australia. In relation to endangerment in particular, the Victorian Supreme Court accepted in *Neal* that a person is able to provide informed consent to the risk of contracting HIV in the context of endangerment offences:

[I]nformed consent is capable of providing a defence to a charge of recklessly endangering a person with HIV through unprotected sexual intercourse ... if the accused puts consent in issue, the Crown must prove beyond reasonable doubt that the complainant did not give informed consent to the risk and that the accused did not honestly believe that the complainant had given informed consent to the risk.⁵⁸

This now-confirmed risk/consent structure of endangerment offences is a significant feature of HIV-related lawmaking and ethics in general,⁵⁹ and the

⁵⁶ Ibid.

⁵⁷ The Brisbane *Courier-Mail*, who reported the story, has been criticised for failing to mention that HIV cannot be transmitted by saliva: Laurence Barber, "Stigmatising": Courier Mail Slammed over Story on Spitting Man's HIV Claim', *Star Observer* (online, 6 August 2018) <<https://www.starobserver.com.au/news/national-news/queensland-news/stigmatising-courier-mail-slammed-social-media-story-spitting-man-hiv-claim/170939>>, archived at <<https://perma.cc/K9VX-5ULW>>.

⁵⁸ *Neal* (n 37) [72] (Nettle and Redlich JJA and Kyrou AJA) (citations omitted).

⁵⁹ Albeit not necessarily always a feature universally accepted by scholars and practitioners. See, eg, the playing out of this risk/consent structure in discussions surrounding the reform of the former STI disclosure regime found in New South Wales. The statutory review process surrounding this reform uses this very conception where, in its final report, it highlights how 'knowledge of the HIV or STI status of a potential sexual partner is needed to enable individuals to make an informed choice on whether to engage in sexual activity': NSW Ministry of Health, *Statutory Review of the NSW Public Health Act 2010* (Final Report, 17 November 2016) 36.

finding here in Neal's case supports the place of communication, mutual responsibility and consent as core features of safe(r) sex advocated in the field of communicable disease transmission prevention.

C Disclosure and Reasonable Precautions

A third and final class of criminal offence criminalises non-compliance, by people living with HIV, with public health laws concerning the duty to disclose sexually transmissible infections; that is, not taking reasonable precautions against transmission.

Many jurisdictions have at one time established a duty or requirement of those who know they are HIV-positive, or who have another sexually transmissible condition, to disclose that status to potential sexual partners. Disclosure requirements are an area of active reform by a range of stakeholders who wish to either remove the requirement entirely, or to modify the requirement by updating its construction of when disclosure is required. New South Wales has recently reformed its law that required disclosure of HIV status,⁶⁰ in line with these reform aims.⁶¹ A creature of the *Public Health Act 2010* (NSW), the former disclosure law was typical of those found in other jurisdictions. Earlier, it had established a duty for a person who knew that they had a sexually transmissible infection to disclose that infection in a manner that achieves voluntary acceptance of the risk of transmission on the part of the potential sexual partner.⁶² The reform of this section now reframes the duty of persons who have a sexually transmissible disease or condition, requiring them to 'take reasonable precautions against spreading the disease or condition'.⁶³ With this reframing, New South Wales joins the Australian

⁶⁰ *Public Health Amendment (Review) Act 2017* (NSW) sch 1 item 32, amending *Public Health Act 2010* (NSW) s 79 ('NSW Public Health Act').

⁶¹ A move that was welcomed by key stakeholders in the governance of HIV in that State: see, eg, 'Changes to the Public Health Act: Preventing the Spread of Sexually Transmissible Infections', NSW Government: Health (Web Page, 18 October 2017) <<https://www.health.nsw.gov.au/phact/Pages/pha-s79.aspx>>, archived at <<https://perma.cc/R7QX-X9WC>>. Cf 'ACON Statement on Public Health Act Amendments', ACON (Web Page) <https://www.aconhealth.org.au/acon_statement_on_nsw_public_health_act_amendment>, archived at <<https://perma.cc/27SP-E4AD>> (supporting the repeal but not the new offence).

⁶² *NSW Public Health Act* (n 60) s 79(1), as at 19 September 2017.

⁶³ *Ibid* s 79(1). Although the section's heading retains the language of 'sexually transmissible diseases or conditions', the revised offence itself applies to those who know that they have a notifiable disease, or a scheduled medical condition. This is a broader set of conditions, and will require some clarification as to whether the revised s 79 offence applies to sexually

Capital Territory in its similar requirement of reasonable precautions,⁶⁴ the South Australian requirement of reasonable steps or precautions,⁶⁵ Tasmania's requirement of 'all reasonable measures' (which includes a defence of disclosure and voluntary acceptance of risk),⁶⁶ and Queensland with its defence of disclosure and voluntary acceptance of risk as a defence to a charge of reckless endangerment or transmission found in the *Public Health Act 2005* (Qld).⁶⁷

Whilst differently labelled and coupled with a lower penalty regime than most endangerment offences, reasonable precautions offences undeniably share a family resemblance to endangerment: they mirror the basic contours of endangerment offences in so far as they criminalise the exposure of another to risk of danger/harm when that harm has failed to eventuate. Given the longstanding criticism of the application of endangerment offences to those living with HIV, it is interesting to note that there has been no significant criticism of the real potential for 'reasonable precautions' offences to act as an endangerment-type offence, nor of their constitution as a quasi-endangerment offence of strict or absolute liability. This is most surprising, given the controversy of applying low-threshold strict or absolute liability offences in settings of interpersonal violence,⁶⁸ or in socially complex and charged scenarios of sex, risk and harm that is the context of HIV transmission. Most especially, the introduction of a strict or absolute liability offence of failing to take reasonable precautions is a very large step of greater criminalisation than has been acknowledged in a jurisdiction like New South Wales, where no general endangerment offence is known to law and where no offence has ever criminalised HIV transmission risk as the basis of a specific endangerment offence.

Reform to disclosure requirements that embeds 'reasonable precautions' sees a long-held belief by public health and HIV community advocates realised in law. For many years, professional and scholarly literatures have argued that disclosure requirements transform the (better) duty of *mutual*

transmissible diseases or conditions that are also notifiable or scheduled, or to all such notifiable or scheduled diseases or conditions.

⁶⁴ *Public Health Regulation 2000* (ACT) s 21.

⁶⁵ *South Australian Public Health Act 2011* (SA) ss 14, 56.

⁶⁶ *Public Health Act 1997* (Tas) s 51. For the defence based on disclosure and acceptance of risk, see especially at s 51(2).

⁶⁷ *Public Health Act 2005* (Qld) s 143.

⁶⁸ This can be likened to so-called 'one-punch' laws: see, eg, Julia Quilter, 'The Thomas Kelly Case: Why a "One-Punch Law" Is Not the Answer', *The Conversation* (Web Page, 13 November 2013) <<https://theconversation.com/the-thomas-kelly-case-why-a-one-punch-law-is-not-the-answer-20106>>, archived at <<https://perma.cc/7Q7B-7ZRK>>.

responsibility for safer sex and care into one that unduly burdens only the person living with HIV.⁶⁹ So, too, have arguments been made as to the practical effect of such a regime being an unrealistic and risk-filled scenario where ‘no disclosure’ must therefore mean no risk of transmission.⁷⁰ Given that disclosure and voluntary acceptance of risk may be sufficient to meet the duty to take reasonable precautions, then perhaps, despite reforms, disclosure will remain a significant feature of negotiating sexual intercourse. Moreover, the criticism of earlier disclosure regimes as disproportionately placing the burden for achieving safe(r) sex upon the person living with HIV is not resolved by simply ‘swapping out’ a duty to disclose for one to take reasonable precautions. Rather, the burden here remains — largely at least — upon the person living with HIV to ‘take’ the reasonable precautions, or at least to ensure that their sexual partner has done so.⁷¹

The support for law reform oriented around the concept of ‘reasonable precautions’ does, however, emerge from a broader change now materialising in the nature of ‘responsibility’ when it comes to safe(r) sex. For our purposes in particular, advocates in Australia and elsewhere have greeted the advent of PrEP and TasP as altering what it means to be ‘responsible’ in relation to safe(r) sex, and the care of others in that context. They have argued that disclosure regimes should reflect this advance by understanding that ‘normative concepts of “safe(r) sex” need to be expanded to include sex that is “protected” by means of the positive person being virally suppressed [through

⁶⁹ Carol L Galletly and Steven D Pinkerton, ‘Conflicting Messages: How Criminal HIV Disclosure Laws Undermine Public Health Efforts to Control the Spread of HIV’ (2006) 10(5) *AIDS and Behavior* 451. More recently in relation to treatment-as-prevention in particular, see also Bridget Haire and John Kaldor, ‘HIV Transmission Law in the Age of Treatment-as-Prevention’ (2015) 41(12) *Journal of Medical Ethics* 982. But see the complex influence of medical advances on criminal liability in the (US) criminal law context: Rebeca Herrero Sáenz and Trevor Hoppe, ‘Disease on Trial: Medical Risk and Molecular Responsibility in HIV Exposure and Disclosure Jury Trials (1994–2015)’ (2020) 68(1) *Current Sociology* 97.

⁷⁰ In particular, in ‘situations of high HIV risk and vulnerability when men from different micro-cultures encounter each other’: Barry D Adam et al, ‘Silence, Assent and HIV Risk’ (2008) 10(8) *Culture, Health and Sexuality* 759, 759. See also Nicolas Sheon and G Michael Crosby, ‘Ambivalent Tales of HIV Disclosure in San Francisco’ (2004) 58(11) *Social Science and Medicine* 2105; and the accounts of risk, responsibility and ethics from Adam and, more recently, Sandset: Barry D Adam, ‘Constructing the Neoliberal Sexual Actor: Responsibility and Care of the Self in the Discourse of Barebackers’ (2005) 7(4) *Culture, Health and Sexuality* 333; Tony Sandset, ‘“HIV Both Starts and Stops with Me”: Configuring the Neoliberal Sexual Actor in HIV Prevention’ (2019) 23(2) *Sexuality and Culture* 657.

⁷¹ Which may well be the case with a seronegative partner who is taking PrEP: see Haire and Kaldor (n 69) 984–5.

TasP]⁷² and by use of PrEP. I present an overview of these two forms of ‘protection’ in the part that follows in order to then introduce how TasP and PrEP will likely figure in a future interaction with HIV transmission-related criminal law.

III NEW FORMS OF HIV TRANSMISSION PREVENTION AND TREATMENT AND THEIR LEGAL MECHANISM OF ACTION

This article focuses on PrEP and TasP as new biomedical HIV prevention and treatment practices. In this part, I also focus on their potential ‘legal mechanism of action’. What I mean by this phrase is not a description of how the pharmaceuticals at the heart of PrEP and TasP produce their pharmacological effects. Rather, what I mean is how their various features — from their pharmacological mechanisms of action to the social practices associated with their use — intersect with HIV transmission-related criminal offences and their elements; in other words, how these new technologies will interface with legal doctrine and the conduct of prosecutions. Despite their obvious connection, PrEP and TasP are quite different technologies, used in quite different contexts and by different populations. They therefore introduce different opportunities and challenges in their interaction with criminal legal processes related to HIV transmission.

A Pre-Exposure Prophylaxis ('PrEP')

PrEP is a biomedical preventative practice for individuals who have not contracted HIV but who are at high risk of exposure to the virus. Those utilising PrEP take a preventative regimen of ART, which has thus far proven to be an effective protection against HIV transmission.⁷³ PrEP acts by increasing antiretrovirals in the individual’s bloodstream.⁷⁴ Upon coming into contact with HIV, enhanced levels of antiretrovirals prevent HIV cells from

⁷² Ibid 982.

⁷³ Okwundu, Uthman and Okoromah (n 12); Monica Desai et al, ‘Recent Advances in Pre-Exposure Prophylaxis for HIV’ (2017) 359 *BMJ* j5011:1–16.

⁷⁴ I refer specifically to Gilead Sciences’ Truvada (300 mg tenofovir disoproxil fumarate / 200 mg emtricitabine): see Gilead Sciences, ‘Gilead Sciences to Provide Free Truvada for PrEP to Support US Initiative to End the HIV Epidemic’ (Press Release, 9 May 2019) <<https://www.gilead.com/news-and-press/press-room/press-releases/2019/5/gilead-sciences-to-provide-free-truvada-for-prep-to-support-us-initiative-to-end-the-hiv-epidemic>>, archived at <<https://perma.cc/8GAB-27YW>>.

replicating and establishing themselves.⁷⁵ In this way, PrEP is an alternative to condom usage, the efficacious — but not necessarily fully effective — ‘corner-stone’⁷⁶ of safe(r) sex practice, ethics and law.⁷⁷

PrEP is a relatively recent innovation, now growing rapidly in use. The landmark 2010 iPrEX study was the first to report the effectiveness of PrEP in limiting HIV transmission.⁷⁸ Other studies, like the large-scale English PROUD study⁷⁹ and Australian implementation studies,⁸⁰ have continued to demonstrate the efficacy of the approach, while stressing the need for consistent adherence for PrEP to be effective.⁸¹

Given the efficacy of PrEP, clinical guidelines recommend the drug for high-risk populations.⁸² Use of PrEP by the HIV-negative partner ‘substantially reduces the risk of HIV acquisition’,⁸³ such that there is a ‘negligible possibility of transmission’ in either anal–penile or vaginal–penile intercourse.⁸⁴ In line with clinical guidelines, an Australian medical consensus has

⁷⁵ Barré-Sinoussi et al (n 10) 4.

⁷⁶ Brisson, Ravitsky and Williams-Jones make this point in relation to condom usage and sexual/public health ethics rather than law. These are, however, intimately integrated fields: Julien Brisson, Vardit Ravitsky and Bryn Williams-Jones, ‘Towards an Integration of PrEP into a Safe Sex Ethics Framework for Men Who Have Sex with Men’ (2019) 12(1) *Public Health Ethics* 54, 59.

⁷⁷ Although, there is a developing account of opposition to PrEP described by Brisson, Ravitsky and Williams-Jones (as represented by Tim Dean and Hervé Latapie): see *ibid* 55. I do, however, respectfully differ with Brisson, Ravitsky and Williams-Jones as to their characterisation of Latapie’s arguments regarding PrEP as requiring critique simply because they ‘lack empirical basis’. Admittedly, our difference of opinion here might well be simply due to the use of the word ‘empirical’ in this context in a manner that seems to dismiss whole approaches to argumentation and modes of intellectual inquiry that do not conform to the ‘empirical’ model.

⁷⁸ Robert M Grant et al, ‘Preexposure Chemoprophylaxis for HIV Prevention in Men Who Have Sex with Men’ (2010) 363(27) *New England Journal of Medicine* 2587.

⁷⁹ Sheena McCormack et al, ‘Pre-Exposure Prophylaxis to Prevent the Acquisition of HIV-1 Infection (PROUD): Effectiveness Results from the Pilot Phase of a Pragmatic Open-Label Randomised Trial’ (2016) 387(10013) *Lancet* 53.

⁸⁰ See, eg, Iryna B Zablotska et al, ‘Expanded HIV Pre-Exposure Prophylaxis (PrEP) Implementation in Communities in New South Wales, Australia (EPIC-NSW): Design of an Open Label, Single Arm Implementation Trial’ (2018) 18 *BMC Public Health* 210:1–10.

⁸¹ See JM Molina et al, ‘On-Demand Preexposure Prophylaxis in Men at High Risk for HIV-1 Infection’ (2015) 373(23) *New England Journal of Medicine* 2237.

⁸² Edwina Wright et al, ‘Australasian Society for HIV, Viral Hepatitis and Sexual Health Medicine HIV Pre-Exposure Prophylaxis: Clinical Guidelines’ (2017) 3(3) *Journal of Virus Eradication* 168.

⁸³ Boyd et al (n 10) 410.

⁸⁴ *Ibid.*

emerged that PrEP use reduces risk of transmission to an acceptably low level and ‘represents taking reasonable precautions to prevent HIV transmission’.⁸⁵

After being approved by the United States Food and Drug Administration ('FDA') in 2012,⁸⁶ introduction into the Australian market was inhibited by cost: a year's supply could 'cost as much as \$10,000'.⁸⁷ To pave the way for government subsidy, a number of Australian studies tested the utility of PrEP in the local context, providing study participants with PrEP free of charge. By the end of 2017, approximately 16,000 gay and bisexual men at high risk of contracting HIV were taking PrEP through one of these multiple Australian studies.⁸⁸ On 1 April 2018, PrEP was added to the Pharmaceutical Benefits Scheme, creating a subsidised supply in Australia,⁸⁹ transforming trial-only public provision into mainstream availability. This pattern has been repeated in other legal jurisdictions. In the United Kingdom,⁹⁰ for example, PrEP is available in Scotland through the National Health Service,⁹¹ and England and Wales are running trials or short-term pilots of public provision of PrEP.⁹² In

⁸⁵ Ibid 412.

⁸⁶ David Holmes, 'FDA Paves the Way for Pre-Exposure HIV Prophylaxis' (2012) 380(9839) *Lancet* 325.

⁸⁷ 'PrEP, the Pill That Can Stop HIV Infection, on PBS from April 1', *healthdirect* (Blog Post, 22 March 2018) <<https://www.healthdirect.gov.au/blog/Anti-HIV-drug-PrEP-to-be-added-to-the-PBS>>, archived at <<https://perma.cc/VCA7-39FP>>.

⁸⁸ Kirby Institute, *HIV, Viral Hepatitis and Sexually Transmissible Infections in Australia: Annual Surveillance Report 2018* (Report, 2018) 4 ('Annual Surveillance Report 2018').

⁸⁹ Greg Hunt, Minister for Health, 'New Medicine to Help End the Transmission of HIV' (Media Release, 21 March 2018). See PrEPaccessNOW, 'PAN Welcomes Announcement of PrEP to Be Listed on the PBS' (Press Release, 9 February 2018).

⁹⁰ See generally 'PrEP (Pre-Exposure Prophylaxis)', *Terrence Higgins Trust* (Web Page, 3 August 2017) <<https://www.tht.org.uk/hiv-and-sexual-health/prep-pre-exposure-prophylaxis>>, archived at <<https://perma.cc/U9AJ-PC9Z>>.

⁹¹ 'How Do I Get PrEP through My National Health Service', *PrEP in Europe* (Web Page) <<https://www.prepineurope.org/en/get-prep/how-do-i-get-prep-through-your-national-health-service>>, archived at <<https://perma.cc/2SFC-G565>>; Roger Pebody, 'How to Get PrEP in the UK', *NAM Aidsmap* (Web Page, July 2019) <<https://www.aidsmap.com/about-hiv/how-get-prep-uk>>, archived at <<https://perma.cc/83EF-LY96>>.

⁹² In relation to England specifically, see 'PrEP Trial Updates', *NHS* (Web Page, February 2020) <<https://www.england.nhs.uk/commissioning/spec-services/npc-crg/blood-and-infection-group-f/f03/prep-trial-updates/>>, archived at <<https://perma.cc/MJM6-F4HM>>. Information on the PrEP Impact Trial itself can be found at 'Welcome to the PrEP Impact Trial Website', *PrEP Impact Trial* (Web Page, February 2020) <<https://www.prepimpacttrial.org.uk>>, archived at <<https://perma.cc/LN3H-EKFR>>. In relation to Welsh public provision, see 'PrEPARED in Wales: Pre-Exposure Prophylaxis Aiming for Reduced Infection and Early Diagnosis of HIV in Wales', *Frisky Wales* (Web Page) <<https://www.friskywales.org/wales-prep-project.html>>, archived at <<https://perma.cc/9AT8-65LT>>.

the United States, PrEP is approved for use by the FDA, with the United States Centers for Disease Control and Prevention also having developed clinical practice guidelines that support its use.⁹³ The FDA approval has been recently extended to include prescribing for adolescents.⁹⁴

Despite this expanded access and proof of utility for preventing HIV transmission, PrEP still represents only a partial solution to the question of sexually transmissible infection.⁹⁵ Importantly, the technique does not provide protection from the transmission of other infections like gonorrhoea, including forms of multi-drug-resistant gonorrhoea that are now a reality in Australia.⁹⁶ On the other hand, nor does condom use alone prevent the transmission of conditions like gonorrhoea. There have been often lively cultural and political responses to the introduction of PrEP in some contexts, including the rise of PrEP-related stigma.⁹⁷ Despite these challenges, PrEP has rapidly established itself as a key feature of the Australian ‘test-and-treat’ approach to STI management in relevant populations.

B *Treatment-as-Prevention* (‘TasP’)

Treatment-as-prevention is the use of antiretroviral treatment by a HIV-positive individual to prevent the transmission of the virus. Individuals who

⁹³ Centers for Disease Control and Prevention, Department of Health and Human Services (US), *Preexposure Prophylaxis for the Prevention of HIV Infection in the United States — 2017 Update: A Clinical Practice Guideline* (Guidelines, March 2018).

⁹⁴ Ibid 11, 18–19, 33, 47–9, 52. Technically, this change removes the earlier limitation on approval for prescription to only those over the age of 18, to one based on a minimum body weight of the patient (35 kg): see Letter from Debra B Birnkrant, United States Food and Drug Administration to Kim Lindstrom, Gilead Sciences Inc, 15 May 2018, 1.

⁹⁵ In relation to particular jurisdictions (eg Canada), it represents only a partial solution to the question of reasonable precautions against HIV transmission: see especially the discussion in Part IV(B)(2) below regarding *R v Cuerrier* [1998] 2 SCR 371 (‘Cuerrier’).

⁹⁶ See, eg, Monica M Lahra, Rodney Enriquez and CR Robert George, ‘Australian Gonococcal Surveillance Programme: Annual Report, 2017’ (2019) 43 *Communicable Diseases Intelligence* 13:1–12.

⁹⁷ Marked by the rise of the term ‘Truvada whore’, and some emerging reports of condom insistence (regardless of PrEP use), as being an increasingly complex position to maintain with the rise of PrEP acceptability and use: see Bridget G Haire, ‘Preexposure Prophylaxis-Related Stigma: Strategies to Improve Uptake and Adherence — A Narrative Review’ (2015) 7 *HIV/AIDS: Research and Palliative Care* 241, 243; Tim Dean, ‘Mediated Intimacies: Raw Sex, Truvada, and the Biopolitics of Chemoprophylaxis’ (2015) 18(1–2) *Sexualities* 224; Sarah K Calabrese and Kristen Underhill, ‘How Stigma Surrounding the Use of HIV Preexposure Prophylaxis Undermines Prevention and Pleasure: A Call to Destigmatize “Truvada Whores”’ (2015) 105(10) *American Journal of Public Health* 1960.

are HIV-positive and consistently use antiretrovirals lower the viral load in bodily fluids to a level that is not detectable in blood tests. When the virus is so weak that it cannot be detected, the risk of transmission to sexual partners is negligible. Clinical and observational trials strongly reinforce this. In HPTN 052, the leading clinical trial, '[n]o linked infections were observed when HIV-1 infection was stably suppressed by ART'.⁹⁸ Similarly, the observational PARTNER study confirmed that condomless sex between serodiscordant/serodifferent heterosexual and male/male couples, where the HIV-positive partner was using suppressive ART, reduced the rate of transmission to zero.⁹⁹ Reflecting these results, clinical guidelines now incorporate TasP as a guiding principle, as successful trials continue to reinforce its efficacy.¹⁰⁰

Given the considerable evidence supporting TasP, various medical consensus statements now hold that, provided a person living with HIV is able to maintain a UVL, the risk of transmission is negligible.¹⁰¹ Notable in this regard is the Prevention Access Campaign's 'Risk of Sexual Transmission of HIV from a Person Living with HIV Who Has an Undetectable Viral Load' consensus statement ('U=U Consensus Statement'),¹⁰² the International Expert Consensus Statement,¹⁰³ and the Australian Medical Consensus

⁹⁸ MS Cohen et al, 'Antiretroviral Therapy for the Prevention of HIV-1 Transmission' (2016) 375(9) *New England Journal of Medicine* 830, 830. Cases were observed where the partner was likely infected by someone other than the index participant: at 837.

⁹⁹ Alison J Rodger et al, 'Sexual Activity without Condoms and Risk of HIV Transmission in Serodifferent Couples when the HIV-Positive Partner Is Using Suppressive Antiretroviral Therapy' (2016) 316(2) *Journal of the American Medical Association* 171. For the final study report, see also Alison J Rodger et al, 'Risk of HIV Transmission through Condomless Sex in Serodifferent Gay Couples with the HIV-Positive Partner Taking Suppressive Antiretroviral Therapy (PARTNER): Final Results of a Multicentre, Prospective, Observational Study' (2019) 393(10189) *Lancet* 2428. Note well that the study design was influenced by the risks regarding criminal prosecution, with particular jurisdictions included or excluded in the study design based (in part) on their history and availability of criminal prosecution: Alison Rodger et al, 'Partners of People on ART: A New Evaluation of the Risks (The PARTNER Study)' (2012) 12 *BMC Public Health* 296:1–6, 4–5.

¹⁰⁰ Australasian Society for HIV, Viral Hepatitis and Sexual Health Medicine, *PrEP Guidelines: Prevent HIV by Prescribing PrEP* (Guidelines, 2019).

¹⁰¹ 'U=U Consensus Statement' (n 9); Barré-Sinoussi et al (n 10).

¹⁰² 'U=U Consensus Statement' (n 9).

¹⁰³ Barré-Sinoussi et al (n 10). This statement uses language that differs from the Australian statement. For example, it states that 'there is no possibility of HIV transmission when a person has an undetectable viral load' in the context of anal-penile intercourse: at 6. The Australian statement, however, states instead that '[w]hen a condom is used correctly, or the HIV-positive partner has a very low or undetectable viral load, or the HIV-negative partner is taking effective PrEP, there is a negligible possibility of transmission through anal-penile

Statement.¹⁰⁴ The Australian Medical Consensus Statement holds that '[w]ith continuing adherence to treatment ... [h]aving an undetectable viral load dramatically reduces the risk of transmitting HIV',¹⁰⁵ concluding that transmission in that context is 'a negligible possibility' through vaginal–penile and anal–penile intercourse, 'no possibility' through oral sex,¹⁰⁶ and 'represents taking reasonable precautions to prevent HIV transmission'.¹⁰⁷ The Australian Medical Consensus Statement also holds that where a combination of two or more prevention strategies — condom usage, TasP and PrEP — are simultaneously employed, the 'risk of transmission approaches zero' in relation to anal–penile or vaginal–penile intercourse.¹⁰⁸ It is interesting to note that the Australian Medical Consensus Statement explicitly uses language and terminology mapped to the elements and definitions of HIV transmission-related offences, notably 'reasonable precautions' of criminal offences emanating from Australian public health law, and the (negligible) 'possibility' language found in various tests of the requisite level of foresight required to prove assault offences based upon recklessness.¹⁰⁹

Although HIV testing, mutual responsibility practices and continued promotion of condom use remain core strategies for reducing risk, TasP and PrEP are now a part of clinical guidance and everyday clinical practice in Australia.¹¹⁰

'intercourse' and that '[w]here two or more of these prevention strategies are simultaneously employed, risk of transmission approaches zero': Boyd et al (n 10) 410 (emphasis omitted).

¹⁰⁴ Boyd et al (n 10) 410.

¹⁰⁵ Ibid.

¹⁰⁶ Ibid.

¹⁰⁷ Ibid 412.

¹⁰⁸ Ibid 410.

¹⁰⁹ See the discussion of this language and terminology question in the recent International Expert Consensus Statement, which highlights the difference between 'public health' or 'population-level' terminology and that used in the consensus statements: Barré-Sinoussi et al (n 10) 3. Perhaps of most interest in this international statement is the use of 'possibility' language as applied to a 'single sexual encounter', where the statement recognised 'that the possibility of HIV transmission during a single sexual encounter ranges from no possibility to low possibility'. This seems to mix population-level conceptualisations with those that are more applicable to the criminal legal setting. This is a potentially productive reframing of the question of risk; however, how it might be applied to criminal law is more problematic, given the law's interest in the question of transmission in that single encounter, rather than the possibility of transmission more generally.

¹¹⁰ 'Antiretroviral Guidelines: US DHHS Guidelines with Australian Commentary', ASHM (Web Page, 18 December 2019) <<https://arv.ashm.org.au>>, archived at <<https://perma.cc/G8JT-Z6VJ>>.

Given the growing use of PrEP and TasP, there is a need to assess the potential impacts of both new forms of HIV transmission reduction on criminal prosecutions for HIV transmission-related offences. I pursue this analysis in the next part.

IV REDUNDANCY OF HIV-RELATED CRIMINAL OFFENCES?

The effectiveness of PrEP and TasP are significant advances in the prevention of HIV transmission. So, too, are they starting to underwrite a reshaping of the event of transmission, of the nature of being HIV-positive and, perhaps, of HIV itself. The combined effect of these new biomedical prevention practices has the potential to reshape criminal legal engagement with the virus.

I engage with four distinct claims here in relation to the reshaping of criminal legal engagement with HIV: first, that the reduction in onward transmission brought about by PrEP and TasP will reduce the opportunity or ‘need’ for criminal prosecutions of HIV transmission-related offences; second, that the use of these forms of HIV transmission prevention should interact with the assessment of mens rea at the base of HIV transmission-related offences, such that both intention and recklessness should be far more difficult to prove where either party to sexual intercourse is, is said, or potentially is understood to be using PrEP/TasP; third, I claim that the advent of PrEP and TasP will support the already advancing reconfiguration of HIV as a bodily disease that no longer warrants the epithets ‘grievous’ or ‘really serious’.

The fourth claim that I make concerns the potential that these new biomedical innovations have for significantly reducing the prosecution of HIV transmission-related criminal offences. I argue that this potential is unlikely to be realised — at least, not with the advent of PrEP and TasP alone. Instead, the profile of those drawn into criminal prosecutions in Australia either as defendants or complainants means that they are unlikely, at present, to access either TasP or PrEP, respectively. For this reason, despite the multiple positive impacts that the advent of PrEP and TasP should bring about in relation to the criminalisation of HIV transmission, the impact of these will be unevenly distributed — along lines of gender, ethnicity and sexuality — and will not be the direct cause of any reduced opportunity to prosecute.

A Opportunities for Prosecution Will Be Reduced where PrEP and TasP Is Available and Used

My first claim is that that the opportunity will be reduced for prosecution of HIV transmission-related offences as PrEP and TasP achieve reductions in the

transmission of HIV. Admittedly, this is a simple and relatively uncomplicated claim. It rests on the observation that TasP and PrEP will together result in fewer transmission events upon which a prosecution may be based and, eventually, fewer people living with HIV against whom HIV transmission-related offences may be used.

As to reductions in transmission, the evidence is clear that, in contexts where they are utilised, PrEP and TasP are already having an impact on transmission rates. Transition from ‘trial-only’ to mainstream availability and access to PrEP in Australia, for example, have already achieved a 32% fall in the new diagnosis rate among men who have sex with men in New South Wales.¹¹¹ Similarly promising results have been shown in the United States and elsewhere where PrEP is achieving low or lowering of new infection rates among study groups.¹¹² So, too, has TasP achieved significant impacts on transmission. Thus far, large-scale trials and surveillance efforts have shown that when suppressed by effective treatment, the risk of onward transmission of the virus is negligible,¹¹³ with maintaining viral suppression by use of effect ART regimes providing a durable, protective effect.¹¹⁴

Evidence of the ability of PrEP and TasP to reduce HIV transmission in populations that utilise these methods is clear. We should expect that sustained utilisation of these methods will continue to reduce transmission among those who access them, and so, too, will the opportunity for criminal prosecutions reduce. Note well that this is not a claim that there will *necessarily* be fewer prosecutions.¹¹⁵ Rather, it is a claim that the opportunity for them — compared with our historical experience in Australia — will be reduced as fewer transmission events occur. Certainly, prosecution rests also upon numerous other practices alongside the application of formal and

¹¹¹ Andrew E Grulich et al, ‘Population-Level Effectiveness of Rapid, Targeted, High-Coverage Roll-Out of HIV Pre-Exposure Prophylaxis in Men Who Have Sex with Men: The EPIC-NSW Prospective Cohort Study’ (2018) 5(11) *Lancet HIV* e629.

¹¹² PS Sullivan et al, ‘The Impact of Pre-Exposure Prophylaxis with TDF/FTC on HIV Diagnoses, 2012–2016, United States’ (Conference Paper, International AIDS Conference, 23–27 July 2018).

¹¹³ Boyd et al (n 10); Robert W Eisinger, Carl W Dieffenbach and Anthony S Fauci, ‘HIV Viral Load and Transmissibility of HIV Infection: Undetectable Equals Untransmittable’ (2019) 321(5) *Journal of the American Medical Association* 451.

¹¹⁴ The PARTNER 2 study, in particular, demonstrated no transmission events flowing from the approximately 77,000 condomless sexual acts between serodiscordant partners whilst the person living with HIV had achieved viral suppression and their sexual partner was not using PrEP: see above n 99 and accompanying text.

¹¹⁵ See also my argument in Part IV(D) below in relation to the likely impact on prosecutions.

informal discretion, including healthcare record-keeping and referral to police, policing and investigation processes and, finally, prosecutorial decision-making and conduct. For this reason, fewer instances of transmission, and potentially fewer persons living with HIV, does not necessarily lead to fewer prosecutions. There is a chance that prosecution may well rise due to a shift in associated practices and discretion that would see the fewer persons living with HIV subject to an increased burden of prosecutorial activity (on a ‘per capita’ basis, as it were). However, this seems unlikely according to current trends and would involve a pronounced shift in otherwise well-established practice in this domain in Australia.

Although these population-level reductions in transmission and transmission-related events will likely continue where PrEP and TasP continue to be used, the distribution of such reductions is, however, not uniform at both a national and sub-national level. The global incidence of HIV remains high, and many nations are currently not able to achieve international targets for the reduction in new infections.¹¹⁶ This means that the reduction in criminal prosecutions for HIV transmission-related offences in settings where PrEP and TasP are not widely available will likely not be achieved until access challenges are overcome. Moreover, the movement of people between communities that have differing burdens of disease, difficulty accessing PrEP or TasP, or where safe(r) sex supportive policy and cultural practices are not fully developed, will present opportunities for transmission.¹¹⁷ This is not limited to cross-border, international movements of people. It includes movement between different communities or sub-populations within a shared geography. For example, with the conclusion of large-scale trials of PrEP that provided the drug free of charge to participants, how those living in Australia who do not have access to the PBS will access PrEP remains an open question.¹¹⁸ Will groups such as international students, those on various forms of

¹¹⁶ Robin Schaefer et al, ‘HIV Prevention Cascades: A Unifying Framework to Replicate the Successes of Treatment Cascades’ (2019) 6(1) *Lancet HIV* e60.

¹¹⁷ At present, data collected on the likely place of HIV acquisition is not sufficiently robust enough to draw solid conclusions, with between 17% and 28% of new diagnoses having reported the likely place of acquisition as ‘unknown’: *Annual Surveillance Report 2018* (n 88) 38–9. However, of those who did report a likely place of acquisition, only 70% of Australian-born men with new HIV diagnoses associated with male-to-male sex as their exposure risk reported Australia as their likely place of acquisition, whilst 48% of men born outside Australia reported Australia as the likely place of acquisition.

¹¹⁸ Daniel Reeders, ‘We Are Creating New Inequities around PrEP’, *Bad Blood* (Blog Post, 22 March 2018) <<https://badblood.blog/we-are-creating-new-inequities-around-prep/>>, archived at <<https://perma.cc/K4HJ-5YV2>>.

temporary visa and others who have differential access to the PBS — like prisoners — continue to access the drug, now that it will not be provided free of charge as part of trial participation? There might be other populations, too, who experience similar differences in access that may result in different exposures to criminal prosecutorial risk within a given jurisdiction, including, for example, women living with HIV, as has been the case in Canada.¹¹⁹ Given these challenges, the need to be engaged in both local and global efforts to enhance access to treatment and prevention is paramount, both as a matter of health justice and equity and as an investment in the reduction of criminal prosecutions.

B *The Legal Mechanics of PrEP and TasP*

Both PrEP and TasP have proven effective in widespread clinical application. However, given that their availability is not universal, and that transmission still occurs, there is a need to examine how PrEP and TasP will figure in the operation of transmission-related criminal offences. In this section, I present my second claim regarding the impact of PrEP and TasP: that is, that these forms of HIV transmission prevention should interact with the assessment of mens rea at the base of HIV transmission-related offences, such that both intention and recklessness should be far more difficult to prove where either party to sexual intercourse is, is said, or potentially is understood to be using PrEP/TasP. To do so, I provide a survey of the known interaction between HIV transmission-related criminal offences, PrEP and TasP before the courts, together with an analysis of those findings. This includes cases from a range of jurisdictions where criminal prosecution has encountered these technologies of HIV treatment and transmission prevention. Although there are few cases — particularly emanating from superior courts — that deal directly with PrEP or TasP, some early engagements are worthy of review.

¹¹⁹ See, eg, the work of Krüsi et al, who find that 'exempting people from criminal liability for HIV non-disclosure, conditional on maintaining an undetectable viral load for 6 months [as some Canadian prosecutorial guidelines recommend], continue[s] to put a large proportion of [women living with HIV] in Canada at risk for criminal prosecution', especially those who are the most marginalised: A Krüsi et al, 'Marginalized Women Living with HIV at Increased Risk of Viral Load Suppression Failure: Implications for Prosecutorial Guidelines regarding Criminalization of HIV Non-Disclosure in Canada and Globally' (Conference Paper, International AIDS Conference, 23–27 July 2018). See also Andrea Krüsi et al, 'Positive Sexuality: HIV Disclosure, Gender, Violence and the Law' (2018) 13(8) *PLoS ONE* e0202776:1–16.

1 Australian Consideration of PrEP and TasP

In Australia, the issue of a low or undetectable viral load was raised numerous times in the appeal of Neal's convictions in Victoria.¹²⁰ The matter was raised in that case by way of the applicant's statement to complainants ('PC', 'MB' and 'SB') that he maintained a UVL and could not transmit HIV on that basis.¹²¹ At various times, Mr Neal had, in fact, maintained a low viral load, and the Court was willing to accept arguments surrounding that fact as relevant to the question of mens rea,¹²² meaning, in that particular case, whether the defendant subjectively 'believed that he was capable of infecting others with HIV'.¹²³ The Court's consideration of mens rea pivoted upon the question regarding the knowledge or belief of Neal as to his 'infectiousness' (to use the criminal law's unfortunate language on the topic). The true novelty of this consideration went unremarked in the judgment, despite the radical novelty of such a question. Until this point, a person living with HIV would follow a trajectory where initially they would contract HIV and were then capable of transmitting the virus to another person. In that state, they are both 'infected' and 'infectious', to again use the unfortunate language of the Court. Until recently, this identity of 'infected' and 'infectious' was a given, even after beginning effective treatment, and even in the situation of appropriate condom use. However, this identity no longer holds. With the engagement in successful treatment that achieves a UVL, the same person now enters a period where they remain 'infected' but are no longer 'infectious'. Living with HIV had earlier meant, in the language of the criminal law, that a person was *necessarily* infectious.¹²⁴ Knowledge of HIV-positive status brought with it

¹²⁰ *Neal* (n 37). See generally above n 37 and accompanying text.

¹²¹ *Ibid* 460 [8], 461 [15], 462 [22] (Nettle and Redlich JJA and Kyrou AJA).

¹²² This related to the definition in the relevant statute of the mens rea required for attempt: see *Vic Crimes Act* (n 22) s 321N(2)(b), which requires that 'the person must ... intend or believe that any fact or circumstance the existence of which is an element of the offence will exist at the time the offence is to take place'.

¹²³ In particular, see the discussion of the second ground of appeal (Ground 2(a) specifically): *Neal* (n 37) 466 [40] (Nettle and Redlich JJA and Kyrou AJA). See especially at 466 [40], 467 [46].

¹²⁴ Although, a person who was living with HIV, whilst 'infectious' according to the logic applied here, would not be able to transmit HIV where safe(r) sex (eg condom) use was adhered to. This situation might be read as the person living with HIV, not on treatment, but who practises safe(r) sex as also being not infectious in any material or meaningful sense (when it matters). However, this scenario I take as distinguishable from what I am describing in this part. The condom scenario is, quite literally, a barrier precaution placed between a continuously 'infectious' individual (again, according to the deeply troubling language of the criminal law). The condom use itself does not, in my view, affect the same sort of 'ontological'

subjective knowledge of the risk of transmission in all but the most unusual of cases.¹²⁵ This is no longer the case. The risk of transmitting HIV is no longer dependent upon HIV-positive status, but is instead dependent upon the viral load maintained at the relevant time. The relationship, then, between HIV ‘infection’ and ‘infectiousness’ is now motile and mutable; once, it was not.

This new scenario of a changeable relationship between infection and infectiousness intersects with the criminal law as it comes into contact with a defendant’s knowledge or belief. In *Neal*, for example, a tripartite relationship between infection, infectiousness and knowledge of the same played out in an examination as to whether Mr Neal, who was aware of being HIV-positive, was also aware that he *may* be infectious or that he knew he *was* infectious at the relevant times. Again, this is a new subject position for someone living with HIV to inhabit, and an inquiry by the criminal law into this question would have made little sense in earlier years. Now, however, the difference between a defendant knowing or believing that they *are* infectious — or, alternatively, that they *may* be infectious — becomes a real and important distinction. The Court in *Neal* accepted the contention that, in instances relating to the offence of attempted infection, the correct test is that the defendant must have believed or known that he or she ‘*was* infectious’,¹²⁶ rather than that he or she ‘*may* be infectious’.¹²⁷

While the finding in *Neal* was made as an expression of correct doctrinal interpretation for that particular historical offence in Victoria,¹²⁸ it intersects with other transmission-related offences, including those in other jurisdictions. All offences that rely on subjective knowledge of the risk of transmission will turn on the level of knowledge that the defendant held at the relevant time: is it that the defendant knows that they are currently ‘infectious’ and not merely ‘infected’? A person maintaining a UVL (and thus engaged in TasP)

transformation that I believe the Court is bearing witness to with the advent of TaSP. Whilst I don’t dispute that the condom-using person living with HIV should also not be regarded by the Court as ‘infectious’, what I think is being gestured at here by the Court is a change in its own HIV imaginary — a diremption of ‘infected’ and ‘infectious’ that should perhaps have been in place from the very beginning in relation to condom usage, but, however, was not.

¹²⁵ Here, I am thinking of a situation where, for whatever reason, a person living with HIV might know of their own status and yet not come into subjective knowledge that this meant they were able to transmit HIV.

¹²⁶ It seems that the Court preferred the language be that the applicant ‘knew that he *was* infectious’: *Neal* (n 37) 467 [44] (Nettle and Redlich JJA and Kyrou AJA) (emphasis in original).

¹²⁷ Ibid (emphasis in original). See especially the discussion at 466–7 [40]–[47].

¹²⁸ The now-repealed *Vic Crimes Act* (n 22) s 19A offence: see above nn 28–34 and accompanying text.

would subjectively believe or know that they were not infectious unless information was presented to them that indicated the contrary was true at the time.¹²⁹ For a person in this position, such a state of mind would not be sufficient to establish the mens rea required for the prosecution of offences that relies on the defendant believing or knowing that they actually ‘were’ infectious: namely, intentional transmission offences or attempts.¹³⁰ Where engaged in TasP, an intentional transmission offence (or an attempt) will no longer be a viable charge.

HIV transmission-related offences based upon recklessness as to transmission will also follow a similar pattern to those based on intention. In these cases, the relevant standard will be whether the person living with HIV subjectively foresaw that their actions might ‘possibly’ cause transmission or that they ‘probably’ would.¹³¹ The New South Wales case of *Aubrey* was one such case.¹³² On appeal to the High Court, the Court affirmed the longstanding position in New South Wales that the accused’s foresight must be of the *possibility* of the risk materialising, rather than the higher standard of *probability* that applies to homicide offences in that jurisdiction.¹³³ In such circumstances, committing an HIV transmission-related offence based upon recklessness as to transmission requires that the defendant be subjectively aware of the ‘possibility’ of transmission occurring, and yet run the risk regardless.¹³⁴ The same is not the case in other Australian jurisdictions. In Victoria, for example, similar offences to the New South Wales offence of recklessly inflicting grievous bodily harm require proof of foresight of the *probability*, or likelihood, as opposed to the possibility, of grievous bodily harm.¹³⁵ Nor would the effect be the same in Queensland, where s 320 of the *Criminal Code Act 1899* (Qld) establishes an offence of unlawfully causing grievous bodily harm that does not require proof of the presence of subjective fault where ‘a person who knows that he or she has HIV, and who engages in

¹²⁹ For example, knowledge of an abnormal spike in viral load, or difficulties maintaining their own treatment regime due to an illness or other misadventure.

¹³⁰ This, of course, is a broad statement that should be read subject to the particular doctrine in each state or territory.

¹³¹ Dependent upon the jurisdiction and its particular test.

¹³² *Aubrey (Appeal)* (n 39). See also *Aubrey* (n 39). See generally above n 39 and accompanying text.

¹³³ *Aubrey* (n 39) 329–31 [47]–[50] (Kiefel CJ, Keane, Nettle and Edelman JJ, Bell J agreeing at 331 [53]).

¹³⁴ *R v Crabbe* (1985) 156 CLR 464 (‘Crabbe’); *R v Coleman* (1990) 19 NSWLR 467, 475 (Hunt J, Finlay J agreeing at 489, Allen J agreeing at 489).

¹³⁵ See *Vic Crimes Act* (n 22) s 17.

unprotected sexual intercourse without informing the other person of that fact ... [causes] that the other person contracts HIV from that sexual contact.¹³⁶ In such an instance, measurement of the level of foresight is redundant.¹³⁷

In all jurisdictions where a recklessness offence based upon subjective foresight might arise, a person living with HIV who believes — subjectively, or ‘actually’ — that they have achieved a UVL and thus pose *no risk* of transmission should work to support arguments that they did not possess the requisite mens rea for an offence based upon recklessness in circumstances where they are found to have transmitted the virus.¹³⁸ Subjectively knowing or believing that there is *no risk* of transmission should mean that the threshold for recklessness is not reached, regardless of whether the test of recklessness is that the defendant subjectively knows or believes that their actions present a possibility or probability of transmission.

Unfortunately, the language selected by the authors of the Australian Medical Consensus Statement does not assist in some jurisdictions in relation to a recklessness-based offence. The statement, although excellent on almost all points, uses the language of a ‘negligible possibility’¹³⁹ to describe the ‘highly unlikely, if not impossible’ risk of transmission with a HIV-positive partner who maintains a UVL in either vaginal–penile or anal–penile intercourse.¹⁴⁰ The use of ‘possibility’ here mirrors and thus enlivens the epithet used to describe the threshold of subjective foresight to establish recklessness in New South Wales: ‘possibility’ not ‘probability’.¹⁴¹ Given the similarity of the language, if the Australian Medical Consensus Statement is read through the lens of the criminal law of recklessness in that State, engaging in unprotected vaginal or anal sex whilst maintaining a UVL presents a (negligible) possibility of transmission and thus, if a defendant were aware of this possibility, it may be open to find them to have been reckless should transmission occur. The statement does, however, modify its use of ‘possibility’ with the operator ‘negligible’.¹⁴² Consideration of a ‘possibility’ of transmission will always take

¹³⁶ *Zaburoni* (n 40) 487 [2] (Kiefel, Bell and Keane JJ). Cf *Qld Criminal Code* (n 22) s 317.

¹³⁷ Rather, s 320 of the *Qld Criminal Code* (n 22) is ‘constituted simply by doing grievous bodily harm’: *R v Reid* [2007] 1 Qd R 64, 73 [14] (McPherson JA).

¹³⁸ That is, through some set of circumstances where they had either fallen out of maintaining a UVL, or been misinformed as to their status as having maintained a UVL.

¹³⁹ Boyd et al (n 10) 410.

¹⁴⁰ Ibid.

¹⁴¹ See above nn 131–34 and accompanying text. See especially *Crabbe* (n 134).

¹⁴² Boyd et al (n 10) 410.

place within an assessment of a defendant's own subjective state of mind and will not rely on the objective scientific consensus regarding modes or population measures of risk. For this reason, the statement's use of the term 'negligible' should be read in context, particularly alongside how other material regarding TasP presents the likelihood of transmission to those living with HIV. It is this material that will form a hypothetical defendant's state of mind, and in that context the operator 'negligible' should be read as lowering the meaning of 'possibility' to something below that which the criminal law understands as a threshold for a recklessness-based offence in New South Wales. The same challenges will not present themselves in other jurisdictions that base recklessness definitions on the subjective foresight of probability, or likelihood, of transmission. In fact, the description of transmission being 'highly unlikely, if not impossible'¹⁴³ intersects with offence definitions that set the threshold for recklessness as being subjective foresight that an event is probable or *likely*, as in Victoria.¹⁴⁴

2 International Consideration of PrEP and TasP

Recent consideration of low or undetectable viral loads has occurred in cases emanating from jurisdictions outside Australia. In 2009, a Swiss court chose to quash a conviction for an endangerment-related offence in part because the Court accepted that the risk of transmission was negligible.¹⁴⁵ However, other jurisdictions have not followed suit. The Canadian Supreme Court, for example, in *R v Mabior*¹⁴⁶ and *R v DC*¹⁴⁷ considered the requirement for individuals to disclose their HIV-positive status prior to sex. Building on the test from *R v Cuerrier*,¹⁴⁸ the Court found that a 'significant risk' of HIV transmission triggers the legal duty to disclose, and that a significant risk is present unless a person has low viral load *and* uses a condom. In so doing, the Court found that non-disclosure was a correct basis for criminal punishment

¹⁴³ Ibid.

¹⁴⁴ See *R v Campbell* [1997] 2 VR 585; *R v Nuri* [1990] VR 641; *Ignatova v The Queen* [2010] VSCA 263; *Paton v The Queen* [2011] VSCA 72.

¹⁴⁵ See Edwin J Bernard, 'Swiss Court Accepts that Criminal HIV Exposure Is Only "Hypothetical" on Successful Treatment, Quashes Conviction (Updated)', *NAMaidsmap* (Web Page, 25 February 2009) <<https://www.aidsmap.com/news/feb-2009/swiss-court-accepts-criminal-hiv-exposure-only-hypothetical-successful-treatment>>, archived at <<https://perma.cc/SSS7-87ME>>.

¹⁴⁶ [2012] 2 SCR 584 ('Mabior').

¹⁴⁷ [2012] 2 SCR 626 ('DC').

¹⁴⁸ *Cuerrier* (n 95) 430–6 [125]–[139] (Cory J).

in the context of a ‘realistic possibility of transmission’.¹⁴⁹ The Court confirmed that only condom use *combined* with ART reduces this risk enough to preclude liability,¹⁵⁰ and this remains the threshold that applies in relation to the duty to disclose in that jurisdiction.¹⁵¹ Canada is not alone in this approach. Following two years of review, the Norwegian Law Commission concluded that a UVL is not a valid defence to a person with HIV having unprotected sex whether or not transmission results, although it may be a consideration in sentencing.¹⁵²

Whilst engagement by courts remains an important part of the criminal legal engagement with HIV transmission, it is vital to underline that formal prosecutorial processes are a minor part of the jurisprudence of HIV transmission, at least in Australia. Rather, practices of formal and informal decision-making by clinical and public health authorities remain an absolutely central, if under-studied, source of the criminal law’s engagement in this and other, similar fields.¹⁵³ In Australia, for example, formal clinical guidelines that govern the ‘management’ of those living with HIV and AIDS operate in a stepwise manner, oriented towards eventual referral to police by clinicians

¹⁴⁹ *Mabior* (n 146) 590 [4], 616–24 [84]–[110] (McLachlin CJ for the Court); *DC* (n 147) 628–9 [1]–[2], 637 [29]–[31] (McLachlin CJ for the Court). In both cases, the Court held unanimously that a person living with HIV who engages in sexual intercourse, and who fails to disclose their HIV status prior to intercourse where there is a ‘realistic possibility’ of HIV transmission, can be convicted of aggravated sexual assault. This extends the reasoning in *Cuerrier* (n 95), where the Court established that non-disclosure can be grounds for a finding of fraud that negates consent to sexual intercourse. The facts of *DC* are particularly confronting: see Isabel Grant, Martha Shaffer and Alison Symington, ‘Introduction’ (2013) 63(3) *University of Toronto Law Journal* 462, 464–5.

¹⁵⁰ *Mabior* (n 146) 619 [94] (McLachlin CJ for the Court).

¹⁵¹ See Hartford’s analysis of the evidence used by the Court to justify this stance: Patrick Hartford, ‘Case Comment: A Critique of the Supreme Court of Canada’s Use of Statistical Reasoning in *R v Mabior*’ (2014) 13(2) *Law, Probability and Risk* 169. See also Alison Symington, ‘Injustice Amplified by HIV Non-Disclosure Ruling’ (2013) 63(3) *University of Toronto Law Journal* 485. For an engagement within a broader context of ‘criminalisation creep’, see Erin Dej and Jennifer M Kilty, ‘“Criminalization Creep”: A Brief Discussion of the Criminalization of HIV/AIDS Non-Disclosure in Canada’ (2012) 27(1) *Canadian Journal of Law and Society* 55.

¹⁵² Aslak Syse et al, *Om Kjærlighet og Kjøletårn: Strafferettlige Spørsmål ved Alvorlige Smittsomme Sykdommer* (Report No 17, 19 October 2012) 350–7.

¹⁵³ Linda Steele makes this point in relation to those living with disabilities in general, claiming that law participates in and provides for the heightened carceral control of those living with disability, simply because of their designation as disabled, ‘across multiple jurisdictions, legal orders, service systems, material spaces and modes of intervention’: Linda Roslyn Steele, ‘Troubling Law’s Indefinite Detention: Disability, the Carceral Body and Institutional Injustice’ [2018] *Social and Legal Studies* 1:24, 1.

should a patient fail to submit adequately to their control and be ‘unreformable’¹⁵⁴ in relation to their HIV-related behaviours. As such, whilst due focus should be placed upon the application of criminal law in the courtroom at both first instance and appeal, so too should the processes of public health be drawn into any critical or reform-minded activity that hopes to reduce criminal prosecution.

C *HIV Is No Longer a Grievous Bodily Disease*

My third claim is that HIV should no longer be regarded as a grievous bodily disease and thus does not warrant criminalisation, at least in its current form. Particular pressure should be placed upon the interpretation of HIV seroconversion as a harm sufficient to be regarded as a *grievous* or ‘really serious’ bodily harm due to the changed clinical progression and physical and social impacts of the virus in a contemporary Australian context.

Living with HIV and the impact of the virus on the physical and social body presents a radically different prospect today from what it did in earlier years, at least in Australia and other similar jurisdictions. HIV in Australia now has a well-known disease course. We know with great certainty that, given contemporary social, healthcare and clinical treatment contexts, life expectancy in high-income countries like Australia has increased markedly since the first criminalisation efforts in the 1980s and 1990s.¹⁵⁵ No longer is progression to AIDS-related illnesses the primary threat to health.¹⁵⁶ Those diagnosed and treated in contexts such as Australia during the past two decades have a normal life expectancy.¹⁵⁷ So improved are outcomes that recent discussions have argued that the complete elimination of death due to HIV-related causes is a ‘feasible goal’,¹⁵⁸ and that any such HIV-related death should now be treated as an event that triggers investigation into the failure of HIV care that led to the unnecessary outcome.¹⁵⁹

¹⁵⁴ This is a point underscored by some recent critical scholarship on the question: see, eg, the case of Lam Kuoth as described in Carter (n 6).

¹⁵⁵ ‘[A]lthough there is ‘considerable variability between subgroups of patients’: Antiretroviral Therapy Cohort Collaboration (n 8) 293. But see Katz and Maughan-Brown (n 8).

¹⁵⁶ Steven G Deeks, Sharon R Lewin and Diane V Havlir, ‘The End of AIDS: HIV Infection as a Chronic Disease’ (2013) 382(9903) *Lancet* 1525.

¹⁵⁷ Margaret T May et al, ‘Impact on Life Expectancy of HIV-1 Positive Individuals of CD4⁺ Cell Count and Viral Load Response to Antiretroviral Therapy’ (2014) 28(8) *AIDS* 1193.

¹⁵⁸ Jeb Jones, Patrick S Sullivan and James W Curran, ‘Progress in the HIV Epidemic: Identifying Goals and Measuring Success’ (2019) 16(1) *PLoS Medicine* e1002729:1–8, 1.

¹⁵⁹ Ibid.

Beyond life expectancy impacts, HIV has been reconceptualised in biomedical public health, and increasingly in popular discourses, as a lifelong chronic disease.¹⁶⁰ It shares practices of chronic disease self-management with other communicable and non-communicable chronic conditions like diabetes, arthritis or asthma¹⁶¹ and, like those conditions, HIV is well managed within the primary care/general practice setting. Certainly, life course is modified in particular ways following diagnosis. Many people experience profound changes to their lifestyle as a result of living with HIV/AIDS. However, this is another feature shared with other chronic conditions that we do not regard as a grievous bodily disease. Living with any condition necessitates adaptation in physical health, psychological functioning, and social relationships. Today, however, these changes and their associated challenges are as well-known and predictable in relation to HIV as they are with other chronic illnesses.¹⁶²

Where HIV differs most markedly from other chronic conditions is the level of stigma and other structural and socially generated impacts of diagnosis. Following diagnosis, those living with HIV experience detrimental changes in their employment, accommodation, finances and relationships.¹⁶³ Quality of life measures are negatively impacted by diagnosis in terms of social relationships, social and other supports, sex life, negative feelings and financial assets.¹⁶⁴ Given this state of affairs, much of the ‘harm’ associated with HIV is no longer located in the fact of transmission itself, nor its impact upon the body or bodily integrity of the person affected. As Matthew Weait, the leading scholar of HIV criminalisation, has concluded, the harm of HIV infection is not primarily bodily or corporeal.¹⁶⁵ It is, rather, a harm to the

¹⁶⁰ Thurka Sangaramoorthy, ‘Chronicity, Crisis, and the “End of AIDS”’ (2018) 13(8) *Global Public Health* 982. But see also Sangaramoorthy’s claims that the transition to an “end of AIDS” discourse, obscure[s] the on-going HIV crisis in particular global communities, especially among marginalised and ageing populations who live in under-resourced areas: at 982.

¹⁶¹ See, eg, Swendeman, Ingram and Rotheram-Borus, who note that ‘self-management of HIV has more in common with all chronic diseases than differences’: Dallas Swendeman, Barbara L Ingram and Mary Jane Rotheram-Borus, ‘Common Elements in Self-Management of HIV and Other Chronic Illnesses: An Integrative Framework’ (2009) 21(10) *AIDS Care* 1321, 1321.

¹⁶² Ibid.

¹⁶³ See SM Skevington, ‘Is Quality of Life Poorer for Older Adults with HIV/AIDS? International Evidence Using the WHOQOL-HIV’ (2012) 24(10) *AIDS Care* 1219.

¹⁶⁴ Ibid.

¹⁶⁵ Weait, *Intimacy and Responsibility* (n 21) 110–12.

social body, an opening of the newly diagnosed person to the structural and socially generated harms that follow diagnosis.¹⁶⁶

The harm to the social body sits awkwardly within the law of assault. Criminal law is interested in the ‘fact of infection’,¹⁶⁷ isolating it as the ‘wrongful conduct, [with] the moment of infection … as its centre of attention’.¹⁶⁸ The harm, interference or risk thereof that criminal law punishes is that inflicted upon the physical body of the person in violation of their corporeal autonomy,¹⁶⁹ turning its mind to non-physical impacts in expressions of curial recognition of the impact on the victim of the assault,¹⁷⁰ or in giving sentence. This focus upon the physical body/harm that marks the law of assault has been criticised as de-contextualising both lives lived with HIV and transmission events. As Weait writes, ‘where transmission occurs in the context of sex, we should reflect on other ways of thinking about what the harm might be … the traditional analysis … fails to capture the various and complex meanings of HIV infection’.¹⁷¹

One approach to this currently unsatisfactory focus upon the physical impact of transmission would be to revise our understanding of the harm of HIV to include the non-physical harms to the social body. This would risk, however, widening the net of current assault provisions, inviting assessment of the harm of transmission to include the social and structurally generated harms associated with a new HIV-positive status. This expanded notion of harm would potentially reinforce, rather than reduce, the applicability of the

¹⁶⁶ Weait, ‘HIV and the Meaning of Harm’ (n 29).

¹⁶⁷ Weait, *Intimacy and Responsibility* (n 21) 111.

¹⁶⁸ Ibid.

¹⁶⁹ A point that Poberezny-Lynch makes well in his recent article, drawing our attention to the centrality of the ‘injury itself’ and its ‘direct physical effects’ for (NSW) law and its consideration of the ‘grievousness’ of the injury: Thomas Poberezny-Lynch, ‘Criminalising Infection: Questioning the Assumption that Transmitting HIV Constitutes Grievous Bodily Harm’ (2019) 44(2) *Alternative Law Journal* 138, 141, quoting *Swan v The Queen* [2016] NSWCCA 79, [71] (Garling J).

¹⁷⁰ For example, in comments regarding the impacts of the assault:

There has always been an enormous amount of stigma associated with having HIV infection and the majority of those infected lead socially isolated lives with ongoing fear of rejection or worse by their partner, families and by their community. Many of those factors are now being experienced by both victims … Further the risk of the spread of HIV has enormous and dire implications for the health and welfare of the general community and I consider this to be a seriously aggravating factor in these cases.

Kanengele-Yondjo (n 36) [16] (Hislop J, McClellan CJ at CL agreeing at [1], Sully J agreeing at [2]).

¹⁷¹ Weait, *Intimacy and Relationships* (n 21) 110–11.

criminal law to HIV transmission, finding new forms of harm to legitimate its interest in the event of transmission and upon which to justify imposition of punishment.

The difficulties associated with an engagement between the criminal law and the real harms of HIV transmission do not foreclose reform of relationship along the lines advocated by those dissatisfied by the criminal law. Instead, as Poberezny-Lynch advocates, it is indeed time for assumptions regarding HIV and harm to be revisited.¹⁷² In this vein, might a reform strategy that *accepts* the otherwise unsatisfactory privileging of the physical body by criminal law be more productive for reform? Mobilising the significantly less serious physical impacts of HIV seroconversion may well support a revision of HIV transmission as no longer representing a harm worthy of the epithet ‘grievous’. This approach would require accepting the doctrine as it stands, using its inability to take account of the ‘enduring differences which infection produces’¹⁷³ upon the social body to argue that HIV seroconversion no longer exceeds the threshold of a ‘grievous’ bodily disease — at least as experienced in Australia and in similar jurisdictions, where it is now a chronic illness that requires self-management but creates no material impact on life expectancy.¹⁷⁴ Naturally, this strategic approach leaves intact the criminal law’s exclusion of many of the detrimental impacts generated by social and structural means for those living with HIV. However, such harms, as real as they are, extend beyond the purview of the law of assault, at least as currently configured. However, unsettling or potentially overturning the interpretation of HIV transmission as a *grievous* harm to the body will still bring with it some significant good for those living with HIV, whilst reflecting more accurately the true nature of the (physical) ‘harms’ of seroconversion. In the end, any such reclassification of the harm of HIV to the physical body may well contribute to a concomitant reduction in the harms of HIV to the social body by means of criminal law’s expressive power.¹⁷⁵

¹⁷² Poberezny-Lynch (n 169).

¹⁷³ I am slightly reversing Weait’s argument, taking it as given that the criminal law is in fact interested only in the moment of transmission, a feature that Weait rightly criticises: see Matthew Weait, ‘Criminal Law and the Sexual Transmission of HIV: *R v Dica*’ (2005) 68(1) *Modern Law Review* 121.

¹⁷⁴ This is not the view necessarily espoused by the public health community. However, here I am reflecting on the disease and its impacts as within the context of law and its construction and use of ‘harm’ more broadly.

¹⁷⁵ Richard H McAdams, *The Expressive Powers of Law: Theories and Limits* (Harvard University Press, 2015) 175–7.

D *The Hope that PrEP and TasP Will Eliminate Criminal Prosecutions Is, at Present, Unlikely to Be Realised*

The first three claims I have made hold out hope for a positive impact of PrEP and TasP upon criminal legal engagement with HIV. The fourth and final claim, however, strikes a more sombre tone. This claim is that the potential for these biomedical innovations in HIV transmission control to significantly reduce the prosecution of HIV transmission-related criminal offences is unlikely to be realised — at least not directly due to PrEP and TasP themselves. Instead, prosecutions are likely to remain a feature of the legal engagement with HIV in Australia unless change occurs in prosecutorial practice itself. This is due to a misalignment between those populations who are taking up these new biomedical treatment and prevention practices, and those who have been historically involved in prosecutions for HIV transmission-related criminal offences in Australia. If this misalignment continues, it will render unlikely any significant reduction in criminal prosecutions for HIV transmission-related offences.

This claim regarding the impact on prosecutions is based on two features of the field of HIV transmission prevention and transmission-related criminal prosecutions. First, the burden of criminal prosecution for HIV related-transmission offences does not match the profile of HIV transmissions more generally in the Australian community. Instead, convictions are weighted disproportionately towards male-to-female transmission events and towards recent migrant defendants than one might expect, given the general profile of those living with HIV in Australia. Secondly, given this particular prosecutorial profile, current targeting and take-up of PrEP and TasP will not significantly impact those who have recently stood as complainants or defendants in transmission-related prosecutions. Complainants in transmission-related offences have predominantly been members of communities who are not primary targets for PrEP (eg women or those who understand themselves to be in monogamous sexual relationships) and who are unlikely to be using PrEP at the time of their seroconversion, while defendants have historically not been sufficiently engaged in healthcare treatment to have maintained a UVL and thus are not targets for engaging in TasP. I deal with each of these features in an analysis of the recent history of criminal prosecution of HIV transmission-related offences in Australia.

1 Recent Prosecutorial History of HIV Transmission-Related Offences in Australia: A Profile at Odds with the Occurrence of HIV in the General Community

The recent history of criminal prosecution in Australia has seen 19 defendants who we know publicly to have faced and been subject to HIV transmission-related criminal proceedings.¹⁷⁶ Within this cohort, three cases are related to either biting or spitting, which is perhaps the most spurious and medically unjustified form of transmission-related proceeding. HIV cannot be transmitted by spitting, while transmission by biting could occur only under the most specific and unlikely of circumstances. In any event, it would be merely by happenstance that a police officer or other person subject to the spitting or biting would be on a course of PrEP, and thus the introduction of PrEP would not intersect with these prosecutions. Moreover, the mere fact that such medically/factually unjustified charges are laid at all indicates that the likelihood of them being laid in the future would unfortunately not be influenced by the maintenance of a UVL by the defendant. If authorities are willing to lay charges that are unjustified according to current scientific knowledge, the fact that a defendant carried a negligible risk of transmitting the virus due to their maintenance of a UVL would seem unlikely to influence a similar decision in the future. In short, neither PrEP nor TasP would have an impact on these prosecutorial decisions.

Excluding the three cases of biting or spitting, of the remaining 16 prosecutions, approximately 45% (n = 7) of defendants are subject to prosecution for male-to-female transmission events. This profile is at odds with the general community of those living with HIV in Australia, which is 'predominantly Anglo-Celtic, male, and gay'.¹⁷⁷ In Australia, of the approximately 28,000 people living with HIV, it is difficult to know with any certainty how many identify as heterosexual men.¹⁷⁸ However, we do know that 8–12% of all people living with HIV in Australia are reported to be women,¹⁷⁹ the majority

¹⁷⁶ See below Part VII (Appendix).

¹⁷⁷ Gosia Mikołajczak, Jennifer Power and Graham Brown, 'Profiles of PLHIV in Australia: Understanding the Complexity of Needs and Capacity to Access Health and Support' (Research Paper, Australian Research Centre in Sex, Health and Society, La Trobe University, 2018) 1.

¹⁷⁸ Power et al state that, 'relative to the overall number of PLHIV in Australia, the number of heterosexual men living with HIV is very small': J Power et al, 'HIV Futures 8: Service Use, Social Support and Connection among People Living with HIV' (Report, Australian Research Centre in Sex, Health and Society, La Trobe University, 2017) 6.

¹⁷⁹ See ibid 2; *Annual Surveillance Report 2018* (n 88) 15 [tbl 1.1.2], 16 [fig 1.1.1].

of whom identify that they contracted HIV through heterosexual sex.¹⁸⁰ On an annual basis, heterosexual sex accounted for approximately 25% of all transmission events during 2017;¹⁸¹ however, this figure creates a false impression as to the reality of heterosexual transmission events, as the high proportion of transmission events is partially attributed to the reduction in the *proportion* of HIV transmission events in men who have sex with men during the same period.¹⁸² In fact, the underlying trend is that the *number* of women coming to be HIV-positive has remained essentially static over the past 10 years,¹⁸³ as has the *number* of new diagnosis notifications linked to heterosexual sex.¹⁸⁴ Given this, women complainants/victims are vastly over-represented in HIV transmission-related prosecutions launched during the past decade. Instead, what would be expected of even a rough equivalence of transmission events to prosecutions would see male complainants outnumbering by at least sevenfold cases with a female complainant.¹⁸⁵ Instead, we see merely a 2.3-fold difference. Given this, the burden of criminal prosecution for HIV-related transmission fails to represent — even in broad terms — the gender and sexuality profile of HIV transmissions more generally in the Australian community.

Disparities related to gender and sexuality are not the only ground upon which prosecutorial activity is unbalanced. So, too, is there an over-representation of defendants from particular ethnic groups, with a significant over-representation of men with an African background in criminal prosecutions. More than half of all prosecutions involving heterosexual sex between 2001 and 2012 were defendants with an African background,¹⁸⁶ a feature out of all proportion to the more generalised experience of transmission.

¹⁸⁰ See, eg, in 2017, when 108 women reported a seroconversion, with 93 of those women reporting their newly diagnosed HIV status as attributed to heterosexual sex: *Annual Surveillance Report 2018* (n 88) 15 [tbl 1.1.2], 26 [fig 1.1.13].

¹⁸¹ In 2018, the Kirby Institute noted ‘a 7% decrease in the number of HIV notifications in Australia in the last five years due to a decrease in notifications among men reporting male-to-male sex’: *ibid* 5.

¹⁸² See *ibid*.

¹⁸³ *Ibid* 18 [fig 1.1.3].

¹⁸⁴ *Ibid* 23 [fig 1.1.9].

¹⁸⁵ *Ibid* 18 [fig 1.1.3]. Naturally, I am not arguing that prosecutions should be representative of transmission events more generally. Rather, I am here describing this difference by way of highlighting how the prosecutorial profile is so vastly different from the transmission profile more generally.

¹⁸⁶ Australian Federation of AIDS Organisations, ‘HIV and Sub-Saharan African Communities in Australia’ (Briefing Paper No 2, January 2014) 3.

Prosecutions for HIV transmission-related offences are unevenly distributed in Australia along lines of gender, ethnicity and sexuality when compared to the general profile of HIV transmission in the Australian community. This feature is the first basis upon which I make a broader claim about the likely impact/non-impact of PrEP and TasP. The second such claim is that this particular prosecutorial profile, skewed as it is, is misaligned with the current targeting and take-up of PrEP and TasP. In the 'gap' between prosecution on the one hand, and PrEP and TasP take-up on the other, lies the potential for future criminal prosecutions to be largely unaffected by the advent of these otherwise revolutionary technologies in HIV transmission prevention.

2 A Misalignment between the Prosecutorial Profile and the Current Targeting and Take-Up of PrEP and TasP

The prosecutorial profile outlined above demonstrates that the recent history of criminal prosecution for HIV transmission-related offences is unevenly distributed along lines of gender, ethnicity and sexuality when compared to the general profile of HIV transmission in the Australian community. What is important about this is not so much that there is a misalignment between the general community impact of HIV and prosecutions, but more that the particular contours of this misalignment will nullify much of the potential impact of PrEP and TasP to reduce criminal prosecutions. This is because those taking up these new biomedical treatment and prevention practices are not the same groups as those who have been historically prosecuted for, or complainants in, HIV transmission-related criminal offences in Australia. Instead, the distribution of PrEP and TasP on the one hand, and criminal prosecutions on the other, is concentrated in gender, ethnicity and sexuality profiles that largely do not overlap. The prosecutorial profile for HIV transmission crimes are focused overwhelmingly on a mix of defendants and complainants who do not fall within the groups currently targeted for PrEP or TasP.¹⁸⁷

In relation to male-to-female transmission events, PrEP is primarily prescribed to men who have sex with men in Australia. PrEP is recommended for heterosexual men and women who may be at high risk of acquiring HIV — for example, those whose partner is HIV-positive and not on treatment or who has a detectable viral load. However, these numbers are so low that modelling excludes heterosexual people when attempting to construct

¹⁸⁷ Targeting is perhaps an awkward term to use in relation to treatment-as-prevention, as this mode of transmission prevention is really a by-product of good adherence to and the efficacy of ART.

risk criteria and eligibility for PrEP.¹⁸⁸ Implementation data reflects this too. The largest-scale study of PrEP implementation in Australia, the EPIC-NSW study,¹⁸⁹ enrolled a total of 3,700 participants, less than 1% of whom identified as heterosexual ($n = 9$), with 4% identifying as bisexual ($n = 149$).¹⁹⁰ Only a single trial participant was female.¹⁹¹ Given this, the likelihood that any of the female complainants would have otherwise accessed PrEP is very low. This low likelihood is compounded by the regularity with which female complainants were unaware of their partner's HIV-positive status, knowledge of which would be the single most important predictor for take-up of PrEP by females engaging in heterosexual sex.

Drawing firm conclusions about the potential impacts of PrEP or TasP on the remaining prosecutions is more difficult. For example, male-to-male transmission events that have resulted in prosecution may well have been good opportunities for PrEP or TasP to prevent transmission and thus prosecution. Alternatively, their use by one or both partners would have been opportunities where either technology might have played an evidential or legal role at trial.¹⁹² However, the particular cohort of male-to-male prosecutions undertaken during the past decade includes a range of features the presence of which supports an interpretation that PrEP or TasP would be unlikely to feature in any great respect should the same fact scenario arise in the future. For example, many of these prosecutions related to scenarios where sexual relationships were understood, by the complainant's testimony at least, to have been monogamous, accompanied by a choice to abstain from condom use.¹⁹³ There is the potential for many, if not all, such instances to mean that PrEP, were it being used earlier in the relationship, may be ceased at the time condom use was ceased. Aside from any interpersonal decision-making around safe(r) sex practices within monogamous relationships,

¹⁸⁸ Kirby Institute and the Centre for Social Research in Health, 'Estimates of the Number of People Eligible for PrEP in Australia, and Related Cost-Effectiveness' (Discussion Paper, University of New South Wales, 2017) 8. See also at 9: 'As the likely numbers of recipients who receive PrEP based on heterosexual behaviour ... is believed to be small, we have confined these analyses to gay identifying men'.

¹⁸⁹ Zablotska et al (n 80).

¹⁹⁰ Grulich et al (n 111) e632 [tbl 1].

¹⁹¹ Ibid.

¹⁹² This is obviously the case with *Neal* (n 37) where, as described above, the question of the defendant's maintenance of a UVL was a significant feature of the court's reasoning regarding mens rea: see above nn 120–3 and accompanying text.

¹⁹³ See, eg, below Part VII (Appendix) (Case 15).

engaging in monogamy itself would also place the complainant outside the priority groups to whom PrEP is recommended within clinical guidelines.

PrEP is not the only reasonable precaution against transmission. Should their HIV-positive partner be able to maintain a UVL, then the risk of transmission is significantly diminished. However, as was the case in many of the male-to-male transmission events that made their way to prosecution, many included instances of non-disclosure of HIV status, and given that transmission occurred, an inability to maintain a UVL.¹⁹⁴ In those instances without disclosure, future complainants, like those in the prosecutions surveyed here, will not gain the advantage of knowledge regarding the serodiscordant relationship in which they were engaged, and thus will not be able to utilise this as a prompt for (re)engaging in PrEP.

Given the contouring of recent prosecutions along the lines of gender, ethnicity and sexuality described here, the profile of those subject to prosecution in Australia clearly means that they are unlikely, at present, to access either TasP or PrEP, such that the potential effects of these watershed biomedical transmission prevention practices will manifest in a reduction in the prosecution of HIV transmission-related criminal offences in Australia.

V IMPLICATIONS AND REFORM

The aim of most writing on the criminalisation of HIV is to bring about a radical reduction in criminalisation and of prosecutions of HIV transmission-related offences. Whilst PrEP or TaSP has the potential to achieve a reduction in HIV transmission itself, the most significant barrier to achieving a concomitant reduction in the prosecution of transmission will have little to do with these technologies. Rather, the misalignment of prosecutions along lines of gender, ethnicity and sexuality, with the picture of HIV transmission more generally within the Australian community, will remain the most significant barrier to a reduction in prosecution. This misalignment will see the potential for PrEP or TasP to *directly* reduce criminalisation and prosecutions unrealised.

Given this misalignment, the most effective method of achieving an end to transmission-related prosecutions is certainly not to transform prosecutorial activity so that it better represents the reality of transmission within the community. It is, rather, to continue to reform and decriminalise transmission-related offences based on public policy, public health grounds and,

¹⁹⁴ Ibid (Cases 1, 4, 13–16, 18).

importantly, upon grounds that HIV transmission no longer represents a harm so serious that it is worthy of criminal punishment. However, until such a reform agenda arises, there are both theoretical and practical implications of the arguments above. I deal with three in turn.

First, as Bridget Haire and John Kaldor argue, it is time that ‘normative concepts of “safe(r) sex” were expanded to include sex that is “protected” by means of the positive person being virally suppressed’.¹⁹⁵ This means that all Australian jurisdictions will need to continue law reform towards ‘reasonable precautions’ approaches, while practically and legally embedding within public health and criminal law regimes recognition that sex that had earlier been protected by condom use alone can now be protected by a combination of a UVL and/or PrEP.

Secondly, the cluster of causes that has brought the prosecutorial experience of the past decade to be so unevenly distributed along the lines of gender, sexuality and ethnicity must be questioned. This may include facing up to difficult secondary effects of the ‘responsibleilisation’ of men who have sex with men regarding (mutual) responsibility for HIV transmission control — a responsibleilisation that has not (yet) reached heterosexual communities and that results in both over-reporting of transmission to police by heterosexual complainants and a comparative under-reporting by men who have sex with men.

Finally, an ever-present effort must be made to expand and embed access to PrEP, TasP and safe(r) sex supportive policy and legal regimes within and across both the Australian community and internationally. The past decade has seen more Australians living with HIV describe their seroconversion as having occurred overseas.¹⁹⁶ Moreover, early but nonetheless worryingly diverging patterns of HIV transmission within Australia highlight the global and integrated challenge of HIV transmission reduction. For example, although new infections have dropped by 43% in Australian-born men who have sex with men, they have ‘risen [by] 13% in overseas-born [men who have sex with men]’.¹⁹⁷ ‘[O]verseas-born [men who have sex with men] now exceed Australian-born [men who have sex with men] *in raw numbers* of diagno-

¹⁹⁵ Haire and Kaldor (n 69) 982.

¹⁹⁶ See Western Australian Centre for Health Promotion Research, Curtin University and Australian Research Centre in Sex, Health and Society, La Trobe University, *HIV and Mobility in Australia: Road Map for Action* (Report, 2014) 15–16.

¹⁹⁷ Daniel Reeders, ‘Making Trouble within the Discursive Ecology of HIV’, *Bad Blood* (Blog Post, 20 April 2018) (emphasis in original) <<https://badblood.blog/making-trouble-within-the-discursive-ecology-of-hiv/>>, archived at <<https://perma.cc/H6XS-7WEB>>.

ses.¹⁹⁸ Without action supporting transmission reduction both here and abroad, both transmission and the potential for criminal prosecution will continue to be present.

VI CONCLUSION

The biomedical practices of TasP and PrEP are major advances in the field of HIV transmission reduction. They bring with them an opportunity to underwrite a significant reconceptualisation of HIV transmission, of what it means to be mutually responsible, to practice care for others and to reduce transmission in those populations able to access both technologies and their associated practices. The interface between HIV and the criminal law will take account of these new possibilities in multiple ways. This includes a reduction in the opportunity for prosecution through fewer transmission events. So, too, will it include a reconceptualisation of endangerment and assault in an era where the identity between HIV ‘infection’ and ‘infectiousness’ is now rendered motile and mutable.

I argued that challenges will remain at this interface between the criminal law and HIV transmission due to the misalignment between HIV transmission-related prosecutions and the individuals who are recommended to access and use PrEP and TasP. This is a significant barrier to realising the full potential of these two transmission prevention practices to reduce criminal prosecutions for transmission. However, it should also be remembered that formal prosecutorial processes are a minor part of the jurisprudence of HIV transmission. Sexual ethics and attitudes operating in broader culture will always decisively influence what is experienced as a harm, and how such harms are received by the moral and legal agent. It is in the wake of these broader cultural influences that practices of formal and informal decision-making by police and prosecutors and clinical and public health authorities alter the flow of events towards or away from formal criminal investigation, charge and prosecution.

In this challenging terrain, rather than dashing the potential for the impact of PrEP and TasP to end the difficult history of criminal prosecution of HIV transmission, what their entrance into the field may do is contribute to the transformation of the HIV virus itself — such that being HIV-positive is no longer a state of bodily disease worthy of the epithets ‘grievous’ or ‘really serious’ or, potentially, even considered a ‘harm’ at all. One result of this

¹⁹⁸ Ibid (emphasis in original).

process will be to render prosecution of the risk or occurrence of HIV transmission an activity that no longer makes sense.

VII APPENDIX: RECENT AUSTRALIAN HIV TRANSMISSION-RELATED CRIMINAL OFFENCES 2009–18

The following table summarises charges and trials known to have occurred in Australian jurisdictions from 2009–18 inclusive. A case is listed here where, on the public record, some criminal justice system activity or event is known to have occurred during that period. This may include instances where charges were laid but later modified or dropped, as well as complete prosecutions with a finding of guilty or not guilty.

Cases of HIV transmission-related offences often attract significant media attention. This includes ‘sensationalised headlines’¹⁹⁹ and can include media reports of varying quality, including ‘inaccurate or overtly sensational’²⁰⁰ treatments.

Cases listed in the table are sourced primarily from the longstanding anti-criminalisation archive maintained by the HIV Justice Network. The archive of cases is constructed primarily from global media reporting.

Table 1: Australian HIV transmission-related criminal offences 2009–18

Case ²⁰¹	Offence	Relevant Features
1 ‘MOG’ (2018) ²⁰²	Found guilty of recklessly causing	Reported that non-disclosure of status and that the accused and

¹⁹⁹ Australian Federation of AIDS Organisations, ‘HIV Criminal Cases’, *HIV Media Guide: Information for Journalists* (Web Page) <<https://www.hivmediaguide.org.au/media-toolkit/hiv-in-the-news/criminal-cases-involving-hiv-transmission-or-exposure/>>, archived at <<https://perma.cc/CH83-REKQ>>.

²⁰⁰ Ibid.

²⁰¹ Cases are sourced from the HIV Justice Network unless otherwise noted: ‘Global HIV Criminalisation Database’ (n 5). I have chosen to pseudonymise most cases listed here. The exceptions are those that have resulted in a well-known and reported judgment.

²⁰² [Update] Australia: Gay Man Jailed for a Maximum Term of Four Years and Six Months for Alleged HIV Transmissions and Non-Disclosure’, *HIV Justice Network* (Web Page, 26 September 2018) <<https://www.hivjustice.net/cases/australia-gay-man-pleads-not-guilty-to-charge-of-recklessly-inflicting-grievous-bodily-harm-for-alleged-hiv-transmission-and-non-disclosure/>>, archived at <<https://perma.cc/L4BB-LD3K>>. See also Lucy Hughes Jones, ‘Sydney Man Pleads Guilty to Infecting Lover with HIV’, *news.com.au* (Web Page, 14 March 2018) <<https://www.news.com.au/lifestyle/health/health-problems/sydney-man-pleads-guilty-to-infecting-lover-with-hiv/news-story/222fa246789cd2f2d6e44eab8a74ceb9>>, archived at <<https://perma.cc/JJC2-ANBT>>; Laurence Barber, ‘Sydney Man Jailed for Four Years over HIV Transmission’, *Star Observer* (online, 27 September 2018) <<https://www.starobserver.com.au/news/national-news/new-south-wales-news/sydney-man->>

Case ²⁰¹	Offence	Relevant Features
	grievous bodily harm.	his partner were reported to have been engaged in sexual relationship.
2 'CUV' (2018) ²⁰³	Reported to have been charged with serious assault and obstructing police. Upgraded to assault occasioning bodily harm in relation to allegedly spitting in the face of a security guard whilst claiming he was HIV-positive.	A 'spitting case'. HIV cannot be transmitted in this way.
3 'Rozelle Man' (2018) ²⁰⁴	53-year-old man charged with transmission relating to two women.	Male-to-female transmission.
4 'IEF' (2018) ²⁰⁵	Aggravated grievous bodily harm to two men.	Non-disclosure alleged.
5 'DPW' (2018) ²⁰⁶	Criminal negligence, did not take reasonable care	Defendant unaware of HIV status. Allegedly disclosed to a client that

jailed-for-four-years-over-hiv-transmission/172072>, archived at <<https://perma.cc/37UK-YRYK>>.

²⁰³ 'Australia: Queensland Police Upgrades Charges against Man Accused of Spitting at Security Guard Because of Suggested HIV', *HIV Justice Network* (Web Page, 5 August 2018) <<https://www.hivjustice.net/cases/australia-queensland-police-upgrades-charges-against-man-accused-of-spitting-at-security-guard-because-of-suggested-hiv/>>, archived at <<https://perma.cc/3WXY-ZBA7>>.

²⁰⁴ See 'Australia: Man Charged for Alleged HIV Transmission in New South Wales', *HIV Justice Network* (Web Page, 23 March 2018) <<https://www.hivjustice.net/cases/australia-man-charged-for-alleged-hiv-transmission-in-new-south-wales/>>, archived at <<https://perma.cc/4MER-326P>>.

²⁰⁵ 'Australia: 28-Year-Old Man Faces Criminal Charges for Alleged HIV Transmission', *HIV Justice Network* (Web Page, 7 March 2018) <<https://www.hivjustice.net/cases/australia-28-year-old-man-faces-criminal-charges-for-alleged-hiv-transmission/>>, archived at <<https://perma.cc/CS3X-9H7J>>.

²⁰⁶ See Joanna Menagh, 'Transgender Perth Sex Worker Found Guilty of Infecting Client With HIV', *ABC News* (Web Page, 19 January 2018) <<https://www.abc.net.au/news/>>

Case ²⁰¹	Offence	Relevant Features
	or precautions.	the defendant underwent regular STI testing.
6 <i>Aubrey</i> (2017) ²⁰⁷	Charged with maliciously causing another to contract a grievous bodily disease (an offence now repealed in New South Wales), and one count of maliciously inflicting grievous bodily harm (now also repealed).	Non-disclosure.
7 'USJ' (2017) ²⁰⁸	Pledged guilty to causing grievous bodily harm. Reported to have had sex without the use of a condom with a woman while aware of HIV-positive status.	Non-disclosure. Male-to-female transmission.
8 <i>Zaburoni</i> (2014) ²⁰⁹	Unlawfully (recklessly) causing grievous bodily harm.	Male-to-female transmission.
9 'DXN' (2014) ²¹⁰	Accused of biting a police officer whilst	Biting case. Complainant a police officer.

2018-01-19/transgender-sex-worker-who-gave-client-hiv-guilty/9344074>, archived at <<https://perma.cc/D34Q-64SC>>.

²⁰⁷ *Aubrey* (n 39). See generally above n 39 and accompanying text.

²⁰⁸ 'Australia: Queensland Man in Court, Charged with Causing Grievous Bodily Harm, for Alleged HIV Transmission', *HIV Justice Network* (Web Page, 7 February 2017) <<https://www.hivjustice.net/cases/australia-queensland-man-in-court-charged-with-causing-grievous-bodily-harm-for-alleged-hiv-transmission/>>, archived at <<https://perma.cc/3ACQ-QUUJ>>.

²⁰⁹ *Zaburoni* (*Supreme Court*) (n 40). See generally above n 40 and accompanying text.

²¹⁰ 'Australia: Man with HIV / Hepatitis C Charged with Serious Assault for Biting Brisbane Cop', *HIV Justice Network* (Web Page, 19 January 2014) <<https://www.hivjustice.net/cases/australia-man-with-hiv-hepatitis-c-charged-with-serious-assault-for-biting-brisbane-cop/>>, archived at <<https://perma.cc/2VBT-CP7N>>.

Case ²⁰¹	Offence	Relevant Features
	allegedly claiming to be HIV- and Hepatitis C-positive.	
10 'New South Wales Man' (2012) ²¹¹	Gay man, 65, found guilty in New South Wales of 'maliciously inflicting grievous bodily harm' following alleged transmission to former partner.	
11 'PZX' (2013) ²¹²	Grievous bodily harm.	Non-disclosure. Male-to-female transmission.
12 'North Albury Spitting' (2013)	'An aggressive drunk who spat blood into the face of an Albury policeman and boasted about having HIV and hepatitis is likely to be jailed next month.' ²¹³	A 'spitting case'. HIV cannot be transmitted in this way.
13 'PMU' (2013) ²¹⁴	Pleaded guilty to reckless conduct	Non-disclosure. Multiple charges, including sexual assault of a

²¹¹ 'Australia: Gay Man, 65, Found Guilty in New South Wales of "Maliciously Inflicting Grievous Bodily Harm" Following Alleged Transmission to Former Partner', *HIV Justice Network* (Web Page, 2 September 2013) <<https://www.hivjustice.net/cases/australia-gay-man-65-found-guilty-in-new-south-wales-of-maliciously-inflicting-grievous-bodily-harm-following-alleged-transmission-to-former-partner/>>, archived at <<https://perma.cc/ZN4-3HHH>>.

²¹² 'Australia: Queensland Man Accused of "Knowing" HIV Transmission Has Name Released Following Hearing', *HIV Justice Network* (Web Page, 3 April 2013) <<https://www.hivjustice.net/cases/australia-queensland-man-accused-of-knowing-hiv-transmission-has-name-released-following-hearing/>>, archived at <<https://perma.cc/2YPP-B8EX>>.

²¹³ 'HIV Threat, then Drunk Spat Blood', *Border Mail* (Albury-Wodonga, 7 February 2013) 5.

²¹⁴ See Mark Russell, 'HIV-Infected Sex Worker "Had Up to 20 Clients a Day"', *The Age* (online, 8 June 2020) <<https://www.theage.com.au/national/victoria/hiv-infected-sex-worker-had-up-to-20-clients-a-day-20120608-2010l.html>>, archived at <<https://perma.cc/2EXA-WV4F>>; Emily Portelli, 'Judge Says Man Had No Excuse for HIV Lie', *Herald Sun* (online, 1 August 2013) <<https://www.heraldsun.com.au/news/law-order/judge-says-man-had-no-excuse-for-hiv-lie/news-story/2cf83e10dba5ac6cdefd9cbdc6372dcb>>, archived at <<https://perma.cc/BRA5-L3EQ>>.

Case ²⁰¹	Offence	Relevant Features
	endangering persons.	minor. Methamphetamine use. Reported to have had a high viral load at the time of the offence. Subject to Public Health Order.
14 'VXK' (2012)	Found guilty of causing grievous bodily harm. ²¹⁵	Non-disclosure. Active deception regarding HIV status.
15 'Balmain Local Court Charge' (2010)	Man charged with inflicting grievous bodily harm following successful civil litigation against him by former partner.	In relation to civil claim, media reported that the couple 'had repeated conversations about their HIV status. The court accepted that the defendant assured he was negative and, after consenting to engage in unprotected sex, the plaintiff contracted HIV.' ²¹⁶
16 'OXX' (2010) ²¹⁷	'OXX' was found guilty of two counts of endangering life but was acquitted of another five counts.	Alleged to have not disclosed status, and at other times removed condoms during sexual intercourse.
17 'MJW' (2009) ²¹⁸	Pleaded guilty to grievous bodily harm.	Male-to-female transmission.
18 'FDH' (2009) ²¹⁹	Pleaded guilty to three counts of endangering	Failed to disclose status. Male-to-female transmission.

²¹⁵ See 'Former Sex Worker Jailed for Infecting Man with HIV', *Brisbane Times* (online, 4 November 2014) <<https://www.brisbanetimes.com.au/national/queensland/former-sex-worker-jailed-for-infecting-man-with-hiv-20141104-11goww.html>>, archived at <<https://perma.cc/87BC-ZHH9>>.

²¹⁶ '\$750,000 Payout for HIV Infection', *Star Observer* (online, 27 April 2010) <<https://www.starobserver.com.au/news/national-news/new-south-wales-news/750000-payout-for-hiv-infection/24523>>, archived at <<https://perma.cc/8V2C-K4YS>>.

²¹⁷ See '[Update] Australia: More Delays in Stuart McDonald Trial', *HIV Justice Network* (Web Page, 15 April 2009) <<https://www.hivjustice.net/cases/australia-more-delays-in-stuart-mcdonald-trial/>>, archived at <<https://perma.cc/7LKW-WH7T>>.

²¹⁸ 'Australia: Sydney Husband Gets 4 1/2 Years after Pleading Guilty to Infecting Wife', *HIV Justice Network* (Web Page, 11 May 2009) <<https://www.hivjustice.net/cases/australia-sydney-husband-gets-4-12-years-after-pleading-guilty-to-infecting-wife/>>, archived at <<https://perma.cc/28QZ-JTU2>>.

Case ²⁰¹	Offence	Relevant Features
life.		
19 Victorian Man (2009) ²²⁰	Pledged guilty to one count of reckless conduct endangering life. Sentenced to five years gaol.	Failed to disclose status. Male-to-female transmission.

²¹⁹ See 'Australia: Bail for African Migrant Accused in Adelaide', *HIV Justice Network* (Web Page, 24 March 2009) <<https://www.hivjustice.net/cases/australia-bail-for-african-migrant-accused-in-adelaide/>>, archived at <<https://perma.cc/J9HW-FMPN>>.

²²⁰ 'Australia: Man Pleads Guilty to Infecting Wife, Gets Three Years', *HIV Justice Network* (Web Page, 15 March 2009) <<https://www.hivjustice.net/cases/australia-man-pleads-guilty-to-infecting-wife-gets-three-years/>>, archived at <<https://perma.cc/V9UG-7K2B>>; Gina Mitchell, DLA Phillips Fox, *Criminal Transmission of HIV: A Guide for Legal Practitioners in NSW* (Guide, 1st ed, May 2009) 53 (erroneously referred to therein as a 2008 judgment/sentence).

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