

HIV & The Law

Legal Opinion 2011

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+BODY POSITIVE→

• NEW ZEALAND •

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Dear Bruce

HIV and criminal liability

You asked me to update my 2004 opinion on the legal liability of HIV positive persons engaging in sex.

The update takes into account:

- (1) post-2004 developments in New Zealand, the United Kingdom, Canada, Australia and the United States; and
- (2) developments in treatment apparently making it possible for persons with HIV to be symptom-free with low or undetectable viral loads, thereby reducing or perhaps eliminating the chance of transmitting HIV to sexual partners.

My 2004 opinion concluded that:

- (a) Persons with HIV positive status who have consensual sex (protected or unprotected) with another after disclosing their HIV status commit no criminal offence.

The potential offences are either: breaching a duty of care under s 156 of the Crimes Act 1961 and so committing "criminal nuisance" under s 145 (relevant if the sexual partner is not infected); or reckless infliction of "grievous bodily harm" under s 188(2) (relevant if a partner is). Whether a victim's consent may serve as a defence to these crimes turns ultimately on principles of judge-made common law rather than any statutory provision. There are certain crimes to which consent is not a defence. But I suggested that it is a defence in the HIV context. Those who engage in sex after their partner's disclosure are not consenting to infection with HIV (and so, according to case-law to date, grievous harm) but simply to a lawful activity that carries a small risk of that infection.

- (b) Where there is no disclosure, condom use is capable of discharging the duty of care sufficient to avoid liability for criminal nuisance under s 145 as well as recklessness causing grievous harm under s 188. The question whether there is a breach of the duty of care, or recklessness, is one of fact to be decided by juries or (in judge-alone trials) judges. There is no legal principle to the effect that use of a condom, even careful use, is insufficient to avoid liability. Conversely, there is no legal principle that it is always sufficient. In every case recklessness or lack of care must be proved beyond reasonable doubt on the basis of evidence about a particular case. Those who used condoms in the relevant sexual acts may point to evidence as to the general efficacy of condoms in preventing HIV transmission as well as to facts about their particular case (for example, the quality of the condom and the care that they took in using it, each of which is material to risk). Such evidence can raise a reasonable doubt that there was recklessness or breach of care and lead to acquittal.

These conclusions were consistent with the case of *R v Mwai* [1995] 3 NZLR 149 (NZCA) which was and remains the most authoritative case in New Zealand on the legal consequences of HIV positive persons having

unprotected sex. In that case Mr Mwai had neither disclosed his HIV status nor used a condom, and was found guilty. The case did not speak to the case of protected sex, save in passing.

I now review post-2004 cases, noting where relevant whether they confirm or require reformulation of my 2004 conclusions. I conclude with general comments about the current legal position in New Zealand.

I can summarise what follows by saying:

1. Essentially all post-2004 developments confirm that consent after disclosure negates criminal liability and that protected sex without disclosure is capable of being regarded as reasonable care, or as negating recklessness.
2. Developments in ART leading to greatly reduced viral loads (and so to reduced risk of transmission) contribute to and affirm that approach, because evidence of low viral load will be relevant to establishing the level of risk in a particular sexual encounter (and hence the extent of the accused's duty and whether it was breached).
3. The new issue opened up by the success of ART is whether reduced viral loads can lead to acquittals in cases of unprotected sex without disclosure. Here I suggest caution. All will turn on the evidence that is available in individual cases. It is not possible to say, as a matter of law, that (for example) there is a certain viral load or statistical probability of transmission below which there is no risk of criminal liability. Certainly it would in my view be unwise to counsel HIV positive persons on ART with low viral loads that they are immune from criminal prosecution for unprotected sex without disclosure. Essentially this is because, as things stand at present, a prosecution case can be built on general statistics as to transmission rates for HIV in unprotected sex and it need not form part of a prosecution case to establish the viral load of a particular accused. Rather, it would be for an accused person to adduce evidence as to their viral load at the relevant time along with expert evidence as to transmission rates, so as to generate a reasonable doubt as to breach of duty or recklessness. This carries risks for HIV positive persons (for example whether the necessary relevant evidence is available to them and is sufficiently contemporaneous to the sex).
4. The fact that being HIV positive is no longer, as a result of ART, as life-threatening or life-changing as it once was has not yet translated into legal conclusions that HIV infection is no longer "grievous bodily harm", or that transmission of HIV is not an "aggravated assault" (this being the phrase in relevant Canadian law).

The detail now follows.

REVIEW OF POST-2004 DEVELOPMENTS

1. New Zealand

(a) *Police v Dalley* (2005) 22 CRNZ 495

Dalley was HIV positive and was charged with criminal nuisance arising out of oral and vaginal sex with the complainant (who remained free of the virus). Dalley did not disclose his HIV status. They used a condom for the vaginal sex but not for the oral sex. There was evidence that the condom had been carefully placed in position by his sexual partner.

Police pressed for a finding that Dalley could discharge his duty of care only by *disclosing* his HIV status (para [25]). The contention was that reasonable precautions extended to making sure that his partner did not take a risk in ignorance (para [28]). This was a bold submission, suggesting that care could not be demonstrated through the use of condoms; only by giving the partner a chance to refuse. That argument, if accepted, would have led to the law being very different from what I suggested in 2004 (although it incidentally supports my opinion, reflected also in comments in *Mwai*, that disclosure negates duty).

However, the judge rejected the Police submission that only disclosure could discharge the duty. Her reasoning (with which I agree) was that s 145 (criminal nuisance) in combination with s 156 (duty of care) required taking of reasonable precautions to avoid the risk inherent in the dangerous thing. The offence did not speak to any

requirement of disclosure. And, having regard to the evidence of the relatively low risk of transmission through protected sex, reasonable precautions had in fact been taken. That being so, there was no basis for finding that non-disclosure was legally culpable.

The judge said there might be a 'moral duty' to disclose but the legal duty was to take reasonable precautions, and Dalley had done that. She felt fortified in that conclusion by evidence that relevant health professional bodies chose not to advocate that HIV positive persons be counselled to disclose their status to sexual partners, but instead emphasised prevention through using protection (paras [47-48]).

The *Dalley* case therefore supports my 2004 opinion. The duty is about taking reasonable precautions to prevent danger from materialising, and, importantly condom use can fulfil the duty. Disclosure is conceptually distinct. Disclosure would mean that any sex that then eventuates could not be regarded as criminal, the sexual partner having consented to run the risk. But the absence of disclosure does not mean that reasonable precautions have not been taken.

I should also briefly mention the 'oral sex' aspect of the *Dalley* decision. A separate charge of criminal nuisance had been laid in respect of the oral sex. All the experts agreed that the risk of transmission of HIV through oral sex was negligible. On that basis, Dalley argued that he owed no duty to his partner in relation to the oral sex (as indeed he also argued in relation to vaginal sex for the same reason – of negligible risk). If he owed no duty, there could be no failure to discharge a duty. But the judge rejected this 'no duty' argument, saying that s 156 was clear that anyone who had in their control a thing that could endanger human life must take 'reasonable precautions'. And Dalley had such a 'thing', the HIV infection. That said, she then went on to say (I am speaking here about the oral sex) that he had discharged his duty. She gave two reasons: first, that the risk was so low 'it does not register as a risk'; second, because 'in any event Mr Dalley did not ejaculate'. For these two reasons she held that reasonable precautions and reasonable care had been exercised.

That reasoning is a little suspect. In my view, if the risk in the encounter was 'virtually none' (para [37]) and '[did] not register as a risk' (para [39]) – each of which appear to have been conclusions about oral sex generally and not about 'oral sex without ejaculation' – then the conclusion ought to have been that there was no duty. The evidence would really mean that HIV is not a dangerous thing in a context where there is no or negligible risk of transmission. If that is so, then there is nothing "special" about the performance of oral sex that needs to be done to take care to avert any risk. In the *Dalley* case it is possible to read the judgment as if the non-ejaculating was taken to be the exercise of care. But, as I say, if the evidence about negligible risk related to oral sex with ejaculation then this was not a relevant factor in *Dalley*.

As to the vaginal sex, there was evidence from his doctor that Dalley had a low viral load. This evidence contributed to the finding that the risk of transmitting HIV through unprotected sex was low (8 to 20 per 10,000 exposures) with condom use reducing that risk by 80-85%. My 2004 opinion did not discuss viral loads. But I did emphasise throughout that the question as to whether reasonable care was taken turns on the facts. The thing to add now in light of *Dalley* is that a person with medical tests indicating reduced or undetectable viral loads will be able to advance those medical tests in evidence, and they will form part of the factual matrix that determines the level of risk in the relevant sexual act, and hence the level of care that the accused was legally required to take. In *Dalley* the salient facts were both low viral load and condom use.

There is some academic commentary on *Dalley*. In Robertson (ed) *Adams on Criminal Law* it is discussed in para CA156.02 consistently with my views above. In an article by a VUW student Amelia Evans similar views are expressed and I note she also shares my view about the illogic of the reasoning on the oral sex point ("Critique of the Criminalisation of Sexual HIV Transmission" (2007) 38 VUWLR 517).

So, overall, *Dalley* affirms my 2004 opinion and points to the fact that available evidence as to an accused's viral load can be important.

(b) *R v Lee* [2006] NZCA

This was not an HIV case: it is a case about the availability of the defence of 'consent' to a manslaughter charge. But it sets out a general analysis of when consent operates as a defence in criminal law. This is relevant to

whether persons can give a legally “valid” consent to sex with an HIV positive partner, so precluding criminal liability for that partner on criminal nuisance, grievous bodily harm, and (we shall see) sexual violation charges. It is an important case, and it contains some incidental remarks about HIV cases which it is necessary to consider.

Mr Lee was a church pastor who conducted an exorcism on a parishioner over several hours, with the parishioner’s consent. This involved the application of physical force by way of pressing on her chest and neck. The parishioner died as a result of that force. Lee was convicted of manslaughter at trial, in that he had applied force amounting to assault as a result of which she died. On appeal, Mr Lee argued that the parishioner had consented to the use of force, but that the trial judge had incorrectly withdrawn the defence of consent from the jury. (The judge had done so because he considered it not legally possible for a person to consent to the use of force causing death.)

The Court of Appeal allowed the appeal. It held that the judge was wrong to withdraw the defence of consent, which ought to have been left to the jury to decide. The judge had wrongly applied a results-based test – that because a death resulted there could be no legal consent to the force that was used.

The Court of Appeal held that persons can consent to the use of force in the context of an exorcism, conduct of which is part of the right to manifest religious belief in s 15 of the New Zealand Bill of Rights Act 1990. The evidence was plain that the victim had consented to an exorcism and to the force it involved – at least up to the end point where from the evidence at trial it appeared she may have been indicating a withdrawal of consent. But whether she withdrew her consent was a question of fact for the jury to decide (indeed, there were other possible explanations for her behaviour in the end stages). Hence the issue of consent should have been left to the jury. If there had been consent then her death might have been an accidental consequence of lawfully applied force (lawful because of her consent).

The significance of this to cases about HIV is as follows. While persons generally may validly consent to activities involving force that would otherwise be assault, there are limits. If the intended force would lead to grievous bodily harm, then courts have said that reasons of public policy dictate that consent cannot be a defence. But not always: amputations are grievous bodily harm but persons can consent to those being carried out by doctors for good reason. In deciding whether public policy requires that consent be ruled out as a defence, a Court will take into account the right to personal autonomy, the social utility or otherwise of the activity, the level of seriousness of the injury intended or risked, the degree of the risk of such injury, the rationality of any consent, and any other relevant factors.

In HIV cases there are two features of this calculus that are especially relevant: the degree of the risk and whether the consent is fully informed. It was in this regard that the Court of Appeal in *Lee* discussed two United Kingdom cases about HIV transmittal, *R v Dica* and *R v Konzani*. I discuss those two cases further below, but it is enough to say here that in combination they establish that, before consent to sex will operate as a consent to assume the risk of infliction of grievous bodily harm through HIV transmittal, the complainant must have been informed (or otherwise know) that the accused was HIV positive. It is not enough that they simply know that all sex carries risks. Their consent must be given with knowledge of the *actual* risk they are about to run.

After discussing those UK cases the Court of Appeal in *Lee* said this:

It may be that the Court [in *Konzani*] thought that consent to unprotected sexual relations could be a consent to the risk of HIV being passed on unknowingly by a person but could not constitute consent to a person having unprotected sexual intercourse while knowing they were HIV positive but without informing his or her sexual partner. *The precaution of using a condom is such an easy one to take and the consequences of HIV so devastating.*

In this paragraph the New Zealand Court is explaining why the English Court of Appeal in *Konzani* felt it had to clarify its earlier decision in *Dica* (something I also explain in a moment). What interests me is, however, is the italicised sentence: that appears to assume that condom use can discharge the duty of care or prevent a finding of recklessness.

The Court returns to the point in para [309] of *Lee* where, in summing up its lengthy decision, it said:

Cases such as *Konzani* and *Mwai* suggest that any consent must also be informed. We do not consider that there is anything intrinsically unfair or contrary to principle in such an approach. Normally, if the scope of the activity is understood by the person consenting, then the person will be assumed to have been consenting to any risks of that activity. Where, however, there is a known information imbalance about the risks involved between those giving and seeking consent it does not seem unreasonable to require the person seeking consent to correct that imbalance. *This requirement may, however, be limited to cases where the risk is major because of the very serious consequences if it does eventuate (such as with unprotected sex and HIV).*

Again, that indicates the Court's view that unprotected sex where the accused fails to disclose HV status may constitute a criminal offence, but that protected sex is different because it is not "major". This, of course, is what *Dally* decided. But because *Dally* is only a District Court decision, the Court of Appeal's passing observation in *Lee* is important as a clue as to how that Court might approach such a case.

I emphasise that *Lee* is not about HIV transmission and so its comments cannot be read as if they set out any legal principle. But it is nonetheless significant that the Court appears to regard the greatly reduced risk in protected sex as militating against the conclusion that only disclosure can negate criminal liability and that use of condoms cannot be enough.

Finally I add that the paragraph just cited from *Lee* is capable of being read as if the information imbalance spoken of (where one partner knows he is HIV positive but the other does not know) might vitiate the consent so as to convert apparently consensual sex into an offence of sexual violation by rape, rather than "merely" an offence of criminal nuisance or grievous bodily harm. But it is clear enough that no such radical shift was intended, and of course the case itself was not even about HIV. This comes out in the next case to be discussed, *M v Accident Compensation Corporation*.

Overall, then, the *Lee* case supports my 2004 opinion that condom use reduces the risk such that there can be a defence to criminal nuisance and recklessness charges. And, further, that a consent to sex after disclosure of HIV status will preclude criminal liability for the disclosing partner.

(c) *M v Accident Compensation Corporation* [2006] 3 NZLR 127 (HC)

M claimed for compensation for mental shock arising out of learning that her sexual partner of three years was HIV positive throughout. She had not contracted the virus. A charge of criminal nuisance under s 156 was brought against her partner, to which he pleaded guilty. Whether M was entitled to ACC cover turned on interpretation of the relevant ACC legislation. Ultimately that point reduced to this: cover was available for nervous shock to victims of certain named criminal offences, but criminal nuisance was not one of them. However, if she were able to demonstrate that the act of her partner also constituted sexual violation then she would have been entitled to cover (even though her partner had not been charged with that). That then raised a fundamental question about the nature of consent to sexual intercourse when a partner fails to disclose HIV status or indeed any sexually transmitted disease: might that failure vitiate the consent (because it was not fully informed) such that apparently consensual sex is in fact sexual violation by rape?

This took the High Court into the same issue that the Canadian Supreme Court dealt with in *R v Cuerrier*, a case discussed in my previous opinion and also further discussed below.

The starting point is that in New Zealand, as elsewhere, rape is "sexual connection" without consent. This is an offence in which lack of consent is an element of the charge to be proved by the Crown.¹ Generally the complainant will testify to absence of consent. If an accused can point to evidence suggesting there was consent, the prosecution must prove beyond reasonable doubt there was no such consent. In HIV cases of the type we are concerned with, of course, the sex is always by agreement and so the crucial issue is whether the "consent" is negated by concealment or deceit about HIV status.

¹ Most other offences against the person do not specify that lack of consent is an element of the offence, but the law may nonetheless recognize that the fact of consent negates criminal liability. In the case of s 148 (criminal nuisance) and s 188(2) (grievous bodily harm) consent operates in this latter way.

In Commonwealth law, this issue has been long recognised as complex. In matters of sexual interaction it is clear that there will often be half-truths, lies and soon-to-be-broken promises. It is a big step to say that deceit about a person's status or intentions vitiates consent so that an act of consensual sex becomes one of rape. No country goes that far. But, significantly, in the English case of *R v Clarence* (1889) 22 QB 23 it was held that a husband who knew he had gonorrhoea committed no offence when he had sex with his wife (who didn't know). The knowledge imbalance on that issue did not, said the court, alter the fact that the sex was consensual. *R v Clarence* was also the notorious case that said a wife is deemed to consent to sex with her husband such that there could never be marital rape, and on this aspect it was overturned by the United Kingdom House of Lords in a 1992 case. But *Clarence* remains good law on the issue of consent to sex being effective to preclude rape charges despite non-disclosure of a sexually transmitted disease.

Returning to New Zealand law, it essentially follows the *Clarence* approach as to the efficacy of consent. Deception in sex vitiates consent only in narrow circumstances covered by s 128A of the Crimes Act 1961. This says, in part, that there will be no valid consent if a complainant is mistaken about who the sexual partner is (which may happen in the dark or when alcohol is involved), or as to the *nature and quality* of the act (as, for example, when a person is tricked into a sexual act by a person posing as a physician). There may also be other reasons why consent does not count. But so far in New Zealand law is concerned it is *not* the case that ignorance about a proposed partner's HIV status or other STDs means there is no consent. In such cases there is no mistake about who the sexual partner is, nor, it is said, about the nature and quality of the act.

That is why, in the New Zealand cases to date such as *Mwai* and *Dalley*, the charges have been "grievous bodily harm" or "criminal nuisance", and not sexual violation as such.

The argument in *M v ACC* was essentially that New Zealand law should be changed, and that it was competent for a court to change it. The change sought was this: that sexual partners whose consent is not informed (due to non-disclosure of HIV status) be regarded as suffering under a mistake as to the "quality" of the act of sex. Or alternatively, that their consent be disregarded because it is not fully informed (the *R v Lee* case discussed above was said to support this).

Justice Randerson of the High Court declined to accept the argument. After reviewing the Canadian Supreme Court decision in *R v Cuerrier* (which involved interpreting then new Canadian legislation about consent in assault cases) and the two English cases I discuss below, he held that non-disclosure of HIV could not vitiate consent such that the resulting sex amounted to rape or indecent assault. He regarded it as a sufficient safeguard that the offences of criminal nuisance and grievous bodily harm were available in such cases. He considered that if the law were to be changed to require a fully informed consent in order to preclude a rape charge, then it would be difficult to draw the line as to what needed to be disclosed in order for a consent to sex to be informed. What, he asked, of failure to disclose a family history of obesity, or mental or physical disease, to a woman wanting children, or of a failure to disclose a sexually transmitted disease of lesser impact than HIV? Such a complex law change, he said, should be left to Parliament to consider. It was not an appropriate development for a court to make.

That meant that the woman failed in her case, because she could not establish that the sex she had had with her partner amounted to a crime of sexual violation. Her consent to sex, though in ignorance of her partner's HIV infection, precluded a finding of rape. But, to be clear, the sex could still amount to criminal nuisance (and her partner had been so convicted) or grievous bodily harm (if she had been infected). As we shall see, this is the position in the United Kingdom as well.

Canada differs. Following a law change and the interpretation given to that law in *R v Cuerrier*, non-disclosure of HIV status is (as discussed in my 2004 opinion) capable of vitiating consent such that there is aggravated sexual assault but only if there is a significant risk of serious harm in the sex act. It was said that condom use might reduce the risk below that threshold, meaning that protected sex without disclosure is not an aggravated assault. So Canadian law is different from New Zealand law on this point. It is significant that the change in that country (which had previously followed the *Clarence* case also) was brought about by legislation.

I am not aware that Parliament is in fact looking at any law change to this area of law in New Zealand.

It follows that there is nothing in the *M v ACC* case that alters my 2004 opinion.

2. United Kingdom cases

(a) *R v Dica* [2004] QB 1257.

Dica was HIV positive and had unprotected sex with two women. Both became HIV positive as a result, leading to grievous bodily harm charges.

He wished to argue consent. The trial judge had ruled that no issues about consent could go to the jury because it was, he said, irrelevant. His reasoning was that if the women did not know of Dica's HIV status then their consent was not an informed one and not legally sufficient for that reason. But if they *did* know, then their consent was still irrelevant because (so it was said) no person can lawfully consent to the infliction of such serious harm.

On this basis the jury convicted, for recklessness was not contested. Dica appealed against the consent ruling. The Court of Appeal allowed the appeal and ordered a new trial. Its reasons were these:

Assuming first that the accused concealed his HIV status and the women did not know of it, then the women's consent to the act of sex was sufficient to mean that the accused could not be guilty of their *rape*. (This is because of the English law position noted above, shared by New Zealand, that non-disclosure of sexually transmitted diseases, and indeed other types of deceit inducing sex, does not vitiate consent to sex unless the woman makes a mistake as to identity or as to the nature and quality of the act.) Even so, said the Court of Appeal, if there were no disclosure the victims' consent would not be sufficient to operate as a defence to charges of *grievous bodily harm*. Without disclosure, the women would not have known they were running any risk of infection; hence they were not consenting to running that risk.

Assuming, next, that the accused *had* disclosed his HIV status or that the women otherwise knew of it, and that the women nevertheless consented to have sex, the Court of Appeal held that he would indeed have a defence. While the law would not allow consent as a defence for the infliction of grievous harm, that was not the case here. The women were consenting only to a risk (not a certainty) of infection. The Court of Appeal pointed to various reasons why citizens might wish to take risks in relation to sexual matters and indeed other matters. The law should not intervene in such cases, said the Court of Appeal. It was for Parliament, if it wished, to legislate to interfere in this way with personal autonomy and informed risk-taking.

So the conclusion was that the issue of consent ought to have been put to the jury. A new trial was ordered.

Significance of the case for my 2004 opinion

The *Dica* decision supports my opinion in a number of ways:

First, I advised that disclosure of HIV status followed by consensual unprotected sex would not be a criminal offence. I said that the law would not regard it as impossible to consent to sex that carries a risk (but not the certainty) of infection. That is the view the Court of Appeal took in *Dica*.

Second, while *Dica* was a case about unprotected sex, there was a brief reference to what the position might have been if there had been protected sex only (para [11]):

It was not in dispute that at least on the majority of occasions, and with both complainants, sexual intercourse was unprotected. Recklessness, as such, was not in issue. *If protective measures had been taken by the appellant that would have provided material relevant to the jury's decision whether, in all the circumstances, recklessness was proved.*

This was exactly my point in 2004: that taking protective measures – the use of condoms – is highly pertinent to the factual question of whether there was recklessness; that this is a question of fact for each case; and that there is no legal principle that says that only disclosure can avoid criminal liability.

(b) *R v Konzani* [2005] EWCA Crim 706

In this subsequent case the Court of Appeal had to resolve an issue claimed to have been left ambiguous in *Dica*. Konzani had had unprotected sex with three complainants who each became HIV positive as a result. He had not disclosed his HIV status. He was charged with and convicted of recklessly causing grievous bodily harm. His defence was that, by consenting to sex, the complainants had in fact consented to *all risks of disease associated with sex including HIV*. The trial judge had instructed the jury in a way that did not reflect that defence; hence the appeal.

Konzani's argument would extend the *Dica* case. Recall that in *Dica* the finding was that disclosure of HIV status followed by consent was a defence, as the complainant would then knowingly take the risk. But here it was argued that sexual partners knowingly took the risk of HIV transmission, even if there were no disclosure. They did so because of the *known risk in all sexual encounters*. But the argument to extend *Dica* in this way was rejected, the Court of Appeal holding that (para [42], my emphasis):

If an individual who knows that he is suffering from the HIV virus conceals *this stark fact* from his sexual partner, the principle of her personal autonomy is not enhanced if he is exculpated when he recklessly transmits the HIV virus to her through consensual sexual intercourse.

And again (para [41]):

For the complainant's consent to the risks of contracting the HIV virus to provide a defence, it is at least implicit from the reasoning in *R v Dica*, and the observations of Lord Woolf CJ in *R v Barnes* confirm, that her consent must be an *informed* consent. If that proposition is in doubt, we take this opportunity to emphasise it.

The argument for Konzani was, nonetheless, a reasonably plausible one. It is true that most who consent to sex will know that sex carries risks of infections and that HIV infection is one such risk. In *Konzani* the complainants were young and naive but evidence elicited in cross-examination showed that at least one of them knew the risk of contracting HIV through sex. Even so, as already noted, the Court emphasised the crucial difference between '*running a risk*' – as it might be said all sexual partners do – and '*consenting to a risk*'. To consent to a risk, said the Court, one needs to know of it, not just of its possibility. Hence, said the Court of Appeal, there must be an *informed* consent for there to be defence available to a grievous bodily harm charge.

If the argument for Konzani had been accepted it would have effectively transferred responsibility for the avoidance of HIV infection on to the sexual partners of HIV positive persons. That is to say, an HIV positive person who failed to disclose would not attract a criminal sanction. This would have been an outcome that some would support as quite appropriate. It is the view taken by an English academic commentator Matthew Weait in an article "Knowledge, Autonomy and Consent: *R v Konzani*" (2005) Crim L R 763.

That article is a sustained critique of *Konzani* and *Dica*, and makes principled objections to the Court's reasoning. These include: that the Court's approach does not adequately respect autonomy; that it wrongly builds the concept of "disclosure" into the different question of whether a person is "reckless"; that it is not consistent with a "public health approach" to preventing HIV transmission; and that it is very difficult to draw any sensible line between the HIV context and what might now be argued in relation to *all* sexually transmitted diseases that have serious potential outcomes.

But the Court of Appeal held, as I say, otherwise. If consent is to operate as a defence then it must be an informed consent (given with knowledge that the partner is HIV positive, not just that there is a risk he or she may be). The *Konzani* court did, however, accept that a consent may still be informed *without* disclosure by the accused, such as when the sexual partner is shown to have become aware of the partner's HIV status in some other way (say, by being aware that he was attending a clinic for HIV treatment).

A further aspect of *Konzani* was this. The accused argued that, because informed consent *can* operate as a defence, a person is also entitled to acquittal if he had an honest but mistaken belief that there was such a consent. As a general proposition of criminal law that is indeed correct. But in *Konzani* the Court of Appeal held that the argument was not possible on the evidence. They ruled that the "consent" about which one is honestly mistaken must be the type of "consent" that would be legally relevant if it existed. In other words, the accused would have had to have an honest belief that each of his sexual partners knew that he had HIV and consented to sex *with that knowledge*. On the facts of *Konzani* there was no such evidence. It followed that there was no

basis on which a jury could determine that he honestly believed that each complainant knew that he had HIV. The judges discussed some hypotheticals where it might be possible to say that an accused could have an honest belief that a complainant knew of his HIV status even though he had not told her of it himself (para [44]):

[...] we accept that there may be circumstances in which it would be open to the jury to infer that, notwithstanding that the defendant was reckless and concealed his condition from the complainant, she may nevertheless have given an informed consent to the risk of contracting the HIV virus. By way of example, an individual with HIV may develop a sexual relationship with someone who knew him while he was in hospital, receiving treatment for the condition. If so, her informed consent, if it were indeed informed, would remain a defence, to be disproved by the prosecution, even if the defendant had not personally informed her of his condition. Even if she did not in fact consent, this example would illustrate the basis for an argument that he honestly believed in her informed consent. Alternatively, he may honestly believe that his new sexual partner was told of his condition by someone known to them both. Cases like these, not too remote to be fanciful, may arise. If they do, no doubt they will be explored with the complainant in cross-examination. Her answers may demonstrate an informed consent. Nothing remotely like that was suggested here. In a different case, perhaps supported by the defendant's own evidence, material like this may provide a basis for suggesting that he honestly believed that she was giving an informed consent. He may provide an account of the incident, or the affair, which leads the jury to conclude that even if she did not give an informed consent, he may honestly have believed that she did. Acknowledging these possibilities in different cases does not, we believe, conflict with the public policy considerations identified in *R v Dica*. That said, they did not arise in the present case.

Significance of Konzani for my 2004 opinion

The case is consistent with what I said in 2004. Disclosure can operate as a basis for a consent. If there is disclosure, it will meet the requirement of informed consent.

I did not mention in 2004 the fact that a sexual partner may be held to be aware of the accused's HIV status from some source other than being told by the accused.

The two UK cases are an emphatic rejection of the "sex-has-risks-and-all-should-know-it" approach, and with it, of the idea that sexual participants bear responsibility for themselves. It is worth noting however that these cases involved unprotected sex and that *Dica* at least has the dictum in it that taking protective measures would be relevant to the jury question of whether there was recklessness.

3. Canada

My 2004 opinion is based to some extent on the Supreme Court of Canada decision in *R v Cuerrier* [1998] 2 SCR 371. A quick review of that case enables the post-2004 Canadian cases to be put in context.

The significance of *Cuerrier* in Canada was that it addressed this question. The relevant Canadian statute allowed consent to be disregarded if obtained by "fraud". That statutory change raised the question whether a departure from the United Kingdom approach to consent set out in *R v Clarence* was intended. In other words, was it "fraud" to not disclose one's HIV status to a partner? Or did "fraud" continue to bear a meaning along the lines of inducing a mistake about identity or as to the nature and quality of the act of sex itself?

The Supreme Court of Canada held by majority that there was "fraud" if there was "dishonesty" and that deliberate deceit or concealment of HIV status may count as such. But (recognising that there can be deceit or concealment about all sorts of things in sexual matters) they also said that the necessity to disclose depended on the *deprivation* that the sexual partner might suffer – that is, how serious the harm might be. That was the context in which the Court made the statement that I emphasised in my 2004 opinion (para [129]):

Yet the careful use of condoms might be found to so reduce the risk of harm that it could no longer be considered significant so that there might not be either deprivation or risk of deprivation. To repeat, in circumstances such as those presented in this case, there must be a significant risk of serious bodily harm before the section can be satisfied. In the absence of those criteria, the duty to disclose will not arise.

In *Cuerrier* there was no disclosure and the sex was unprotected so that proviso was not dispositive. The trial judge had directed the jury to acquit the accused, on the conventional approach that there had been consent to the sex with no mistake as to identity or as to the nature and quality of the act. But the Supreme Court's decision that deception about HIV could vitiate consent meant that a new trial was ordered, for a finding of guilt was possible given the Court's conclusion as to what counted as "fraud".²

It is true, as the judge said in *Dalley*, that *Cuerrier* is about different legislation (sexual assault rather than criminal nuisance or grievous bodily harm). That said, it is significant that the Canadian Supreme Court was prepared to recognise that careful use of condoms might reduce risk such that the "deprivation" suffered by a person – that is, the degree of risk to which they were exposed – was too low to vitiate consent and attract criminal consequences. It does not seem a big step to argue that, for the same reasons, careful use of condoms can reduce the risk so that the act of sex cannot count as a lack of reasonable care or recklessness for the purposes of New Zealand legislation. And this of course is precisely what the judge in *Dalley* did conclude. So the *Cuerrier* case is persuasive (but is not, of course, a binding precedent in New Zealand).

It is significant, also, that in Canada this class of case is always brought as one of sexual assault or aggravated sexual assault, even in cases where there is no transmission of the virus. As the post-2004 cases will show, careful use of condoms has resulted in acquittals and even unprotected sex has, in some cases, been regarded as not falling within the definition of fraud on account of the low risk of transmission due to low viral loads.

I now turn to post- 2004 developments in Canada:

(a) *R v Mabior* (2010) 79 CR (6th) 1.

This was decided in the Manitoba Court of Appeal and is currently on further appeal to the Supreme Court of Canada, with a hearing expected on February 7, 2012. It is to be heard in conjunction with an appeal in *R v DC* (Quebec Court of Appeal, 13 December 2010), a case that I mention next.

Mabior was all about the paragraph from *Cuerrier* noted above. It affirms that it has the effect I argued for in my 2004 opinion: that condom use can avoid criminal liability for aggravated sexual assault in Canada, even when there is no disclosure of HIV status.

In *Mabior* the accused had had both protected and unprotected sex with six women. Each said they would not have consented to sex if they knew the accused was HIV positive. At trial he had been convicted of aggravated sexual assault but appealed on the basis that his low viral load and use of condoms meant the acts of sex did not represent a "significant" risk to the women.

The Crown argued on the basis of consent, saying the consequences of HIV were so severe that the slightest risk was serious. In effect, this was an attempt by the Crown to narrow the *Cuerrier* approach severely.

The Manitoba Court of Appeal applied the *Cuerrier* approach, however, noting that advances in medical science – that is, ART – now have a bearing on the seriousness of the risk and, indeed, of the harm suffered by a sexual partner if the risk eventuated.

² The majority on this point comprised 4 judges. Two other judges would have said that "fraud" could not have such a meaning but were nonetheless prepared to interpret it in light of the concept of "fraud as to the nature and quality of the act" which was part of the common law. On this basis they were prepared to extend the idea of fraud as to the quality of the act so that it embraced deceit or non-disclosure about HIV in essentially the same way. The seventh judge would have held that there was fraud if there was dishonesty, *without* the requirement that there be a serious risk of bodily harm. In the result, then, all seven judges agreed that *Cuerrier* should be tried again because his deceit was well capable of constituting fraud on each of the judicial approaches.

As to the nature of the harm, the Court asked whether HIV, because it is now able to be controlled even if not eradicated, is sufficiently serious as to trigger the need for a partner to disclose. But having posed that question the Court rapidly decided it was still sufficiently serious to qualify (para 64):

Nonetheless I do not think that it can be disputed that being infected with HIV subjects an individual to serious bodily harm. Although no longer necessarily fatal if treated medically, HIV is an infection that cannot be cured at this time and is a lifelong, chronic infection. For those who become infected it is a life altering disease, both physically and emotionally.

The Court went on to note that medication must be taken every day, without which the condition is potentially lethal. It also seems that neither party argued that HIV was not sufficiently serious to amount to the level of harm that would attract liability.

I add here that I am confident that a New Zealand court would decide that point the same way, even given the current medical research. That is, it would decide that HIV is a life-altering disease even if able to be managed with medication.

This left the issue of risk of harm. The trial judge had said that even with an undetectable viral load there was still a small risk. So, too, with condom use: it could never eradicate the risk. The accused was convicted.

But the Court of Appeal held that elimination of risk is not the legal test under *Cuerrier*. True, as the seriousness of the risk went up, the chance of the risk occurring might be less for criminal liability to attach. But the legal test was not 'no risk'.

It was, said the Court, a question of fact for every case. Here the Court noted that the medical evidence showed that condom use lowered the risk of transmission substantially. Condom quality and mode of condom use were also important. On the facts of the case, there was evidence of some recklessness about using condoms (an admission that they broke several times during the sex acts, for example).

Importantly, the accused had adduced evidence of his low viral load through the period of at least some of the sexual activity. The trial judge had refused to regard this as relevant, but the Court of Appeal believed it was relevant. The Court noted a Swiss case of 2009 in which, an appeal court had overturned a Swiss man's conviction for unprotected sex (while HIV positive and without disclosure) on the grounds that his viral load was so low that it could not be quantified. Of course, the Swiss case was not a binding authority in Canada, but it illustrated the point that viral loads can rationally be very significant to determining whether a person's conduct was reckless.

The Court of Appeal pointed to the relevance of scientific advances (paras [103] and [104]):

In the decade since *R v Cuerrier*, a substantial body of scientific evidence has established that successful treatment with antiretroviral therapy can dramatically reduce viral loads to levels categorised as "undetectable" by current testing technologies, with a correspondingly measurable impact on lowering the risk of transmission. As indicated earlier, effective [ART] is defined as HIV treatment that stably renders the viral load in blood undetectable (less than 40 copies per millilitre) for at least 6 months.

Since the test in *Cuerrier* is based on a significant risk of serious harm, a trial judge must base his or her decision on what is a significant risk on the evidence adduced in front of him or her, including the medical evidence.

The Court went on to note that a viral load test is for a "moment in time" and that if a dose is missed there may come a point at which a person becomes resistant to the medication, though this depends upon a person's metabolism. Common infections and STDs can lead to fluctuations in the load, and those with undetectable viral loads might experience a sudden spike.

Against this background the Court then reviewed the evidence in relation to each charge against the accused, each corresponding to a different woman. I summarise these findings to give the sense of how the Court regarded the evidence.

Woman no. 1. Unprotected sex and viral load at around that time known to be around 6100 to 6300 copies per millilitre. Evidence was that this meant a low but still possible infectivity. Also that he had another STD at the time which heightened infectivity. The Court said a conviction was rightly entered.

Woman no. 2. Protected sex but evidence that condoms broke several times and that, in response to that, the accused did not disclose his status. (Prophylactic measures might then have been effectively taken.) His viral load was low for some of the time but not all (500 copies, consistent with low but possible infectivity, but reducing later in the relevant period to around 50 copies). Records showed he was listed as a chlamydia contact by another woman during this period. Held conviction rightly entered.

Woman no. 3. One act of protected sex and no suggestion of problems in condom use. Conviction set aside and acquittal entered.

Women 4, 5 and 6. Unprotected sex, and viral load was suppressed such that medical evidence was that he was unlikely to be infectious in this period. Conviction set aside on grounds that it could not be proven beyond reasonable doubt that there was a significant risk of serious harm around the time of this sex.

Mabior illustrates, therefore, how it is a question of evidence whether or not there is a sufficient risk of harm (such that there would need to be disclosure in order to avoid liability for aggravated sexual assault).

That confirms my 2004 opinion. The same reasons as apply in Canada, to the question whether the risk of harm is so low as to make the consent valid and the acts not illegal, will also be relevant here as to whether the acts are in breach of the duty of care in s 156.

What the *Mabior* case adds to my opinion, however, is the possibility that it is not only condom use that can fulfil the legal duty, but that evidence of low viral loads due to treatment can reduce the risk such that it is not regarded as sufficiently serious even in cases of unprotected sex (and that, as a result, the consent is not vitiated by fraud).

Two final aspects of *Mabior* are relevant. The Court recorded a doubt about whether the case ought to have been brought as *aggravated* sexual assault. To be an aggravated assault there had to be “endangerment to life”. It had been assumed in *R v JAT*, which is discussed below, that a risk of serious bodily harm (such as HIV infection) constituted “endangerment to life”. But the Court wondered if this remained the case given medical developments that suggested most HIV positive persons will die of a non-AIDS cause if they are compliant with optimal care. The Court still considered there might be serious bodily harm, but perhaps not endangerment of life. The issue was left for another day, and no final decision made. This is not an issue that bears on New Zealand law where the idea of endangerment to life doesn’t feature.

Second, and importantly, the Court expressed some disquiet about the implications of following the *Cuerrier* approach, as it had dutifully done. There seemed to be two related strains to this disquiet. One was that persons who were lied to about HIV status could well feel that “the nature and quality” of the sex act was indeed fundamentally different from that to which they consented. Even though the risk may be very small, any risk might be thought to be too big because they “could be ‘the one’”. In *Cuerrier* the Supreme Court of Canada had decided there should not be such a wide definition of fraud in the area of consent to sexual activity lest it apply too often and “trivialise the issue”. Even so, the *Mabior* Court expressed the view that in other contexts the law was well able to determine whether consent goes to the heart of the matter and can do so without trivialising the issue. I take this to be a plea by the Manitoba Court for reconsideration of *Cuerrier* by the Supreme Court of Canada, and indeed leave was granted for an appeal (quite rare in criminal cases).

The second element of concern expressed by the Court about *Cuerrier* was this: if courts are to explore what the nature of the risk of transmission is in particular cases in order to decide whether consent is vitiated by fraud (such that an offence is committed), then this can in fact be very difficult. Scientific evidence about statistical probability is one thing, but inquiries into actual cases are another. When the actual condom used is not available (almost always the case) and the sex was months or years earlier and affected by alcohol, how could the Crown prove that care was not taken if the accused is able to point to some evidence that it was? Similar issues arise with viral load evidence: the ability to show that an accused had a common infection or an STD at the time of sex that might have led to a spike in the viral load may very well prove to be elusive.

These are comments that pertain to questions of onus of proof and who benefits from the inability of the court to be really sure about the true facts. For these reasons the Manitoba Court said that the Supreme Court of Canada may well wish to revisit *Cuerrier* to provide all parties with more certainty.

Finally, in a passage not unlike one in Judge Thomas's judgment in *Dalley*, the Court said (para 156):

I am well aware that respect for one's bodily integrity would favour a legal standard that requires disclosure of facts that so closely impact on one's decision to allow physical intimacies. Everyone would want to be told that a potential partner was HIV positive. Most people would agree that there was a moral and ethical obligation to disclose that information. In reaching the conclusion that I have, I do not condone the behaviour of the accused in this case.

As I say, the Supreme Court of Canada is to hear *Mabior* in late 2011 or early 2012, in conjunction with an appeal in the next case mentioned.

(b) R v DC 2010 QCCA 2289 (13 December 2010)

The female accused was HIV positive and had had one act of unprotected sex with the complainant (who had thereupon become her partner although they were to fall out before these charges were laid). The evidence was that the accused had an undetectable viral load and that the risk of transmission was small but not non-existent.

The trial judge had convicted saying that although the risk was small the consequences of receiving HIV were severe. The Quebec Court of Appeal reversed and entered an acquittal, saying that *Cuerrier* was explicit that the test was not "no risk" and that it could not be said that any level of risk was significant. There was one act of unprotected sex, and the evidence was that the chance of transmission was 1 in 10,000. It was held that the risk was so low that the non-disclosure did not amount to fraud that vitiated the consent. The *Mabior* case was referred to.

As I say, the appeal is to be heard in the Supreme Court of Canada on 7 February 2012.

(c) R v JAT 2010 BCSC 766

In this case there were three proven acts of unprotected anal intercourse (and a lie by the accused who said he was not HIV positive when he was). He was charged with aggravated and non-aggravated sexual assault. The complainant was not infected.

The evidence was that there was a risk of transmission of 12 in 10,000. The Supreme Court of British Columbia held (in a trial by judge alone) that this risk was not material enough to establish deprivation sufficient to invalidate the consent of the complainant to sex (and so remove consent as a defence to the charge). This was not a case where treatment had reduced the viral load – the accused's ART had not yet commenced. But the viral load was known (12,000 to 30,000 particles of HV per millilitre of plasma). Evidence as to the transmission risk of 0.12% was based on that load. The judge made several observations en route to his decision: HIV is no longer synonymous with AIDS and death; treatment holds viral particles in check; decreased load means decreased risk of transmission; in the medical expert's 20 years of experience she had never heard of a case of transmission where viral loads were undetectable. In this case, of course, they were detectable. He concluded:

I am not satisfied that a 0.12% risk of transmission of a virus that, while still a serious lifelong harm, is now largely treatable, constitutes endangerment to life. It follows that the Crown has not proved aggravated sexual assault.

Turning then to plain sexual assault, where endangerment was not an element of the crime, the Court asked (as required by *Cuerrier*) whether there was "dishonesty and deprivation". Here there was dishonesty, but was there deprivation?

The Crown said yes, because the complainant relied on the accused's statement and as a result of the lie he had been exposed to a risk of HIV transmission without his consent. The judge referred to the statute which required a "serious risk". Again, he said, "a risk of transmission of HIV of 0.12% is not material enough to establish deprivation invalidating the consent of the complainant." Acquittal was entered. I note that this 12 in 10,000 statistic is not far from the 8-10 in 20,000 figure that was relevant in *Dalley* (although it then appears from the evidence in *Dalley* that the condom use lowered that figure by 85%: the defence expert said that the risk was 1 in 20,000 with a condom).

So, as in *Mabior* and *DC*, this was an instance of *unprotected sex without* disclosure being regarded as sufficiently safe as to not constitute a criminal offence. There is also the idea that contracting HIV is itself no longer as serious as it once was which seems to be a part of the equation in deciding that the risk being run was below the threshold that would negate consent. I will return to that in my conclusions.

(d) *R v Wright (2009) 256 CCC (3d) 254*

In this case the accused had been convicted at trial by a jury on 2 out of 3 counts of aggravated sexual assault. None of the three complainants had tested positive for HIV. The defence case on appeal was essentially an extension of the three cases above and involved argument about the way that the burden of proof ought to have been applied. The accused did not point to condom use, but to viral loads. But he had not put any direct evidence in as to his viral load. He was able to lead some evidence from his own doctor's records from which it appeared that he had been receiving ART in the past. But no report on viral loads was available. He argued that evidence of his being on ART raised an inference his viral loads were low and that this was sufficient to create a reasonable doubt as to whether his load was sufficient to create a risk.

The Crown's medical expert had testified as to general statistics about transmission rates. In cross-examination the defence lawyer had attempted to extract from the Crown's medical expert an acknowledgement that, in order to draw any conclusions about the true risk of transmission in a specific case, one had to know the accused's viral load. So the defence argument was essentially this: that once *some* evidence had been led that the viral load might be low, it was for the Crown to prove beyond a reasonable doubt that it wasn't.

The British Columbia Court of Appeal rejected the argument and dismissed the appeal. It said that the Crown was entitled to rely on the averaged risk of transmission in order to prove a charge. It said that the expert's evidence of transmission risk was an averaged figure taking into account all the factors affecting risk, across a large sample. These factors included, said the Court, the possibility of low viral load brought about by ART. That evidence was sufficient to justify the jury verdict. It was not necessary for the Crown to lead evidence about an accused's viral load as part of its case, when it could point to general statistics.

An accused's viral load would lie within his own knowledge. It was for *him* to adduce it as evidence if he wished to advance it to raise a reasonable doubt about his culpability based on a low risk of infection. Here the accused had not adduced sufficient evidence to generate, if believed, a reasonable doubt. True, his own doctor's record showed he was on ART in 2001 and perhaps likely to have a reduced viral load, but the charges related to events around 4 years later. There was no evidence he remained on ART during that period. Hence, said the Court, it was well open to the jury to decide, on the basis of statistics about averaged risks, that the accused presented a risk of serious harm at the time that he had unprotected sex.

Again, this supports the view that questions about reasonable care and precautions, and recklessness, will turn on the facts of cases and the expert and other evidence given. Further, that the evidence must be pertinent. If the doctor had been able to testify that the accused was on ART at the time of the offences, I still doubt that this would have been sufficient evidence to generate a reasonable doubt. I think he would have needed to adduce evidence of actual viral loads.

There are no legal principles that lay down bright-line rules such that "condom use precludes liability" nor that a reduced viral load means there can be no liability even when there is no condom use. As put by a Canadian judge quoted in *Wright* (Justice Donald in *R v T(J)* 2008 BCCA 463, actually the first instance decision in the *JAT* case mentioned above):

Cuerrier laid down a proposition of law: a significant risk of substantial harm will vitiate consent when combined with deceit. It did not, in my opinion, purport to prescribe for all cases what facts will determine the significance of the risk.

That is correct. When law (as applied by judges in interpreting statutes) contains words such as “significant”, or “reasonable precautions” (as in New Zealand) the question whether any particular risk is “significant” or whether what was done was “reasonable” is a question of fact for the jury or judge, to be decided on the evidence in the case. I return to this point in my final review below.

4. Australia

(a) *Houghton v Western Australia* (2006) 163 A Crim R 226 (Western Australia Supreme Court)

This was an appeal by the accused on several grounds against conviction for grievous bodily harm occasioned through having sex as an HIV positive person. Not all grounds are relevant to the present question.

The complainant became HIV positive as a result of unprotected sex with the accused but at the time of trial had no symptoms and needed no treatment. The question was whether she had suffered bodily injury. It was held that she *had* suffered an injury, because (so the expert medical evidence said) cells comprising her immune system had been damaged and destroyed even though symptoms had not manifested.

Was this *grievous* bodily harm? This had been left to the jury, which had found the accused guilty. The appeal court said it was well open to the jury to reach a guilty verdict because the great likelihood was that the virus would progress and develop ultimately to AIDS. Statistical evidence was adduced about the unlikelihood that a person would remain unaffected.

A further point was that the relevant Western Australian statute required that the infliction of harm be done “unlawfully”, and the issue was what that meant exactly. Did there have to be some *other* law that prohibited the conduct? Here, of course, the accused had simply had sex with the complainant and this was not unlawful in itself.

In this context, each of the 3 judges considered the meaning of “unlawfully” as it related to having sex. This led them to consider, amongst other things, the holding in *Mwai* that HIV in semen could be a dangerous “thing” such that a person breached their duty in not taking precautions to ensure it caused no harm. The unlawfulness would then lie in that breach of duty. One of these three judges doubted that *Mwai* was correct – a virus in a body could not, he thought, readily be called a “thing” that a person has under his “use or management” (to use the words of the Western Australia law). The other two, however, thought that it could.

I don’t think that this greatly affects New Zealand law, however. The Court of Appeal in *Mwai* has ruled that HIV is covered by s 156 and I do not think that will change in consequence of the observation of one judge in the WA decision. In any event, the majority of the WA Court agreed with the New Zealand Court of Appeal.

(b) *R v Reid* [2006] Queensland Court of Appeal 202.

This was a case of unprotected sex leading to transmission of the virus where the accused had lied about his HIV status. He was charged and convicted of *intentionally* causing grievous bodily harm through the HIV infection (rather than recklessly as in *Mwai*). The issue on appeal was whether the trial judge’s jury instruction about the evidence that was needed to establish the accused’s intention was correct. By majority it was held that the judge made no legal error and that it was therefore open for the jury to have decided that the accused was guilty of either intending to infect or being reckless as to whether he did infect or not (either of which could amount to intentionally infecting).

This is not germane to the issues in my 2004 opinion, which was not about intentional communication of HIV. But it does indicate how a charge of intentionally inflicting grievous bodily harm may be able to be made out on

appropriate facts. Here the accused had been HIV positive for some 16 years, without taking treatment, by the time he had sex with the complainant. He had not disclosed his HIV status when asked.

5. United States

In the USA most states have enacted specific legislation about HIV transmission and this varies significantly between states. These state statutes predate the success of ART. As a result they are not nuanced to reflect the varying risks of transmission. Nor do many distinguish protected from unprotected sex.

Rather, the usual pattern is to criminalise an HIV person who has sex with a failure to disclose. On the other hand, the statutes generally do allow consent (after disclosure) to operate as a defence, and so assume (as I do) the general ability of a complainant to give a valid consent.

Recent academic commentary on the US statutes tends to criticise the fact that these laws date from a time when HIV was invariably fatal and do not take into account the changing nature of the HIV/AIDS epidemic. I can supply copies of the literature if you are interested.

Beyond that, there is nothing of critical importance in the US developments that would affect the interpretation of New Zealand law.

REVIEW

Here I offer my comments on the current state of the law in New Zealand in light of the above.

1. Consent of complainant, if it is to operate as a defence, must be informed. The necessary information may come through disclosure by the accused, or (probably less likely in practice) in other ways – for example, when the complainant is a nurse who met the accused in the context of his treatment for HIV and so learned about his status in that way.
2. Consent must be given on the basis of actual knowledge of the accused's infection, and not simply knowledge that sex always carries a general risk of many types of infection. This is what I had assumed in 2004 but the recent UK cases require that we should be explicit about this.
3. When condoms are used it remains the case that an accused will be able to rely on scientific evidence as to risk, as well as his careful use, to raise a reasonable doubt as to whether he was reckless or failed to take care. A person who is able to adduce this evidence is likely to be acquitted. *Dalley* of course affirms this.
4. The scientific advances with ART do not introduce any wholly new element. An accused's low or undetectable viral load can be introduced into evidence and will be just one more reason why a reasonable doubt might be found to exist as to recklessness or lack of care. On the basis of the Canadian cases it is likely to be very cogent evidence.
5. The prosecution does not have to offer any evidence about the accused's viral load. They are likely to lead evidence of general statistics as to transmission. It is for the accused to adduce evidence that, if believed, can generate a degree of reasonable doubt so as to result in acquittal. As things stand, an HIV positive person who has sex without disclosure, is potentially able to be charged on the basis of general statistics about the risks of passing the virus to the partner. (I say "potentially" because if the person could produce evidence of viral load during the investigation then it may result in charges not being pressed.) If evidence of low viral load is able to be adduced, then that will form the basis for expert evidence as to the risk of viral transmission which may well lead to acquittal if it shows the risk is very low or minimal.
6. Obviously a key question, in light of the recent Canadian cases, is whether a low or undetectable viral load (whether due to ART or for any other reason) means that (when allied with expert evidence about low or negligible risk of transmission) there will be no recklessness or lack of care even if there is no disclosure and no condom use.

As to that, the Canadian cases would suggest that in principle this can be the case. It needs to be remembered though that the Canadian cases are not dealing with the same offence and statutory wording, and so I must examine whether and if so how this makes a difference.

Recall that in Canada the charges in *Mabior* and *Cuerrier* were of aggravated sexual assault and the relevant part of the legal definition was (my emphasis):

A person commits an offence when (a) *without the consent* of another person he applies force intentionally to that other person ...

Lack of consent is made an element of the offence, as it is in New Zealand for sexual violation (but not for criminal nuisance or grievous bodily harm). There then follows the list of situations in which there will be no valid consent. One is when a person submits or does not resist by reason of “fraud” – interpreted in *Cuerrier* to mean deceit coupled with “deprivation” (in turn meaning significant harm or the significant risk of significant harm). That was the context for the observation that the use of protective measures might reduce the risk of HIV transmission to the point where the lack of disclosure does not vitiate consent, and a person could not be convicted of assault or aggravated assault.

In New Zealand the relevant offences are “with reckless disregard for the safety of others” causing grievous bodily harm (s 188) or failing to take reasonable precautions and reasonable care so as to commit “criminal nuisance” (s 145).

There are differences between the Canadian and New Zealand offences. In Canada the risk of harm analysis goes to the question of consent as part of the offence, whereas in New Zealand lack of consent does not feature as an element of either offence. In New Zealand risk of harm is relevant to the standard required in order to disprove recklessness or lack of reasonable care.³ Even here, however, consent can negate criminal liability for reasons discussed above: that for reasons of personal autonomy it is accepted that persons can give consent to that which might otherwise be a crime.

The question is whether the different offences in New Zealand as opposed to Canada militate against New Zealand law going in the same direction as Canada, such that New Zealand courts might recognise that it is sufficient care, or is not reckless, to have unprotected sex when viral load is sufficiently low to make the risk of transmission very low. In New Zealand the criminality of the act of sex does not directly turn on consent; rather, it turns on whether reasonable care was taken or whether there was recklessness. But the degree of risk does become material in deciding (as we have seen in *Dalley*) whether the care taken was reasonable. The low degree of risk was the very reason that the Court found sufficient care was taken.

So each country reaches in slightly different ways what I think is the same underlying issue. In Canada it is relative smallness of risk that can mean consent to sex is not vitiated by non-disclosure. In New Zealand it is the relative smallness of risk that can mean reasonable precautions were taken (as in *Dalley*) and (perhaps, for we have only the dicta in *Mwai* to go on) that the use of condoms would preclude a charge of recklessly grievous bodily harm in cases where infection results from consensual sex.

I think there is a symmetry between the low risk that precludes a finding of breach of duty or recklessness (in New Zealand) and a low risk that precludes a finding of vitiated consent to sex (in Canada). It might be said that, because in Canada the offence is “sexual assault” or aggravated sexual assault”, there is a greater willingness to allow evidence of a diminished risk to negate liability for such a serious offence (and that there might not be the same willingness if a “lesser” charge of criminal nuisance were brought in cases where no HIV transmission occurs). But I don’t think that is a true explanation. Ultimately the issue in both New Zealand and Canada is the moral culpability in sexual transactions where precautions are taken and there is no disclosure. I think the same question is reached despite the form of the offences.

So, while the Canadian cases are certainly not precedents in the New Zealand court hierarchy, they have a bearing on how another country’s courts have assessed the true criminality of sexual encounters involving an HIV positive person who does not disclose.

³ I say “disprove” only as shorthand for “adduce evidence that if believed can generate a reasonable doubt as to whether there was carelessness or recklessness”.

The same can be said of the UK position, where the offence *is* grievous bodily harm (for transmission cases) as in New Zealand. As we saw, in *Dica* the UK court held that consent has to be informed if it is to count as a consent that negates criminal liability, but in passing the court indicated that “protective measures” taken would be material to the question whether there was recklessness. Again, that suggests that relative risk affects the standard of care as much as it does whether a consent is vitiated by fraud.

Another way of looking at the issue is this. We have seen that the courts will recognise as legally effective an informed consent to have sex with an HIV positive person. This is because they are consenting not to the infliction of grievous harm but simply to running the risk of it. The risk is not seen as so large as to render it contrary to public policy for consent to operate as a defence. Running such a risk is a legitimate choice for a citizen to make.

To return then, to the question: might the risk of transmission (established by evidence of viral loads and statistics as to transmission rates on the basis of those viral loads) be assessed so low that an HIV positive person would be held not to be reckless, and to have taken reasonable precautions, when he has sex without disclosure and without protections? The Canadian case would suggest that the answer to that question can be yes, in New Zealand, even though the offences are different.

That said, I think it would be very unwise to counsel HIV positive persons along these lines, at least at this stage. Recall that questions of recklessness and reasonable care are factual determinations made on the basis of evidence in an actual case. A person undergoing ART who believes his or her viral load is low or undetectable, but who is charged with an offence, would be placed in a position where he or she faces an evidentiary burden to lead evidence that, if believed, generates a reasonable doubt as to recklessness or lack of care. There are some practical pitfalls that a person might face in assembling this evidence: the possible unavailability of that person’s test results, or the results not being sufficiently proximate in time to the alleged offence, or the non-availability of relevant experts. Further, if people were going to act on this advice they would need to ensure they are regularly tested and are faithful to their treatment so that evidence was available if needed. It could not be gathered after a charge.

Another reason for caution is this. There is the suggestion in *Mabior*, at least, that there are reasons why the Supreme Court of Canada ought to review its *Cuerrier* decision, this time in the context of protected sex and low viral loads. The Manitoba Court hints that in its view, the seriousness of HIV transmission remains (despite its possible management by ART) and that many people might think that even a slight risk should vitiate their consent. The Supreme Court’s 1998 *Cuerrier* dictum about protected sex being sufficiently safe was not a necessary part of its decision, for *Cuerrier* was charged with unprotected sex. So when it decides *Mabior*, the Supreme Court of Canada will be facing this issue for the first time.

I think it would be wise to await that decision and take further advice when it is available, which I would anticipate to be around July or August next year.

In the meantime, I think all that has happened since 2004 affirms the view then taken, and that advances in treatment and prognosis for HIV positive persons will (to the extent they translate into low viral loads and reduced chances of transmission) be further reasons to be advanced in court as to why condom use is reasonable precaution and is not reckless.

The very nature of criminal law in this context does not lend itself to “bright line” rules such as “condom use means acquittal” or “low viral load without condom use is safe”. The relevant questions in criminal cases are all factual ones that depend on evidence in the particular case. What scientific advances do is make it more likely the evidence will be available, but they do not change the basic law (that reasonable care must be taken, and recklessness avoided).

Yours sincerely

Paul Rishworth

17 April 2012

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Dear Bruce

HIV and criminal liability: the Court of Appeal decision in *KSB v Accident Compensation Commission* [2012] NZCA 82

As agreed I write to advise how the above decision might affect criminal liability for HIV positive persons in sexual matters. In particular, the question is whether it alters the conclusions in my opinions of 2004 and 2011. Those conclusions were, in brief:

- that there is no legal principle requiring disclosure of HIV status before safe, protected sex; and
- that, in such cases, charges of criminal nuisance or grievous harm may be defended by adducing evidence of safe sex (so generating a reasonable doubt that there was breach of duty of care or recklessness).

There is also the further question of what the new decision means for cases of non-disclosure followed by unprotected sex.

Summary of this opinion

The new principle that the *KSB* case establishes is that apparent consent to sex is vitiated if (1) there was non-disclosure by the accused of his HIV status, and (2) the apparent consent was to unprotected sex. This will mean that the apparently “consensual” sex, even between long-term partners, constitutes sexual violation. The case itself concerned unprotected sex and the legal principle is expressly limited to such cases.

It follows that the *KSB* case is highly relevant to situations where there is unprotected sex and one partner, knowing he is HIV positive, does not make disclosure to the other. It signifies that, in future, Police may elect to charge such cases as sexual violation. Until now such cases have been treated as criminal nuisance (where there is no transmission, as in *Dalley*) or grievous bodily harm (where there is transmission, as in *Mwai*).

Though *KSB* was a civil case about the sexual partner’s ACC entitlements and not a criminal case against the HIV positive person, it necessarily addressed the question of the latter’s criminal liability (on which the former’s ACC entitlements depended). Hence it is likely to be regarded as authoritative as to the interpretation of the Crimes Act 1961 and the requirements of a valid consent to sexual connection.

In cases of protected sex, which was what my earlier opinions were largely about, I see no reason to revise those earlier opinions. They were to the effect that non-disclosure, without more, does not constitute proof of breach of duty, nor recklessness. Questions of breach or recklessness are issues of fact for the judge or jury in a particular case. Where non-disclosure is followed by *protected* sex (by which I mean the careful use of adequate condoms) it is for the Prosecution to discharge the burden of proving breach or recklessness beyond reasonable doubt. This is likely to be difficult. Careful use of condoms is a fact that tends to negate there being a breach of the duty of care, or recklessness. This was affirmed by the District Court's decision in *Police v Dalley* (in the criminal nuisance context). The *KSB* decision does not speak to these matters.

One particular risk after the recent *KSB* case is that, though expressed in the context of unprotected sex, the principle might subsequently be extended to cases of protected sex. I discuss this possibility but come to the view it is unlikely.

Lastly, I think that the question should be revisited after the Supreme Court of Canada issues its decision in *R v Mabior*, expected to be in June or July.

I now set out my opinion in more detail.

What *KSB* decides

KSB was an ACC case concerning whether *KSB* could make an ACC claim for mental shock suffered when she realised that her previous sexual partner had not disclosed his HIV status.

Under the Accident Compensation Act 2001 persons may claim compensation for mental shock if they were the victim of a crime listed in Schedule 3 of the Act. Sexual violation is listed, but criminal nuisance is not. In fact *KSB*'s partner had been prosecuted for criminal nuisance. But it was accepted that *KSB* could still get ACC cover if the Court were to hold that the partner's conduct *could* have justified a sexual violation charge.

This very same point had been argued in an earlier case, *CLM v ACC* [2006] 3 NZLR 127, a decision of Randerson J in the High Court. I discussed that case at pages 6 to 8 of my 2011 opinion. Randerson J had there held that consensual sex could not be sexual violation unless the partner was misled as to the "nature or quality" of the act. That expression is a term of art that appears in s 128A(7) of the Crimes Act, a section that sets out a number of circumstances in which a person's permitting of sexual activity will not be construed as consent. (It includes consent induced by threats, and so on.) Section 128A(7) deals with cases where a "consent" is induced by deceit about the nature of the sexual act, as when a person is deceived into thinking that her sexual partner is a therapist offering a medical treatment or a doctor making an intimate investigation. Such a person would not have consented to the act otherwise. But, down to *KSB* at least, it had been thought that a person who has sex with her (genuine) partner is a willing participant in the act of sex. She is not mistaken about what she is doing, even if her partner has withheld information about an HIV or other form of infection. This was the orthodoxy since the English case of *R v Clarence* (1889) 22 QB 23, a case in which it was held not to be a sexual assault when a husband failed to disclose to his wife that he had gonorrhoea.

After reviewing relevant precedents, Randerson J affirmed this orthodoxy in *CLM*. As Randerson J put it, there would be very difficult lines to draw if the courts were to hold that consent to sex could be vitiated by non-disclosure or untruths by a sexual partner. What, he asked, of lies about professional status, or marriage intentions, or about one's freedom from

genetic defects. Or of lesser communicable diseases than HIV? Could these vitiate consents too? This, said Randerson J, was an area that the courts should not enter but should be left to Parliament.

As the *KSB* case developed it was allowed to proceed directly from the District Court to the Court of Appeal so as to get that Court's ruling on the question. The High Court stage was bypassed with agreement of all concerned, it being acknowledged that the High Court judge would in all probability follow Randerson J's decision. (Technically one High Court judge does not have to follow the decision of another High Court judge, but it is likely they will do so where, as in *CLM*, the earlier decision was very substantially reasoned.)

In *KSB* the Court of Appeal now departs from Randerson J's approach and the previous orthodoxy. While the Court of Appeal recognises the difficulty that Randerson J had pointed to about sexual negotiations and the possibility of lies and untruths, it held that lies or non-disclosure of HIV status followed by unprotected sexual intercourse are capable of vitiating consent. Whether these features do or do not vitiate consent in a particular case is a question of fact for the judge or jury. In other words, there is no legal principle that the facts of non-disclosure and unprotected sex are sufficient in themselves to vitiate consent. (It may be, for example, that the evidence shows the complainant would have consented regardless of disclosure.) That said, after *KSB*, in most cases it is realistic to think that an HIV positive accused will be convicted of sexual violation if there has been non-disclosure and unprotected sex.

The Court of Appeal decision is limited to deceit or non-disclosure about HIV status.

The Court of Appeal was influenced in its conclusion by the reasoning of the Supreme Court of Canada in *R v Cuerrier* [1998] 2 SCR 371, a case I have discussed in both my opinions. It is helpful to consider that case in more detail than I have done before.

As I explained on p 8 of my 2011 opinion, the starting point is that in Canada there had been a law change, back in 1983, about when consent to sex was vitiated. Until then Canada had had a comparable law to that of the United Kingdom and New Zealand – that deception as to the “nature and quality” of the sexual act could vitiate consent. In 1983 the Canadian Parliament enacted a new law that allowed for consents in all assault cases (not just sexual cases) to be vitiated by “fraud”.

Questions then arose as to what counted as “fraud”. In *Cuerrier* the Supreme Court addressed these questions for the first time. The possibilities ranged from the narrow meaning – that “fraud” simply meant fraud as to the nature and quality of the act as had been the law in the past – to the broad meaning – that fraud now meant any deception inducing consent (and so potentially even a deception by the accused about his professional status or false promises as to fidelity and affection). All judges recognised that some limiting principle was required, for “fraud” could not be given the broad meaning without criminalising much human behaviour, and no-one felt this was the Canadian Parliament's intention.

The majority (four of the seven judges) in a judgment given by Cory J held that fraud denoted an intention to deceive accompanied by a detriment or deprivation. They went on to say that non-disclosure of HIV status would be a matter (amongst others) that would readily count as deceit, but the element of detriment further required that there be a “significant risk of harm” in the sexual act. Careful condom use was given as an example of a possible case where the risk of harm might be reduced to a level where it was not significant, such that otherwise culpable non-disclosure would not amount to fraud.

In my 2004 opinion I placed reliance on that approach. It informed my view that, in New Zealand, it would not necessarily count as criminal nuisance (under s 145 of the Crimes Act 1961), or recklessness (under s 188), if a person, knowing he was HIV positive, had sex with another without disclosure *while taking precautions by way of safe condom use*. Essentially my reasoning was that the question of breach of duty (or recklessness) was a factual question for each case and there was no rule of law that had the effect of requiring disclosure of HIV status in order to avoid criminal liability. In fact, I suggested, evidence of careful condom use could be led so as to generate a reasonable doubt that there was breach of duty, or recklessness (as subsequently illustrated by *Dalley*).

The *Cuerrier* case itself was, it is true, not about recklessness or breach of duty, but about sexual assault. But in my view it effectively turned on the same sort of concept – that the degree of risk/safety involved in the sexual act would determine whether there was “fraud”, and hence whether there was sexual assault. I suggested that, for the same reasons, non-disclosure (when accompanied by safe sexual practices) did not necessarily amount to a criminal offence under ss 145 or 188. Non-disclosure accompanied by *protected* sex was not (in New Zealand) a breach of duty, or recklessness, for the same reasons that (in Canada) it did not reach the level of a sexual violation.

In *KSB* the New Zealand Court of Appeal was effectively addressing the very same issue, although the language of our statute is different. Whereas the Canadian Criminal Code speaks of “fraud”, ours (in s 128A(7)) speaks of consent being ineffective if the partner allows the act “because he or she is mistaken as to its nature and quality”. Though differently expressed, the two approaches effectively speak to the same situation – of sex entered into on the basis of non-disclosure of HIV status.

The Court of Appeal therefore regarded the *Cuerrier* case as relevant. It held that non-disclosure of HIV status *will* mean that the consent is vitiated on the basis of a mistake as to the “nature or quality” of the sexual act within s 128A(7). That is, mistakes as to nature and quality can pertain to matters of HIV infection as much as to cases of mistaken identity such as villains masquerading as doctors or therapists. In the alternative, said the Court, they would also regard their decision as justified by s 128A(8), which reads:

This section [that is, this section setting out when “consent” will not count] does not limit the circumstances in which a person does not consent to sexual activity.

In other words, theirs was a new approach to the question of principle (“what counts as consent?”) and the legislation was expressly written so as to contemplate that Courts might develop new ways in which consent is taken to be vitiated.

In taking this approach, the Court of Appeal has adopted the limiting principle articulated by a further two of the seven judges in *Cuerrier* (rather than the four judge majority described above).

These two judges, McLachlin CJ and Gonthier J, held that there will be “fraud” if consent is induced by *non-disclosure of the accused’s infection with a sexually transmitted disease*. Theirs was advanced as a narrower principle than that of the four-judge majority. Those other judges would recognise the possibility that fraud might lie also in other types of deceit. (Though those judges’ further requirement that there be “significant risk of harm” in the resulting sex would certainly have removed almost all such cases from being criminalised – after all, deceit about the intention to marry or be faithful does not in itself make the resulting sex more dangerous). But for McLachlin CJ and Gonthier J their narrower holding (that *non-disclosure of a disease* constituted fraud) removed the need for any limiting

principle such as “significant risk of harm”, which they criticised as being too vague and uncertain to be a standard for criminal law.

What is significant for present purposes is that McLachlin CJ and Gonthier J expressly addressed the question of condoms when they formulated their approach to consent-vitiating fraud. At para [73] they said, in a paragraph explaining why their principle would not drag in (to criminal law) cases that ought not to be criminal:

[P]rotected sex would not be caught; the common law pre-*Clarence* required that there be a high risk or probability of transmitting the disease.

So, in other words, the risk of harm *does* feature, even in their formulation.

The reference to the law pre-*Clarence* is a reference to the leading English case already mentioned, in which the English Court of Crown Cases Reserved first laid down the proposition that only mistakes as to the nature of the act could vitiate consent (and that consent following non-disclosure of sexually transmitted diseases was *not* a mistake as to the nature of the act). What the Canadian judges in *Cuerrier* were alluding to was that in 1888 *Clarence* had actually represented a change in the law from the previous position whereunder non-disclosure of venereal diseases *did* vitiate consent. Their point was that, *when* that had been the law, the requirement was that there be a high probability of infection before the non-disclosure of a venereal disease could count as vitiating consent. In *Cuerrier*, then, their point was that there was no such high probability of getting HIV from protected sex.

Next, in para [74] McLachlin CJ and Gonthier J in *Cuerrier* go on to say (in the context of defending their approach against the charge that it might discourage persons from taking HIV tests):

In addition, the proposed extension of the law is relatively narrow, catching only deceit as to venereal disease where it is established, beyond a reasonable doubt, that there was a high risk of infection and that the defendant knew or ought to have known that the fraud *actually induced consent to unprotected sex*.

Once again, then, the principle is limited to unprotected sex.

In *KSB* our Court of Appeal relies explicitly on the reasoning of these two judges. Further, our Court of Appeal is itself quite explicit that the principle it establishes applies *only* to cases of unprotected sex and cases involving HIV, not other venereal diseases.

At para [98] the Court of Appeal says (my emphasis):

Accordingly, we have concluded that in the present case where there has been *unprotected* sexual intercourse without disclosure as to HIV status, the appellant’s consent was vitiated by a mistake as to the nature and quality of the act (s 128A(7)).

Further, at [89] the Court in *KSB* explicitly recognised that “McLachlin CJ said use of a condom would mean there is no fraud”. And, then, at [92] the Court said:

We do not have to go beyond the present factual situation, which involves unprotected sexual intercourse and non-disclosure of HIV status.

In effect, both the Canadian and New Zealand courts have now departed from the *Clarence* case, but limiting their departure to the situations where condoms are not used. This is the reason I do not see *KSB* as having any bearing on my opinion insofar as it relates to liability for *protected* sex.

Further, while I had relied on the four-judge majority in *Cuerrier* to fortify my conclusion in 2004 that it is not reckless or a breach of duty simply to engage in protected sex after non-disclosure (this because condom use is evidence of care and of absence of recklessness), I could just as easily have relied on the reasoning of MacLachlin CJ and Gonthier J as well. For they too, as I have explained, equate condom use to a reduction in the level or risk *such that sex after non-disclosure ought not to be criminally culpable as sexual violation*.

In fact, the difference between the four-judge group in *Cuerrier* (for whom Cory J spoke) and the two judges (for whom McLachlin CJ spoke) is very small indeed. The Cory group would prima facie include more instances of deceit within the concept of fraud but then exclude most such instances from criminality because they would not lead to serious risks of harm. (Deceit about professional status, for example, cannot lead to riskier sexual outcomes.) The latter two judges, McLachlin CJ and Gonthier J, limit the concept of consent-vitiating fraud to cases of non-disclosure of sexually transmitted disease when condoms are not used. So effectively the same result is reached by the two pathways.

What matters most for our purposes is that both groups would not have wished to criminalise, as sexual violation at least, persons who, knowing they were HIV positive, failed to disclose their status but engaged in safe protected sex.

This leaves the question whether, in the future, the *KSB* reasoning might be extended in New Zealand in a future case to cases where there has been non-disclosure of HIV status followed by protected sex. I do not see any indication that this is likely, however.

As we know, the issue is back before the Supreme Court of Canada in the context of the appeal in *R v Mabior*, heard in February and (I am told) to be decided by June or July. In that case the issue is whether the fact of low viral loads, which may reduce risk to the same level as would be involved if condoms were used, means that even unprotected sex without disclosure does not rise to the level of “fraud” because of the lack of significant harm.

In that context, it is possible that new divisions may emerge in the Court’s approach. Given the close connection between what the Canadian courts decide on this issue and what our own Courts decide, it will be important to consider the *Mabior* decision when it is released. Since it is imminent I will not speculate about it here.

Conclusion

The *KSB* case is very significant to your organisation insofar as counselling persons to practice safe sex is concerned. This is because unprotected sex coupled with non-disclosure is potentially liable to be prosecuted as sexual violation if not criminal nuisance.

While *KSB* is in one sense a case about ACC eligibility, and not a criminal prosecution, it does explicitly claim to be defining what counts as a consent-vitiating mistake for the purpose of criminal law. I do not think that a criminal court would disavow the *KSB* reasoning. It would see itself as bound by the Court of Appeal decision, even though it was in an ACC context.

It is significant in this regard that at para [5] the Court of Appeal says that the case was “initially argued” on the basis that there might be a different interpretation under the ACC legislation of what constitutes an offence in the criminal law. Then, noted the Court, the Attorney-General intervened and raised the issue of “whether non-disclosure of HIV positive status prior to engaging in unprotected sex could vitiate consent in the criminal law”. Said the Court: “We address both issues”. That is, the Court plainly saw itself as settling the position in criminal law as well as in ACC law.

Even if it had not said this, that is plainly the effect of its decision. It does affect criminal law. It is, I think, impossible for there to be a meaning of s 128A(7) as to the effect of non-disclosure in criminal cases and another meaning that applies in ACC cases.

The *KSB* case is not being appealed to the Supreme Court, because there is no right of appeal in ACC cases. (There had already been three appeals from the initial declining of the claim by the ACC review officer.)

Ironically, had the case been a criminal one against the partner of KSB for sexual violation, it almost certainly would have gone to the Supreme Court of New Zealand. I expect that if and when there is a case of sexual violation brought on similar facts it will end up in that Court, which will wish to review the Court of Appeal decision.

So the case is a big change in relation to the sexual violation offence and its possible use in cases involving non-disclosure and unprotected sex. I do not see it as auguring a change otherwise.

But I continue to think the upcoming *Mabior* decision will be of interest, as it may speak to the impact of low viral loads and what that means even for unprotected sex. *KSB* was a decision rendered with knowledge of the issue being raised in *Mabior* (see footnote 88 in *KSB*).

Logically, if it can be shown that the risk of unprotected sex is as low as it is in protected sex, the reasoning in cases such as *Cuerrier* may be different. But there is still the argument that a sexual partner ought to know of a partner's HIV positive status no matter how small the risk. That argument has not prevailed in New Zealand (the *Dalley* case) but recall that *Dalley* was a case about criminal nuisance and the duty of care (as opposed to whether the sex act was consensual) and so it did not raise quite the same issue.

That said, *KSB* does link the questions of risk and consent – in suggesting that consent is not vitiated when precautions are taken that keep the risk low.

It is likely that we have not heard the last word on this, and that is why we will await the *Mabior* decision with interest.

Yours faithfully

Paul Rishworth