Case Name:
R. v. J.U.

Between
Her Majesty the Queen, and
J.U.

[2011] O.J. No. 4143

2011 ONCJ 457

Court File No. 10-8942

Ontario Court of Justice

S.R. Clark J.

July 29, 2011.

(149 paras.)

Counsel:

Mr. J. Shime and Ms. C. Langdon, for the Defendant, J.U.

Ms. A. Esson, for the Crown.

REASONS FOR JUDGMENT

S.R. CLARK J.:--

1.0 INTRODUCTION

1 The defendant is charged with the following offences:

* on July 27, 2009, attempting to commit a sexual assault on N.-A.O., and endangering her life, thereby attempting to commit an aggravated sexual assault, contrary to s. 463(d) of the *Criminal Code*;
* on July 27, 2009, did for a sexual purpose touch N.-A.O., a person under the age of 16 years directly with a part of his body to wit: his penis, contrary to s. 151;

* during a seven day period last past and ending on June 30, 2009, committed a sexual assault on L.S., contrary to s. 271; and
* during a 60 day period last past and ending on or about the 27th day of July, 2009, sexually assaulted J.S. and endangering her life, thereby committing an aggravated sexual assault, contrary to s. 273(1).

2 The Crown has proceeded by indictment. The defendant has elected to be tried by this Court. He did not testify at trial.

3 There are three separate and distinct allegations of sexual activity with three complainants.

4 The first scenario involves the defendant allegedly sexually touching his niece, and attempting to sexually assault her by putting his penis in her anus, while in the bathroom of her residence. After all the evidence was heard, the Crown acknowledged that there was no direct evidence of either a sexual touching or a sexual assault, however, the evidence does disclose an attempt sexual assault. The defence position is that there is significant reasonable doubt on the basis of the complainant's evidence and the inconsistencies in the corroborating evidence of her mother. Furthermore, given the absence of any physical or forensic evidence, it would be unsafe to convict.

5 The second scenario involves the defendant allegedly performing oral sex and digitally penetrating the vagina of the complainant, L.S., while they were watching television in her apartment. The defence position is that she is neither reliable nor credible and that a reasonable doubt exists.

6 Regarding the third scenario, the Crown contends that the defendant committed an aggravated sexual assault by having consensual, but unprotected intercourse with the complainant, J.S., thereby exposing her to a serious risk of bodily harm. She did not know that the defendant was HIV positive, nor did he disclose this to her prior to having sexual relations. In the result, this vitiates her consent. The Crown led expert medical evidence to support this theory. The defence, on the other hand, submits that the evidence is inconclusive as to whether there was unprotected sexual intercourse at all. In any event, in the alternative, the evidence does not amount to proof beyond a reasonable doubt of significant risk of harm.

2:0 THE CHARGES OF SEXUAL TOUCHING AND ATTEMPT SEXUAL ASSAULT INVOLVING THE CHILD

2:1 Evidence of the Complainant N.-A.O.

7 She was age 7 1/2 at the time she gave her oral evidence at trial. She was just starting grade 2 at school.

8 She adopted her video statement given to the investigating police officers. It was made an exhibit at trial, as was the transcript of same. It forms part of the evidence-in-chief of this witness, pursuant to s. 715.1 of the *Criminal Code*.

9 The essence of the video statement includes the following:

> She was 6 1/2 years old at the time of the alleged offences. She lived with her mother, father, grandmother, several uncles and 1 1/2 year old brother, all in the same house. On the morning of July 27, 2009, her uncle J.U. (the defendant)

> came into the bathroom first and then she went in. As she was brushing her teeth she was just about ready to go out when he laid her on the floor, took off her pants and underwear and then got on top of her and tried to put his "Mr. Winkles" (his penis) inside her bum. She then heard her mother say "open the door". The defendant responded by twice saying "oh, she's just brushing her teeth". Her mother opened the locked door with a cordless plug and came into the room as N.-A.O. was her pulling up her tights behind the door by the shower. Her mother asked her if J.U. was hurting her. The police then came to the house. The defendant does not live at this house, but slept over the night before on the couch. She told the police that the defendant said to her that he has to clean her. She described that he laid her down on the floor and took off her pants. She told the officer that the defendant locked the door so her mother wouldn't come in. She described that "Mr. Winkles" is a part of the body between the legs. The defendant was trying to clean her with his "Mr. Winkles" on her bum. When asked how this felt when it was happening, she replied "not good". When asked how the defendant was trying to clean her with Mr. Winkles, she stated, "I don't know". She did not see any liquid coming out of "Mr. Winkles". When her mother came to the bathroom door, N.-A.O. got up and started pulling up her pants. When her mother asked her why she wasn't answering her, N.-A.O.started to cry. This is when her mother asked if the defendant hurt her, to which she replied "yes". While this was going on she believes that the defendant was washing his hands and her socks. She told the officer that the defendant never removed any of his own clothing. She told the officer about the rules regarding her private parts and that only her mother and grandmother were allowed to touch them. She told the officer that the defendant touched her in the private parts in the bathroom that morning. When asked what the defendant was doing in the washroom when she went in she replied that he was brushing his teeth, then gargled and then was just walking around doing nothing.

10 Her oral evidence at trial substantially confirmed her video statement.

11 The Crown tendered a series of photographs as exhibits showing the layout of the subject bathroom on the second floor of the residence.

12 Exhibit 2 is an agreed statement of facts regarding the medical examination of the complainant. The salient features include her being taken to the Trillium Health Centre, whereupon a sex assault kit was conducted. No injuries were noted to the labia majora and minora; the posterior fourchette and introitus; the hymen; and the anus and rectum. She was also tested for any sexually transmitted diseases, including HIV. All tests were negative. These ano-genital findings are normal, and therefore, neither confirm nor contradict the allegation of attempted sexual assault.

13 Exhibit 3 is an agreed statement of facts regarding testing. Thirteen items were seized and analyzed including underwear from the complainant, underwear from the defendant and various swabs. Semen was not detected on any of the items except for a bath mat, where a trace amount was located. The profile from the semen on the bath mat was a mixture of DNA from at least two individuals. The complainant was excluded as the source of the female. The additional DNA in the mixture was not suitable for comparison. DNA was detected on a number of other items, specifically on a pair of underwear worn by the complainant after the alleged attempt assault; an external geni-

tal/penile swab from her; and on a pair of yellow underwear worn by her during the alleged attempt at sexual assault. The DNA on the defendant's shorts was not compared to anyone. The remaining DNA was not suitable for comparison. Counsel agree that there is no forensic evidence of an assault by the defendant on the complainant.

14 On cross-examination, the complainant acknowledged that she got dressed in her room in the morning as soon as she got out of bed and before she went to the bathroom to brush her teeth and go "pee-pee". When asked if she and her mother got along in their relationship, she responded "not so good". Her mother would get mad at her sometimes, particularly when she bothered her little brother. From time to time her mother would hit her on the arm or would spank her if she did something to her brother. When asked if this happened a lot she stated that it occurred "a hundred times". She described that it was "scary" when her mother hit her and yelled at her in a loud voice. She also acknowledged that when her mother was yelling and getting mad at her that the best thing to do was to just agree with her. Otherwise, if she talked back to her it would get worse. Her mother talked to her about the rules of her body and that no one could touch her "nanny″ (meaning vagina). She described that her grandmother was downstairs on the main floor of the house telling her to brush her teeth. She believed that her mother was still asleep in her bedroom on the second floor at the time. The defendant was already in the bathroom brushing his teeth. She stated that she was not surprised to see him. She started to brush her teeth and then go to the bathroom. This required her to take down her pants and underwear. This is when she recalls her mother calling her. The defendant responded to her mother's call, by saying "Boo's in here. She's brushing her teeth." ("Boo" is the "pet-name" given to the complainant). She acknowledged that she and her mother had talked about how she should have privacy when she goes to the bathroom. She would usually close the door and lock it by pushing a little button on the doorknob. She did not lock the door on this occasion, however, because the defendant was already in there. After her mother called her she came inside the bathroom after a few seconds. Her mother grabbed her by the arm and started yelling at her. She described that this was "a bit scary". Her mother was asking her "Boo, why weren't you answering?" She stated that the water was running and maybe her mother couldn't hear her. She recalls the defendant was still brushing his teeth at the time. She started to cry when her mother was yelling at her. Her mother asked, "is J.U. touching your nanny?", and "did he touch you with it?" She then asked "did he try to put it in you?" followed by "was J.U. hurting you?" She acknowledged that she just kept quiet while her mother asked her all of these questions. She agreed with her mother because at this point she was really scared. She stated that when her mother yells and screams, this is scary and she doesn't want to say no to her because this makes her more angry. She acknowledged that this is why she agreed with her mother that the defendant was doing these things to her. Her mother held her by the arm and kind of dragged her out of the bathroom. She made her take off her pants and looked at her body. She acknowledged that it was her mother who was saying to her that the defendant put "Mr. Winkles" in her bum. Her grandmother was also angry with her. Her father was running around and stomping very hard on the floor. This was scary for her because of all the angry adults who were around. She did not believe that they were angry with her, but with the defendant. She acknowledged that she did not want to disagree with them about why they were angry with him. Finally, she agreed that she was doing a "pee-pee", and when she was pulling up her tights this is when her mother came into the bathroom.

2:2 Evidence of the Complainant's Mother, I.O.

15 The defendant is her half-brother. They have the same mother but different fathers. The defendant grew up in Nigeria. She first met him in August, 2005 when he returned to live in Canada. In July, 2009 he was living in an apartment in Brampton. He would visit her approximately once or twice per month. She heard through her mother that he was either HIV positive or had AIDs. On the morning of July 27, 2009, she was planning to go to the gym at 10:15 a.m. Her alarm went off at 9:30 a.m. She eventually got out of bed at approximately 9:42 or 9:43 a.m. At this time, she called for her daughter to make sure that she was ready to go, as she would have to take her with her to the gym class. She could also hear her own mother yelling upstairs to the complainant. She did not receive an answer. This was unusual because she always received a response from her when she called. She then heard her own mother say that the complainant was upstairs. She looked in the child's room and in her own mother's room but did not see her. She called again approximately four or five more times. She then heard the defendant say, "she's brushing her teeth". She tried to open the door, however, it was locked. She grabbed a phone charger from the outlet outside the bathroom door and used it to effectively pick the lock. She described that the complainant would usually brush her teeth and go to the bathroom by herself but would not lock the door. As she went inside the bathroom she noticed the complainant pulling up her pants while lying on the floor. The defendant was right beside her behind the door standing near the shower stall. She asked the complainant "what's going on here? Why is the door locked? What are you doing here?" The complainant said nothing to her at this point, while the defendant said, "nothing, she's brushing her teeth." He said this over and over. She noticed that there was no toothbrush in anyone's hand nor running water. She then grabbed her daughter's arm and pulled her outside of the room and asked her directly, "did he touch your "nanny?" The complainant stated, "yes", and started to cry. The defendant told her "no, no, I didn't touch her, she was brushing her teeth." She then started swearing at him, stating "what the fuck are you doing, you touched my daughter." She was calling him names such as "pervert" and "sick". This was taking place at the top of the stairs outside the bathroom. She told her own mother who was at the foot of the stairs on the main floor what she thought had just happened. Her mother told her to call the police. She went to her room to get her phone. The defendant went downstairs to speak to her mother. While on the main floor with the complainant and her own mother, she told the child to pull down her pants and open her legs. She did not see any injuries or any evidence of sexual activity. She asked the child, "where did he touch you", and "did he put Mr. Winkles on you." The child said, "yes". She then asked her "where?" The child said, "my bum". She testified that she did not suggest this to her but the complainant told her this. She described that the child's father was also upset upon hearing what had happened. She does not recall having a conversation with the child at this time as to where she was in the bathroom, however, she did have this conversation with her after the incident was reported to the police.

16 On cross-examination, defence counsel asked if her daughter would tell stories that might not be accurate or true. She stated that her daughter would not do this. Counsel then asked her that if the complainant, in her own evidence stated that her mother had hit her hundreds of times would this be accurate? She indicated that this was not so and that she had perhaps only hit her a total of ten to twenty times since she was born. She conceded that this information given by her daughter might be "a little bit excessive". She was then asked if her daughter would get scared when she hit her. She did not believe that the child would be scared since she never beat her, but just tapped her on her bottom or hand. Counsel also asked her if she thought it was scary for the child when she screamed or yelled at her. She responded that she did not believe this to be so. Counsel then questioned her

about the timing of getting out of bed and whether there would have been sufficient time for all that the defendant was alleged to have done to the child. The timeframe appears to be only 1 to 1 1/2 minutes. Counsel then asked a number of questions regarding the various photographs collectively made exhibit 5, particularly photograph #2 which depicts the bathroom door opening up almost to the shower stall. He suggested to her that if this is where the defendant and complainant were positioned, there would be insufficient room for the complainant to be lying on the floor the way she described. He also suggested that if they were behind the door it would have swung open and hit them. She disagreed with these suggestions. She also disagreed with counsel's suggestion that the complainant was not behind the door but was getting off the toilet at the time she entered the room. She acknowledged, however, that she never asked the complainant whether she went "pee-pee", nor was she ever told by her that she did. Counsel then suggested that when she grabbed the child's arm to take her out of the bathroom this would have been scary. She disagreed stating that it was, in fact, of comfort to her. Counsel suggested that hugging her might have been more comforting than grabbing her. She disagreed. Counsel also suggested that the only time she asked the child an open-ended type of question is when she first asked "what's going on" or words to that effect. Thereafter, he suggested that she was the one posing all the questions to the complainant and making statements, asking her to agree with her. He further suggested that the exchange between them was not so much the complainant telling her the details as it was her suggesting to the complainant what she believed had happened. She disagreed with all of the above. He then squarely put to her that she was the one who raised the idea about the defendant touching the child's "nanny" while with her when the child gave her video statement to the police. The child initially said "yeah", however she then shook her head in a negative manner. Counsel also reminded her that she even asked the child if her bum hurt and she said no. She agreed, however, that she was not aware that the complainant described in her own video statement the sequence of events of only brushing her teeth, then washing her hands, then having a pee and then pulled up her pants. She acknowledged that she never checked the child's toothbrush to see if what the defendant had told her was true, nor did she ever ask the child if she had a pee. For that matter, the police never asked her this either. Finally, counsel asked her again if all of this activity could have realistically happened within a minute and a half, including the defendant trying to pull down her pants and then trying to penetrate her. The witness did not directly respond to this suggestion but did state that the defendant had his hand over the child's mouth. She acknowledged that she never told the police about this, however, because she only found out about it after they had given their statements. She agreed that she never thought to call the police subsequently to give them this important information.

2:3 The Positions of the Parties

2:3.1 The Crown

17 Having heard all the evidence, the Crown invited the Court to dismiss the sexual touching charge, as there was no direct evidence that the defendant ever touched the complainant. The evidence suggests that the defendant had his shorts on.

18 Furthermore, the Crown conceded that there is no evidence of a sexual assault. However, there is sufficient evidence to make out the lesser and included offence of attempt sexual assault. The acts and actions of the defendant clearly went beyond mere preparation to penetrate the complainant with his penis.

19 The Crown acknowledges that there are some weak components to the case such as the complainant's mother using very leading questions when asking her what happened, and that she might

have been upset with the child when confronting her. Furthermore, the Crown acknowledges that defence counsel did, on cross-examination, draw out some possible innocent explanations for the defendant's presence in the bathroom.

20 Nonetheless, on the totality of the evidence, the Crown submits that all essential elements of the offence of attempt sexual assault have been made out beyond a reasonable doubt. The factors to consider include the following:

* the bathroom door was locked and it was the defendant who locked it;
* the defendant did not open it but waited until the mother had to pick the lock to get in;
* the complainant, without prompting, told her mother that the defendant tried to put his "Mr. Winkles" in her bum and never resiled from this position, even after cross-examination.

2:3.2 The Defence

21 The defence submits that more than a reasonable doubt has been raised.

22 Even the Crown acknowledged in her submissions that some innocent explanations have been raised by the defence on cross-examination. If so, this constitutes reasonable doubt.

23 Moreover, there is no physical evidence to corroborate the account given by the complainant. Although the absence of corroborative evidence does not necessarily mean that nothing happened, particularly if the offence is one of an attempt, this does make the issue of reasonable doubt more problematic for the Crown.

24 Furthermore, counsel points out the number of inconsistencies in the complainant's evidence, including whether she or the defendant closed the bathroom door, and if the water was running and the defendant was brushing his teeth at the time the complainant's mother called to her. This piece of evidence, alone, should show that the defendant was not doing anything to the complainant. Furthermore, the photographs depicting the dimensions behind the bathroom door do not allow for the scenario of the defendant lying the complainant down on the floor.

25 The defence also submits that the relationship between the mother and the complainant is problematic. The complainant acknowledged that when her mother yells at her it is best to just agree with her.

26 The Crown submitted that the complainant, having been skilfully cross-examined, was impressionable and, accordingly, would change some of her answers. Defence counsel submits that this "cuts both ways" and that the same could be said of the child being impressionable as a result of the skilful questioning by her mother.

27 The defence submits that it would be unsafe to convict on the evidence of the complainant alone. However, when considering the evidence of the mother, there is even more doubt. She tried to bolster the complainant's evidence by stating that the child was always truthful, and yet she acknowledged that the child was exaggerating about being hit by her more than 100 times.

28 More importantly, defence counsel suggests that the mother seems to be completely oblivious to the effect or impact that hitting the child would have on her. The evidence of the mother is that this would not affect the child at all.

29 Counsel also submits that the mother was pre-disposed to being suspicious and biased against the defendant. She automatically assumed the worst and put these ideas in the complainant's head. Her animus toward him when confronting him and calling him a "faggot", and telling him that he deserved to have HIV demonstrates this.

30 As well, the mother's timelines for when all of this sexual activity was to have occurred, does not "add up". If the mother woke up at 9:41 a.m., the child was not even in the bathroom as yet. Yet, some 2 1/2 minutes later, the mother then picked the lock on the door. The defence queries how the defendant could possibly have attempted to sexually assault the child, and that there would still be time for both of them to brush their teeth?

31 Counsel also asks the Court to consider that the mother was a very contrary and difficult witness who would not make concessions easily. Some of her responses to questions on cross-examination were unusual. It defies logic to say, for example, that grabbing the child by the arm rather than hugging her would be more comforting to her.

32 Counsel also asks the Court to place no weight whatsoever on that part of the mother's evidence that the defendant put his hand over the complainant's mouth. There is nothing about this in her statement to the police, nor did she even mention this in her examination-in-chief. The Court should therefore be cautious in accepting this type of "late-breaking" evidence. Furthermore, counsel submits that this demonstrates that the mother will employ such "mis-truths" in an effort to have the Court accept and believe the evidence of the complainant.

33 Finally, counsel asks the Court to consider that the Crown has tendered the whole of the statement made by the defendant to the mother which was effectively exculpatory, by telling her that he did not touch the complainant. The Crown position is that this is self-serving hearsay evidence made outside of Court and the defendant should not be able to make an unsworn statement and compel its admission into evidence through other witnesses, particularly without having to testify himself. The Crown submits that this statement should not be accepted for the truth of its contents. Support for these propositions are set out in the cases of R. v. Simpson, [1988] 1 S.C.R. 3 and R. v. Rojas, [2008] 3 S.C.R. 111. The defence submits, on the other hand, that the Crown did not specify or qualify that this statement was only to be used as narrative. The Crown did not have to tender this statement at all. The fact that the Crown did, means that it can be properly considered, weighed, and evaluated along with all of the other evidence.

2:4 Analysis

34 This incident turns on whether the reliability and credibility of the complainant and her mother, in the absence of any forensic evidence, is sufficient proof beyond a reasonable doubt.

35 Corroborative forensic evidence is not required in order to be satisfied that a charge has been proven beyond a reasonable doubt. However, the lack of same renders the analysis that much more of a contest as to which version of the facts the Court should accept.

36 The Court must, of course, direct itself to the proposition that it cannot reverse the presumption of innocence by presuming the guilt of the defendant.

37 The Court must also direct itself as to the way in which it should assess and evaluate the testimony of a young person. The case of R. v. B.(G) (1990), 56 C.C.C. (3d) stands for a number of propositions. First, the Court should take a common-sense approach when dealing with the testimony of a young child, and not impose the same exacting standard as it does on adults. However,

this is not to say that the Court should not carefully assess the credibility of a child witness. The standard of proof must not be lowered when dealing with children. However, a flaw, such as a contradiction in a child's testimony, should not be given the same effect as a similar flaw in the testimony of an adult. While children may not be able to recount precise details and communicate the when and where of an event with exactitude, this does not mean that they have misconceived what happened to them and who did it. In recent years, the Courts have adopted a much more benign attitude to children's evidence, lessening the strict standards of oath-taking and corroboration.

38 To the extent that credibility assessment demands a search for confirmatory evidence for the testimony of the complainant, such evidence need not directly implicate the defendant, or confirm the complainant's evidence in every respect. The evidence should, however, be capable of restoring the Court's faith in the complainant's account.

39 Although the Court is prepared to find that the child was endeavouring to field the questions in both her videotaped statement to the police, and in her oral evidence, such that her credibility may not be impeached, it is more the reliability of her evidence which is problematic and wanting.

40 The Court cannot be satisfied that her recall of the events is independent and not that of her mother's.

41 The existence or absence of a motive to fabricate is a relevant factor to be considered. The Court finds that in her zeal to buttress the evidence of her daughter, the mother exposed her animus and bias toward the defendant. She did not receive details of what happened by asking open-ended questions of the complainant. To be fair, she is not to be faulted necessarily for doing so, since she was obviously concerned about what may have happened to her daughter. Surely, she should not be required to consider, to a nicety, how she should have conducted her inquiry. The Court should not employ a similar standard as if she were an investigating police officer, for example. Nonetheless, given the heightened emotions of the mother, including swearing and yelling, which were clearly intimidating, it would appear that virtually any suggestion made by her to her daughter would have resulted in the child merely agreeing with most anything and everything.

42 Furthermore, in assessing the mother's credibility, the Court found her responses to some of defence counsel's penetrating cross-examination to be illogical, and at times, bordering on absurd. For example, for her to maintain that her daughter would not be scared by her yelling and grabbing her by the arm was disingenuous and exposed the mother as being careless with the truth. The Court also had the sense that the mother felt that she was being "trapped" or "pinned down" by defence counsel, and was trying to anticipate where he might be going with his line of cross-examination, so much so, that she was "sparring" with him, rather than just giving her evidence.

43 Furthermore, the Court finds the sequence of events as set out by the mother are internally inconsistent. Rising from her bed, calling out her daughter's name, and then having to force her way into the bathroom did not provide sufficient time for all of the alleged acts by the defendant to have taken place. Furthermore, her exchange with defence counsel about the amount of room behind the bathroom door in the shower was circular and almost farcical. Considering the photographs, it is very unlikely that this is where the defendant and complainant could have been as there is so little space to have been lying on the floor in this area.

44 Furthermore, it is quite telling that the mother never asked the complainant if she ever peed, nor did the police. Yet, in her own evidence the complainant stated that she did.

45 In the final analysis, there is certainly suspicion as to what may have been taking in the bathroom. For the door to have been locked, and for the defendant to merely call out and not open it in an effort to show the mother that nothing was going on, adds to this suspicion. However, the Court is unable to determine to the requisite threshold that there was an attempted sexual assault, or any sexual assault.

46 Accordingly, this charge is dismissed.

3:0 THE CHARGE OF SEXUAL ASSAULT INVOLVING THE COMPLAINANT, L.S.

3:1 Evidence of the Complainant, L.S.

47 She met the defendant in the spring of 2009. She lived for a period of time with her father in the same building as the defendant and his roommate, I.P. At the time, she had been involved in a relationship for approximately three or four years with a man named Nash, who was the father of her 3 year old son. She has three other children, two boys ages 5 and 9, and a 14 year old daughter. Her first meeting with the defendant was when he opened a door in the apartment building for her when she was carrying in groceries. They became friends over time. She was in his company approximately three to five times in total. She described that this was not a romantic relationship. She would visit him in his bedroom usually in the evenings. The visits would usually include talking about various subjects. At times she would ask him for cigarettes. On one occasion they watched part of a movie. She described that she enjoyed the visits and thought that the defendant was "good guy". Through their discussions she learned that he was schizophrenic. She was interested in this because her own mother was similarly affected. She believed that people with this affliction need a friend to talk to.

48 The alleged offence took place in the afternoon in the defendant's apartment. Initially, she thought that it occurred around the end of May. After her memory was refreshed by reference to the transcript of her audio statement to the police, she recalled that the incident occurred at the end of June. They were in the defendant's bedroom, talking. He was watching a porno movie. He then started to touch her. She told him that she did not want to be touched "that way". He still persisted. She did not recall him saying anything at the time. He then locked the bedroom door. She told him that she did not want him to do this. She started swearing at him and asking "why are you doing this ... get off me ... I have kids ... I'm your friend". The defendant then put his hand down her pants and tried to pull off her shorts. He then tried to perform oral sex on her. She did not recall if he was clothed. He then touched her genitals with her hands. She told him "no ... no", using a yelling or heavy voice. His reaction was to just look at her. He did not stop at first. She was asked if he penetrated her in any way. She stated that he did not. He put his "force" on her and held her down in her chest area. She tried to push him off with her hands although she became tired and was not successful. She could not recall if she used her feet to push him away. She did not recall what was next in sequence as it had been a while since it happened. She then left and went downstairs to her father's apartment. She did not see the defendant again after this incident. She described that she was angry with him because he betrayed her trust. Thereafter, the defendant came down to her apartment on more than one occasion in an effort to see her. She had her brother speak to him at the door telling him to go away because she did not want to speak to him. The defendant also tried to contact her by

telephone, however she never responded. She explained that she did not initially report the incident because the defendant was still her friend and she did not want to get him in trouble. However, when she heard about another incident between the defendant and one of his family members, she was angry because she now realized that he could affect someone else. She was subsequently tested for HIV, with negative results. She acknowledged that she did not have a clear memory of the incident because it was a long time ago. She also stated that she had "lots of stuff" happening in her life since this incident. After refreshing her memory by listening to the tape of her statement to the police, she testified that the defendant fingered her, while he said words to the effect, "oh ... I want it ... please ... I want it."

49 She stated that at no time did she want him to do this to her.

50 On cross-examination, she acknowledged that after this incident, she started to hear information that people were thinking that she and the defendant might be boyfriend and girlfriend. She also acknowledged that she and the defendant were having a dispute over money, and that they had discussed her obtaining or purchasing marijuana for him. Defence counsel skilfully pressed and challenged her on a number of frailties and inconsistencies in her evidence. She testified that she blocked out most of the things that had happened to her which is why she did not have good recall. She also stated that she had had a tumour. She was also challenged as to why she initially testified that the defendant did not penetrate her. She described that she thought this meant his penis. Counsel also pointed out that in her statement to the police she told them that the defendant tried to lock the door, while in her oral evidence at trial, she stated that he actually did so. Counsel also challenged her on why she did not tell the defendant's roommate, I.P., or another individual named Sonny, or for that matter, her own brother what happened. She stated that she did not want to get the defendant in trouble. When challenged about the inconsistency in telling the police that the defendant tried "oral" on her, while in her trial evidence testifying that he actually did, she stated that her memory was now coming back to her. Counsel suggested to her that her "story" seemed to be growing each time she told it. She disagreed, stating that it was just the truth. Counsel also suggested to her that she told this story to the authorities about what happened to her in an effort to protect her reputation. She disagreed. Counsel also suggested to her that the reason why she didn't tell anyone is because it never happened. She disagreed.

51 On re-examination, she was asked what she meant when she told the authorities that the defendant tried to lock the door. She responded, "it's the state of my words." meaning that she might not have said it the right way. She maintained, however, that he did lock the door.

3:2 The Positions of the Parties

3:2.1 The Crown

52 The Crown acknowledges that the complainant had some difficulties with her recall of some of the details of the incident, including the date of the offence, and in telling the authorities, at first, that the defendant did not penetrate her. However, after having her memory refreshed, she testified that he digitally penetrated her. The Crown asks the Court to consider the demeanour of the complainant when giving her evidence. She was visibly upset and crying when she testified that the defendant fingered her.

53 Despite having some memory problems and difficulties in recall, the Crown submits that the complainant was quite clear in her evidence regarding the defendant forcing himself on her, per-

forming oral sex on her, and in her telling him in no uncertain terms that she did not want him to do this or be touched in this way.

54 Furthermore, the Court should accept her explanation as to why she did not notify the authorities initially, and why she finally disclosed what had happened once the police contacted her.

55 Finally, the Crown submits that the complainant had no motive to fabricate and, in fact, was quite sympathetic to the defendant, recognizing that he had a mental illness.

3:2.2 The Defence

56 The thrust of the defence position is that the credibility and reliability of the complainant are so fragile that it would be unsafe to convict.

57 Regarding the complainant's credibility, although she may not have had any overt animus toward the defendant, she had a significant motive to fabricate. People in her apartment, including the landlord, were talking about she and the defendant being in a consensual relationship. If this information got back to her current partner, Nash, this might create problems in theirs.

58 Furthermore, counsel submits that her evidence is rife with inconsistencies, including the following:

* her inability to remember the date of the incident;
* her inability to remember whether the defendant locked the door;
* her inability to remember whether he held her down once or twice;
* her concession that her story was "growing" over time;
* stating only for the first time in her oral testimony that the defendant tried to pull her shorts off; and
* her concession that the defendant's roommate may have been in the room at the time of the incident.

59 Therefore, the Court should be suspect of the overall quality of her evidence. For her to have indicated that she will never forget what happened and then be so inaccurate in her memory and recall is problematic. Furthermore, defence counsel submits that it is illogical for the Court to accept her explanation that her memory somehow improved over time.

60 Regarding the complainant's reliability, counsel queries why the complainant would be involved at all with the defendant when she is clearly in a relationship with a partner? Once she realized that she had everything to lose by having consensual sexual relations with him, this might now jeopardize this current relationship. Therefore, in an effort to protect her reputation, she had to make it sound non-consensual. Furthermore, counsel asks how could she not know the date of the alleged incident? Why would she not have told anyone about it? Furthermore, when the police first attended at her residence to take a statement, she initially told them that she never had sex with the defendant, or at least he never penetrated her, but he did try to have oral sex. This ought to have been the time to have told them everything.

3:3 Analysis

61 The Crown must prove beyond a reasonable doubt that the defendant intentionally applied force to the complainant; that she did not consent to the force applied; that he knew that she did not consent to the force applied; and that the force took place in circumstances of a sexual nature.

62 The defendant is presumed to be innocent. The Crown bears the burden of proving his guilt beyond a reasonable doubt.

63 There is no presumption that the complainant is credible, nor is there a duty on the defence to have to demonstrate weaknesses in her evidence. Rather, the burden on the prosecution carries with it the duty to convince the Court that the complainant's evidence is honest, reliable, and true in its essential particulars.

64 The Court must be mindful that inconsistencies on relatively minor details are to be expected and do not necessarily affect the overall integrity of the evidence. However, inconsistencies on the more important major issues may expose a carelessness with the truth.

65 The Court has very carefully considered the myriad inconsistencies pointed out by defence counsel. Some of them, on their face, tend to defy credulity, such as not remembering the date of the incident. Another is misconstruing the question of whether the defendant penetrated her. The complainant initially said no, because he did not use his penis.

66 Furthermore, although it is a truism that one's memory is usually better at the time a statement is given to the authorities as opposed to a year later when giving oral evidence at trial, a statement does not necessarily represent all of the detail that might be heard. It is, of course, open to the Court to consider details only brought up for the first time at trial perhaps being as a result of exaggeration, revisionism, or a memory that allows the account to evolve over time. It is also quite probable that the dynamics surrounding the taking of a statement, and the dynamics of giving oral evidence in Court can oftentimes be quite different. Providing a statement to the authorities shortly after an incident very much depends on the state of mind of the complainant at the time, and even the investigative techniques employed by the investigating officers. There is no specific evidence in this trial as to the "atmospheric conditions" surrounding the taking of the statement of the complainant, and accordingly, the Court can only speculate in this regard.

67 The Court has also very carefully considered the manner in which the complainant attempted to field questions, both in examination-in-chief, and cross-examination. Her mood and demeanour was solemn. She endeavoured to listen to the questions asked of her before responding. In examination-in-chief, she stated that the defendant did not put anything in her, while on cross-examination she stated that he put his finger or fingers in her vagina. When asked further by defence counsel how this could be, her response was that she thought that the question asked of her in examination-in-chief was whether he put his penis in her. She was able to field defence counsel's question quite nimbly by giving back to him what the Crown's actual question was to her. On first blush, her actual response, which was "I said he did not put anything in me," then adding "I never said he didn't put his finger in me" sounded as if she was being argumentative with defence counsel. However, the Court did not have this impression at all. This was her interpretation of the question. In retrospect, it is perhaps somewhat surprising that she did not respond more fully by disclosing the digital penetration. However, the fact that she did not, in this Court's view, is not fatal to the integrity or reliability of her evidence otherwise.

68 The Court has considered the somewhat contrarian position that the complainant's memory got better with time. It is not altogether surprising that her full account came out in a piecemeal fashion, once she had time to reflect. It may also have to do with the specific questions put to her in the investigative stage, versus the trial stage.

69 The Court has also given consideration to the fact that she did not seem to know the date or the month in which this incident occurred. On the face of things, this is unusual, because most people who have gone through such a significant and traumatic event will ordinarily be aware, temporally as to when it occurred. In the circumstances of this case, however, it is really of no moment. What is important is that she was able to anchor a time or timeframe as to when this incident occurred, once she had spoken to a lady she met at a barbecue who happened to be the complainant in relation to the third incident (which will be addressed next).

70 The Court is satisfied that the complainant was not being careless with the truth. Although some of her evidence, discussed above, was lacking in detail, other aspects tended to demonstrate that she was not merely telling a generic or formulaic story, but was trying to particularize the details of this specific incident. As a small example, she stated that the incident occurred during the day although she usually met the defendant on other occasions in the evening.

71 In the final analysis, the Court is satisfied that the defendant intentionally applied force to the complainant, licking her vaginally and inserting his finger in her vagina. The Court is also satisfied that the complainant did not consent. She attempted to resist his advances. Furthermore, the Court finds that her state of mind telling the defendant that she did not want him to touch her this way definitely shows that these acts were not consensual. Furthermore, the Court finds that the defendant must certainly have known that the complainant did not consent to the force that he was intentionally applying. The complainant's words and physical gestures in an effort to push him off is clear and unambiguous evidence of this. Finally, there is no doubt that the defendant intentionally applied force in circumstances of a sexual nature such that the complainant's sexual integrity was being violated. The acts performed by the defendant were meant to degrade or demean the complainant for his sexual pleasure.

72 Accordingly, the Court is satisfied that the Crown has proven all of the essential elements of a sexual assault beyond a reasonable doubt. There will be a finding of guilt.

4:0 THE CHARGE OF AGGRAVATED SEXUAL ASSAULT IN INVOLVING THE COMPLAINANT, J.S.

4:1 Introduction

73 The charge of aggravated sexual assault centers around the defendant having consensual intercourse, both vaginal and anal, with the complainant on three occasions. On two of them, he wore a condom. On the third occasion, the Crown alleges that he did not, while the defence submits that the Crown has not proven this fact beyond a reasonable doubt.

74 The essential legal issue in this case is whether having unprotected intercourse, and not ejaculating constitutes a significant risk of bodily harm to the complainant? If so, the defendant had a duty to disclose that he was HIV positive, and in the absence of doing so, this vitiates the consent otherwise given by the complainant. If not, the defendant had no such legal duty to disclose his medical condition, in which case he cannot be found guilty.

75 Counsel agree on the following facts:

1. The defendant is HIV positive. He has known this fact since 2005. He was advised by Public Health to disclose his HIV status before any involvement in any activity that could lead to transmission, including any form of unprotected sexual intercourse.
2. Unprotected anal or vaginal intercourse with ejaculation, by a person who is HIV positive, who has not informed his sexual partner that he is HIV positive, constitutes an aggravated sexual assault because it endangers life, poses a significant risk of bodily harm, and vitiates consent.
3. Protected vaginal or anal intercourse with a person who is HIV positive does not pose a risk of significant bodily harm.
4. The defendant's statement to police on July 27, 2009 was voluntary. There are no *Charter* breaches alleged regarding the circumstances regarding of the taking of a statement.

4:2 Summary of the Evidence

4:2.1 Evidence of the complainant J.S.

76 She first met the defendant through one of her neighbour's friends. They developed a sexual relationship over a period of approximately 1 1/2 months. She had sexual relations with him on three occasions. This took place in the defendant's bedroom. They would usually consume some beer and marijuana, watch movies and then have sex. This included both vaginal and anal intercourse. She also described that the defendant "went down on me" meaning that he performed oral sex on her. She testified that he used a condom twice, and on one occasion they had both vaginal and anal intercourse without him using a condom. She believes that he never ejaculated in her. She was not taking any birth control pills at the time and did not want him to ejaculate in her. She is unaware of whether any fluids passed between them during intercourse. The sex was always consensual, however, she did not know at the time that he was HIV positive. She only discovered this when she was interviewed by the police on July 30, 2009. She never had any conversations with the defendant whatsoever about him being HIV positive. She did not notice him taking any medication or appearing sick while in her company. She stated that if she had known his condition, she would not have agreed to having sex with him. She described that they would basically get together to have sex and she did not consider that they were in any kind of a relationship. Subsequently, she followed a medical protocol, took medication, and did follow-up medical examinations in October, 2009 and March, 2010. It is her understanding that she never contracted any disease. On the occasions when a condom was used, she supplied them. On the occasion where no condom was used, this was because she did not have one with her. The parties never discussed whether or not to use one. This was her idea. She would merely provide one to the defendant who did not object to using it. When she was made aware of the defendant's condition, described that she was angry, shocked, upset, felt betrayed, and had mixed emotions.

77 On cross-examination, both alcohol and marijuana was consumed prior to each sexual liaison. She acknowledged that she did not have a crystal clear memory of all of the details of the events. She recalls however that she consumed no more than three beers when she had sexual relations with the defendant the first time. She recalls that a condom was used on this occasion. On the second occasion, she believes that one was not used. She is not sure of the exact date when this occurred, however it was approximately a week after the first time. She does not recall how many beers she would have consumed on this occasion, but believes it was not a lot. On the third occasion, she con-

sumed no more than two or three beers. She acknowledged drug use as well on all three occasions. She acknowledged that she had been a cocaine addict from the age of 24 to 25 and was hospitalized for a period of time for rehabilitation. She is presently 28 years of age. She used hash while in her teens and used acid on one occasion at the age of 25 or 26, after she overcame her cocaine addiction. While involved with the defendant, she formed the impression that he was not very social or outgoing. She had a general feeling that he was not a "normal" person and was a little bit "off". She acknowledged that she has previously suffered mental illness relating to schizophrenia, commencing in 2007. She has been taking medication as an anti-depressant for paranoia since June or July of 2009. She stated that she was not aware of there being any memory issues with these medications. She acknowledged that it is not a good idea to mix alcohol with any of her prescription drugs. Although she did not disagree with defence counsel's suggestion that mixing alcohol, marijuana and prescription medication might affect her memory, she did recall the three occasions when she had sex with the defendant. She testified that she was certain that there was one occasion of unprotected anal intercourse, because the defendant had a packet of "lube" (lubrication). She also recalled that she was lying her on her front while the defendant was behind her. Counsel suggested to her that the defendant could have reached up and put on a condom and that she would not have been able to see this. She disagreed, stating that she was able to see him. Counsel pressed further that in light of her memory issues, the defendant could have used condoms on each occasion. She disagreed, stating that she could remember the details of the way in which they had sexual relations. Counsel pointed out that many of her answers to the police when giving her statement were qualified by saying "I believe so". Counsel suggested this meant uncertainty on her part. She responded that she was embarrassed at the time and was nervous having to deal with the police which is why she used these qualifiers. Counsel also suggested to her that if she was forming her own impression that the defendant was not her "kind of person" and was a little bit "off", it would not be logical for someone like her to want to have sex with such a person unless one's Judgment was impaired. She responded that the defendant was more "into" her than she was in him. To her, it was just about having sex with him. She did not really care about any of the other information she was hearing about him, or her impressions of him.

78 Defence counsel was given leave to recall the witness to ask her about a charge of possession for the purpose of trafficking and possession of cocaine. The original charge was laid in December, 2008, and was ultimately withdrawn against her on July 16, 2009. Counsel submitted that her using cocaine for a six month period prior to her involvement with the defendant could have affected her memory and credibility, particularly where she stated so clearly that the defendant did not use a condom on one occasion. On further cross-examination, she testified that the last time she used cocaine was in early 2008. Her arrest in December of that same year was as a result of her visiting an ex-boyfriend. She believed that he had quit using drugs which is why she agreed to visit him. She was unaware of there being drugs in his residence when the police attended and made the arrest.

4:2.2 Evidence of Dr. James Moore

79 The defendant is a patient of Dr. Moore. He was referred to him by the Department of Public Health in the fall of 2005, having been diagnosed as HIV positive. The defendant was seen by him between November, 2005 and May, 2009. He referred the defendant for specialized treatment to Dr. David Richardson. Dr. Moore remains as his family doctor. He testified that he discussed the defendant's diagnosis with him on more than one occasion, including the nature of the condition, and the consequences of having it, including the fact that once infected, he would always have it, but that it could be managed over the long-term. He also specifically addressed the issue that there could be

potential infection to all of his sexual partners, and to therefore wear a condom, and to tell all of his partners of his condition. Dr. Moore told the defendant all of this during their first meeting on November 22nd, 2005. He recalls that they spoke at length. He does not recall specifically talking with the defendant about the worst possible consequences, although he believes that he probably stated that if he remained untreated, there was risk of creating "opportunistic infections", which occur in individuals who have immune suppression. He does not specifically recall if they talked about the consequences of not wearing a condom and not informing his partners of his status, although he knows that he did talk about the consequences of a partner being infected. He does not recall the defendant having any specific questions of him other than asking him how he could have become infected. The reason why he told the defendant about the possible consequences is because the defendant needed to know this to avoid affecting other people; so that he knew the risks to his own health; and to tell him about the legal consequences of infecting others. He emphasized to the defendant the moral and legal obligation to disclose to his partners and to wear condoms so that his sexual partners would know that there was a risk and to allow them to decide if they wished to undertake this. The doctor was aware that there is legal precedent in this area and he specifically told the defendant that he could be convicted (he actually meant charged) with aggravated sexual assault if he did not disclose his disease, or did not wear condoms. He does not believe that the defendant asked him any questions about this. He also specifically told the defendant that HIV could be transmitted through anal or vaginal intercourse and that these were the "high risk" activities for transmission of HIV if unprotected. He did not recall if he and the defendant discussed transmission of HIV orally, but he did discuss transmission by blood. He does not recall either if he discussed the impact of ejaculation with the defendant, although he does not believe that he did. He does not recall either whether he talked to the defendant about notifying public health or other authorities as to who his sexual partners were. He further described that between November 2005 and May 2009, the defendant showed symptoms of having HIV including an anal wart infection and a positive skin test, as well as swollen lymph nodes. The defendant also told him that prior to their first meeting, he had fever, headaches, sweats, itching, dizziness, and abdominal pains. None of these were evident, however, on the first meeting. Dr. Moore prescribed anti-depression medication and medication for tuberculosis. He also administered treatment for warts. He does not know if the defendant ever took any antiretroviral treatment although he understands that he did so subsequent to his incarceration.

80 On cross-examination he acknowledged that he would not have told the defendant to not have sex with anyone, but just to use a condom to avoid the exchange of bodily fluids. The condom would block the transmission. If protected, the HIV virus could not pass through. He described that he and the defendant met on 12 occasions.

4:2.3 Evidence of Dr. Mario Ostrowski

81 He has participated in researching and writing 59 medical articles, the majority of which pertain to the science of HIV. His sub-specialty and research focus is in trying to develop a vaccine for HIV. 45% of his work involves actually seeing patients with this virus. He has previously testified on three occasions, twice in relation to pathology, and once in relation to HIV. He has been previously qualified as an expert in the science of HIV.

82 Exhibit 9 is a statement of facts presented to Dr. Ostrowski as the basis for his opinion. They are as follows:

> The complainant is an adult woman who had a brief consensual sexual relationship with Mr. J.U. over a period of approximately 60 days ending on or about July 27, 2009. I'll refer to the complainant as JS. JS did not know that Mr. J.U. was HIV positive. She testified that she would not have had any sex with him if she had known that he was HIV positive.
>
> JS testified that she had intercourse with Mr. J.U. about 3 times, twice with a condom and on one occasion, without a condom. She testified that on that one occasion she and Mr. J.U. had both anal and vaginal intercourse without a condom. Because she was concerned about pregnancy she told Mr. J.U. not to ejaculate inside her. She testified that as far as she knows, Mr. J.U. did not ejaculate inside her. He "pulled out" and went to the bathroom where she believed he ejaculated. She could not say for certain whether any fluid passed from Mr. J.U. to her. There is no evidence about cuts or abrasions at the site of possible HIV exposure. The relationship ended because JS was not interested in seeing Mr. J.U. anymore. On July 20, 2009, about two weeks after JS last saw Mr. J.U., she was interviewed by police and learned that Mr. J.U. was HIV positive. JS was tested for the virus 3 times between July 2009 and March 2010. The tests were negative.
>
> Mr. J.U. was diagnosed as HIV positive in 2005. HIV related diagnoses were generalized lymphdenopathy, anal warts and a positive TB skin test. He was followed by his family doctor Dr. James Moore in Mississauga and by infectious disease specialist Dr. D. Richardson in Brampton from 2005 until his incarceration on these charges July 27, 2009. Antiretroviral therapy was first "recommended" to Mr. J.U. on June 24, 2009. He did not begin this therapy until after his arrest.
>
> On October 3, 2008, Mr. J.U.'s viral load was 2919 copies/mI and his CD4 count was 490. On February 17, 2009 his viral load was 2281 and his CD4 count 360. On June 18, 2009, his viral load was 2426 and his CD4 count was 340. His next tests were in September 2009, after he began the ARV's and after the sexual assault.

83 Exhibit 10 is the opinion letter provided by the doctor. He was asked to provide a written opinion about the risk of transmission of HIV, in particular, sexual activity alleged in this case, that is, one act of vaginal and anal intercourse without (known) ejaculation.

84 His opinion letter answers the specific question as follows:

> The acquisition of HIV from sexual exposure has been extensively studied by epidemiologic investigations in both heterosexual and homosexual individuals. Although one cannot accurately predict the risk of acquiring HIV infection for a given individual due to the inherent variability among people, one can estimate a general risk of transmission based on looking at the average rates of infection in epidemiologic studies. From the information given, one can do such an estimate.

JS had sex 3 times with Mr. J.U. (U). The one time, was noted to be the higher risk exposure as condoms were not used, thus we will examine this exposure test. For the vaginal intercourse event, given U's HIV viral load of about 2000-3000 copies /ml range estimated at the time of intercourse, the risk of acquiring HIV infection in that coital act is 0.0013 or 1/769 average. As I do not know the age of U, it could be estimated to range from 0.0007 (1/1429) if U is older than 35 years old to 0.002 (1/500) if younger than 24 years old. It has been generally shown that the likelihood of transmission is related to HIV plasma viral load in the infected individual. Individuals on antiviral treatment who have undetectable plasma viral loads would thus have the lowest rates of transmission, although not 0 because HIV virus can be detected in semen even when the infected person is on treatment and has no virus detectable in blood. These estimates are based on a seminal study published by Gray et. al THE LANCET * Vol 357 . April 14, 2001. There is no evidence that not ejaculating during sex reduces the risk of transmission, as one would predict, and in fact there have been studies suggesting that "believing withdrawal to be safe" can be a predictor of transmission. Studies, suggest that the rate of transmission is likely to be similar whether one ejaculates or not, probably because virus is likely present in pre-ejaculatory fluid. (Kippax S et. al. AIDS care 1998, 10;677-88, Calzavara L et. al. A. J of Epidemiology 2003, v157, p20-217). For the anal intercourse exposure, the risk has been predicted to be higher. Based on U's viral load, the risk of transmission from anal intercourse would be about 0.0025 or 1/400 according to a meta-analysis examining the rates of infection after anal intercourse (Baggaley et. al. International Journal of epidemiology, 2010, v39 p1048-63 supplemental data). The other two encounters were associated with the condom use, and thus, those exposures would have been associated with an 80% reduced risk compared to the non-condom exposure and thus much lower risk of acquiring infection. It is unclear whether one should group the activity of the one unprotected episode as two separate coital acts, since both vaginal and anal intercourse occurred. If they are taken together as two separate acts then an estimated risk of JS acquiring HIV infection from U would be predicted to be (0.0013 +0.0025) .00038 or 1/263. If we assume that event was one 'coital' act then the risk would be estimated based on the most risky behaviour, being the anal intercourse, thus still at 1/400. It should be noted however that this is a general estimate of risk based on epidemiological studies. Also, there are a number of factors also shown to increase risk such as the presence of other STDs, such as herpes virus or ulcers, and circumcision has been shown to lower the risk of transmission.

85 In his examination-in-chief, he responded to a number of pertinent questions as follows:

* How is HIV transmitted? This is a virus, mainly transmitted sexually, either through penile, vaginal or anal intercourse. It can also be transmitted by exchange of blood intravenously.
* What factors influence the likelihood, or decrease the likelihood of transmission? If there are breaks in the genital mucous membranes there is more likely risk of transmitting the infected fluid from one person to the other. As an example, if one has genital ulcers, like herpes, this could also

increase the risk of both transmission and actually getting the infection. An inflammation in the genital tract can enhance transmission of the virus which actually thrives in inflammatory cells. Furthermore, if one has higher levels of virus in their blood they are more likely to transmit the virus. On the other hand, if there are barriers, for example, a condom, this will markedly decrease the risk of transmission. Furthermore, if one is on antiviral treatment this can also reduce the amount of virus in the blood, which usually translates to reduced amount of virus in the genital secretions, either the semen or the vaginal tract if the woman is transmitting.

* What is viral load? This is a test which was developed in 1995 to identify the actual structure of the virus. It is a nucleic test which measures the amount of virus RNA copies in a person's blood. This number actually tells how many virus copies are present in an individual's blood. They are usually measured as a number per mil of plasma. The reason why the test was first performed in 1995 was due to the scientific realization that even if one did not have any symptoms, a virus could still be detected in the blood. It was subsequently learned that the more viruses one has in the blood, the more likely one was to progress to AIDS. AIDS is a result of the destruction of the C4 immune cell in the body. The viral load is used mainly to determine whether a person is at risk of developing AIDS.
* At what level viral load can it be determined that a person is at risk of developing AIDS? Every person is at risk of developing AIDS, however, the higher the viral load, the faster one progresses. The virus infects a cell called the CD4 cell. As it grows, the CD4 cell starts dying. Once it completes its life cycle, it will produce more viruses to infect other CD4 cells, but as part of that process, the CD4 cells are destroyed. A CD4 cell is important because it orchestrates the entire immune system, allowing the immune cells to work properly. A normal CD count in the blood is around 500 cells per microlitre of blood. Those with HIV infection lose an average of 50 cells per microlitre of blood per year. Once the CD4 cell is reduced to a level of 250, this is the point at which a number of infections are noted in individuals. The Centre for Disease Control has now defined the development of AIDS with a low CD count of less than 250. A person with more than 20,000 copies per mil would represent a high viral load. This amount would alert a physician to start a patient on antiretroviral treatment. For individuals with less than 5,000 copies per mil of plasma, this would be considered as a low viral load. On average, an individual might progress to AIDS after eight years of HIV infection, and will progress to AIDS sooner in perhaps four or five years if they have a high viral load. Some may progress later, up to 12 to 20 years, if they have a very low viral load. 95% of people who are HIV infected will eventually develop AIDS if they do not take treatment. Not every person with HIV will develop AIDS unless treated, however. Only 1% might have viral loads that are undetectable in their blood and who do not need treatment.
* Do viral loads vary over time in a person with HIV? The viral load can fluctuate. During the first six months of infection, the acute phase, there

may be significant fluctuations in the viral load. In the second phase, the steady stage, the immune system will gain partial control of the virus. This usually remains steady over the course of the disease until one develops AIDS, when the CD4 count reaches a level of less than 250. However, even in the steady state, the virus could fluctuate by three times its amount.

* What happens to the viral loads when a person is treated? When the treatment is actually working and when the virus is not resistant to the drugs the viral load drops quite dramatically. After two months of treatment, this could range from 10 to 100-fold reductions. By six months, if the treatment is working, the viral load should be undetectable.
* Does the viral load vary even if a person is being treated? Once the patient becomes undetectable, it should remain so, although occasionally, there might be "blips", in which case there might be a detectable virus load at a very low level. However, generally, the viral load will be undetectable unless the patient stops the treatment or the virus develops a resistance to the drugs.
* Is antiretroviral therapy effective if it is not taken according to the prescription? Usually not. Medical practitioners will always stress that patients should take the pills exactly as prescribed, meaning daily. If an individual takes the antiretroviral treatment for only one month, this would definitely lower the viral load, possibly 10-fold, although this is not certain. It is unclear what the maximum lowering would be at the one month period, because patients are different. However, if one starts with a lower viral load it would suppress faster than starting off with a higher one. For example, a fairly low viral load of 10,000 copies per mil will suppress faster than one starting off with 100,000 copies per mil.
* At what level of viral load is the risk of transmission reduced to insignificant? There are a number of studies considering this. However, the lower the viral load, the less risk of transmission. The study referred to by the author, Gray, suggests that there would be a reduced risk of transmission with a viral load of less than 1,500 copies per mil.
* Is HIV is a lifelong chronic infection? It is. If one does not take treatment, the mortality rate goes up quite substantially. Once one develops AIDS, there's a 50% chance of dying within two years. By taking treatment, this can dramatically reduce the risk of dying, and one can probably have almost a normal life expectancy. However, the treatment itself has side-effects which may shorten life expectancy slightly. For example, HIV infected patients on treatment have a higher risk of heart and bone disease, particularly hardening of the arteries. Currently, there is no cure for HIV which is why patients need to be on treatment for life and take pills daily. Side effects of treatment can also include rashes, chronic nausea, reduced appetite, chronic diarrhoea and nausea. Treatment can also affect one's mental status. One can feel "cloudy" and confused. Some drugs can actually exacerbate psychiatric diseases. If one had a predisposition to depression, treatment might make an individual more depressed or bring out depression. Some patients may complain of bad dreams and feeling dizzy in

the morning. Other patients can tolerate side effects, and some have none at all. It is also possible that an individual on antiretroviral therapy can suffer from lipodystophy, a thinning of fat in the face, and a loss of fat in arms and legs, but increased fat in the abdomen area.

* What is the extent to which living with HIV affects one emotionally and psychologically even if on treatment? The diagnosis of HIV infection, alone, is usually psychologically hard for a patient. There is a stigma associated with it which may affect interpersonal relationships. In some circumstances, it can affect one's work. For example, if one were a surgeon or a dentist, they would not likely be able to continue to practice, depending on their professional standards bodies.
* Can HIV be transmitted in one instance of unprotected vaginal intercourse? Theoretically, it can.
* If the defendant's last viral load test on June 18, 2009 was 2,426, and his CD4 count was 340, what would be the risk of him transmitting the HIV virus in one instance of unprotected vaginal sex? It would be .0013, or .13%, which is a risk of 1 in 769 on average, based on the Gray study. These numbers could change depending on the age of the individual. Dr. Ostrowski did not factor this into his findings, as he was not told. He was advised that the defendant was 32 years of age at the time of the incident. He responded that on the basis of the same study, this would have actually lowered the risk even further to 1 in 2,000. For some unexplained reason, the study shows that the age group between 30 and 35 had the lowest risk of transmission compared to other groups.
* What is the likelihood of transmitting HIV in one instance of unprotected anal sex? Given the defendant's viral load at the relevant time (2,000 to 3,000 copies per millilitre) anal intercourse is almost 10 times riskier, meaning almost 10 times a higher rate of transmission compared to receptive vaginal intercourse. According to the Baggaley study, the general rate of transmission with anal intercourse is a risk of 1 in 400. There is no information from this study as to whether that ratio changes given the age of the defendant.
* Is there any change in these numbers and the risk of transmission for both anal and vaginal intercourse if there is no ejaculation? This is an area which is not well-studied, however, there is evidence that HIV is present in fluid known as pre-ejaculate. There are some epidemiologic studies suggesting that even if one merely thinks that not ejaculating can protect against infection, this can result in an increased risk of transmission. This is known as the Calzavara study. There is another study showing that if one delays putting on a condom, this can enhance the risk of transmission. However, there is an Australian anal sex transmission study which shows that by not ejaculating, the risk is reduced by approximately 50%. It is still unclear whether ejaculating or not changes one's risk. Although Dr. Ostrowski's report stated that there is no evidence that not ejaculating during sex reduces the risk of transmission, he qualified and slightly altered his

opinion in his oral testimony by making reference to this Australian study now showing otherwise.

* If the defendant did take treatment consistently and as prescribed for no more than one month, would this change his viral loads? It would probably make them lower, but he could not say how much. However, if the defendant took it inconsistently, this may not change his risk of transmission.

86 On cross-examination, Dr. Ostrowski acknowledged that when he first became a physician in 1984, the HIV/AIDS infection was deemed to effectively be a "death sentence". There has been significant development and understanding of the illness which has progressed since this time. Treatments and antiretroviral therapies have dramatically changed the course of how the scientific community views this. It is now understood that HIV is, in essence, a chronic, but manageable illness. He acknowledged that at the time he prepared his written report, he did not review the medical records of the defendant from the correctional facility (exhibit 18) nor did he know the defendant's age. He agreed that variables, such as age, and being circumcised, could both lower the risk of transmission. However, he noted that the Gray study, for example, did not show any effect due to circumcision (it should be noted that a letter dated June 23rd, 2011 from the Maplehurst Correctional Complex confirms that the defendant is circumcised).

87 Dr. Ostrowski also acknowledged that the numbers that has given in his report are based on a general estimate of risk based on epidemiological studies, and that different studies come to different conclusions and different risks. He agreed that this is not an exact science, like DNA, for example. He added that this area of study is not so much uncertain, however, there are a lot of variables.

88 He agreed that even with inconsistent antiretroviral therapy for a period of only one month, there could still be a reduction in the viral load. He qualified this by stating that it depends on the patient. Finally, he clarified that he could not exclude the possibility that non-ejaculation might reduce the risk of HIV transmission.

5:0 THE POSITIONS OF THE PARTIES

5:1 The Crown

89 The Crown asks the Court to accept the evidence of Ms. J.S. as being truthful and accurate. She answered all questions in a direct and straightforward manner. She was consistent in her responses. The substance of her evidence should not be considered as unreliable. Quite apart from her acknowledged memory difficulties, she was absolutely unshaken on the key parts of her evidence relating to the defendant not telling her that he had HIV and that they clearly had unprotected sex on one occasion, both vaginal and anal. She clearly stated that she was not on any birth control pills at the time and did not want the defendant to ejaculate in her. She further recalled that the defendant pulled out and went to the bathroom, likely to ejaculate there. The Crown therefore submits that the Court has only the complainant's account to evaluate. The sum and substance of her evidence should be accepted. She readily admitted that her memory may not have been perfect but she had no trouble at all remembering the most important aspects of it relating to the incident of unprotected sex.

90 Regarding the legal issue, the Crown submits that the seminal case of R. v. Cuerrier, [1998] 2 S.C.R. 371 determined by the Supreme Court of Canada in 1998, is still good law. In that case, the defendant had unprotected intercourse with two complainants who did not know that he was HIV positive. Although neither complainant contracted the virus, the Court held that this was not the test,

but whether there was a risk of significant or serious bodily harm. There are two factors which must be present to constitute a fraud vitiating consent. First, there must be dishonesty, which is non-disclosure of one's HIV status. Second, there must be a risk of deprivation, which cannot be trivial harm. The Crown submits that despite the scientific advancements in treating HIV, there is still no cure for it. Once infected, a person has it for life. It can result in deadly consequences and can result in premature death. Although the Cuerrier case contemplates a possible scenario where if a condom is used, there may not be a deprivation, and therefore, no fraud or duty to disclose, this is not the situation in the present case which involves an act of both unprotected anal and vaginal intercourse.

91 Furthermore, even if it can be said that having the HIV virus is not as serious as it once was, in the present case, having unprotected anal and vaginal intercourse, even without ejaculation, exposed Ms. J.S. to a significant risk. The defendant still had significant viral load levels which were not reduced to undetectable levels.

92 The only way in which there could be as close to "safe sex" as possible, is for the defendant to have always used a condom properly, and to have taken treatment as prescribed for at least six months until his viral load was reduced to undetectable amounts, in which case he could not transmit the HIV virus.

93 However, in the present case, the defendant was not taking treatment at the relevant time, or if he was, it was inconsistent. Furthermore, it would only had been taken over a short period of one month between June 24 and July 27, 2009, the date of his arrest. The medical records (exhibit 18) disclose that he was seen by Dr. Richardson in June, 2009 and was prescribed medication. However, the notes also indicate that he refused to take the medication while in custody because it made him feel sick. Dr. Ostrowski's evidence is to the effect that taking medication inconsistently might have a bearing on reducing viral loads, but could not be certain.

94 Furthermore, although non-ejaculation can be a factor which reduces the risk of transmission, there is no definitive evidence in the present case about this. Ms. J.S. stated in her evidence that there may not have been ejaculation in relation to the unprotected anal and vaginal intercourse, but she did not know for sure. In any event, Dr. Ostrowski's evidence on this point is that there may be no difference whether there is either ejaculation or not, since even pre-ejaculate fluid may contain the virus. He also opined that there is a dearth of research as to whether or not ejaculation affects HIV transmission.

95 Dr. Moore testified that he advised the defendant about the consequences of HIV, that he would have it for life, and that he could potentially infect all sex partners. He also told the defendant that having unprotected sex without a condom was a high-risk activity. His evidence, therefore, supports the proposition that HIV is a serious illness, and that the only way to prevent against transmission is to wear a condom.

96 In conclusion, the Crown submits that the complainant's consent has been vitiated by fraud and that her life has been endangered. The risk factor for transmission of the virus through vaginal intercourse was high. The risk was even higher for anal intercourse. Since both acts of unprotected intercourse occurred on the same occasion, this would increase the risk even further.

5:2 The Defence

97 Defence counsel filed a memorandum of law regarding the charge of aggravated assault for the Court's consideration.

98 The main submission, is that on the facts of this case, it cannot be said that there was a significant risk to the complainant and therefore, the Crown has not made out this charge beyond a reasonable doubt. There is no evidence of any exchange of body fluids. Therefore there is no risk. The Crown position is merely theoretical and no more. In rather crude, but simple and straightforward terms, the case law does not allow for a conclusion by this Court that by merely placing one's penis in an orifice this amounts to an aggravated sexual assault.

99 Counsel respectfully submits that the Crown has conflated the legal test, and warns that the Court must not fall into the trap of legal error by concluding that because HIV is so serious, any risk is a serious risk. This is a distortion of the Cuerrier test. Rather, the case law makes it clear that the test is significant risk, not any risk.

100 Furthermore, the defence submits that it is also legal error to articulate the legal test as any unprotected sex amounts to significant risk. Given the evolution of science in this area, there are now situations, where, if there is no evidence of the exchange of bodily fluids, there will not be a significant risk.

101 In any event, counsel submits that this case can be determined solely on its facts, and that the application of any legal test, or a Cuerrier analysis, is actually unnecessary and irrelevant. On the basis of the complainant's evidence alone, not only has the Crown not proven significant risk, but has not proven any risk at all. There is no evidence of the exchange of any bodily fluids between the parties, either pre-ejaculate or ejaculate. In the result, there is no case to be met by the defendant.

102 Counsel concedes that the credibility of the complainant cannot necessarily be impeached, nor can the Court find a motive to fabricate. However, her reliability can certainly be called into question, sufficient to raise a reasonable doubt. She could not recall the total number of times she and the defendant had sexual relations. She acknowledged having significant memory problems and a history of drug problems. Furthermore, she acknowledged when she had sex with the defendant, she had consumed a mixture of drugs, alcohol and medication. Counsel asks rhetorically, therefore, how can the Court confidently find proof beyond a reasonable doubt given all this? It should be noted that in her statement to the police, she only went so far as to say she believed that there were no condoms used. Counsel submits that the integrity of her evidence, therefore, goes much beyond her mere inability to recall. She acknowledged a number of problems in her life which may have affected her memory, and yet she stated in her oral testimony that she was certain of other things. Counsel submits that the Court should be wary of her own oath-helping. Given her memory lapses, counsel asks how the Court can confidently conclude that no condom was used, particularly when the defendant was behind her? She did not know if any fluids passed between them. Her evidence, combined with the evidence of Dr. Moore, who stated that if there is no passing of bodily fluids there is no risk of infection, is really the beginning, middle and end of the Crown's case.

103 In the alternative, if the Court is of the view that the Crown has overcome this factual hurdle and accepts the evidence of the complainant that no condom was used, then the Court should find that even on the basis of the expert and medical evidence, the legal test has not been made out beyond a reasonable doubt. Dr. Ostrowski acknowledges that this is not an exact science. Furthermore, there appear to be too many variables to consider. Therefore, counsel submits, rhetorically, how is the Court to assess the risk of this particular defendant? In any event, any finding should not be made on the basis of expert evidence about the "average risk". If this is all that is required, counsel submits that no trial would need any expert evidence at all.

104 The facts of this case disclose that the complainant did not contract HIV. This must surely have some significance in the overall analysis. An inference can be drawn that there was a low risk of transmission. Although Dr. Moore, and likely any doctor would tell his or her patient to wear a condom, and although this may have universal appeal as a very sound proposition, this only speaks to a medical standard. The function of this Court, however, is to consider a much narrower legal standard.

105 Defence counsel also submits that it is impossible to determine the defendant's true rate of transmission in this case. Dr. Ostrowski cites a plethora of studies, all of which seem to come up with different numbers. Even Dr. Ostrowski's "numbers" did not take into account the defendant's age and the fact that he was circumcised, two factors that clearly could reduce the risk of transmission.

106 Counsel submits, therefore, what is the number that this Court can pick? The simple answer is this Court cannot know, because there are too many variables including age, use of medication, circumcision, and non-ejaculation. The individual and cumulative effect of all of these factors could significantly reduce the percentage of risk, but no one knows by how much. In the result, this must amount to a reasonable doubt.

107 It should also be noted that the defendant must have taken medication for at least some period of time. Otherwise, how else could the note in exhibit 18 be made where he told the medical personnel that he did not take medication because it makes him sick? The inference to be drawn is that he would only know that medication made him ill if he took it.

108 Finally, counsel submits that if the Court is unable to conclude what the defendant's rate of transmission is, how can the Court conclude that the risk is significant?

5:3 Crown Reply

109 The notes in the medical reports in exhibit 18 appear to indicate that the defendant refused treatment. In any event, it appears that he only took medication after September 16, 2009, clearly well after the date of his arrest.

110 Furthermore, Dr. Ostrowski's evidence regarding the risk of transmission is 1 in 2,000 with unprotected vaginal intercourse (.0005%), and 1 in 400 regarding unprotected anal intercourse (.0025%). Added together, this results in a risk factor of 1 in 333 (.0030%). The Crown submits, therefore, that this constitutes a significant risk of harm which would endanger the life of the complainant.

111 Support for this position can be found in the case of R. v. J.A.T., [2010] B.C.J. No. 1024. In that case there were three incidents of unprotected sex, although the person with HIV was the receiver and not the ejaculator. Nonetheless, the evidence of risk of harm of transmission of HIV was 12 in 1,000, which is less than one half of the risk in the case at bar, and yet a conviction was registered in J.A.T..

112 Finally, the Crown acknowledges that the Supreme Court of Canada has not yet ruled on a case where there is evidence of viral load or evidence of estimated viral risk. Therefore, there is no binding authority as to what is the number to pick. What is important is that the Crown does not have to prove positively that any fluids may have passed from the defendant to the complainant. The Crown merely has to prove that there is a risk of same. Furthermore, just because the scientific community and the courts do not know everything yet about the HIV virus, this is no reason not to

be able to make decisions. The Court is quite entitled to make a decision on the basis of the evidence before it. Furthermore, the Court can make its decision based on evidence of average risk.

6:0 ANALYSIS

113 This is still a case about consent. However, the central question is, should an individual with HIV inform sexual partners even if the odds of transmitting the disease are low?

114 The Crown must prove beyond a reasonable doubt that the complainant's consent was obtained by fraud, thereby vitiating consent.

115 In effect, the Court imputes consent to have sexual relations as long as it is not too risky. In other words, where the probability of harm is not great enough, even the uncontradicted evidence of a complainant that she would never have had sex with the defendant is not enough.

116 Although legal measures have been introduced to deter the reckless transfer of HIV by ensuring honesty and frankness leading to safer sex practices, the rationale for excusing a measure of dishonesty in obtaining consent is the belief in criminalizing only deceit that is connected to obtaining consent which has a significant risk of leading to serious harm. The development of the extant caselaw suggests that the test of what constitutes a significant risk should not be so broad, however, as to trivialize such a serious offence.

117 To prove lack of consent, the Crown must show that there was deceit and deprivation.

118 Deceit is conceded, since the defendant did not disclose his medical status to her. Clearly, he had a moral duty to warn. However, not every immoral or reprehensible act will necessarily result in criminal liability.

119 There must also be a corresponding deprivation. The defence position is that the Crown has not proven this element beyond a reasonable doubt.

120 The nature of the harm necessarily affects the threshold of significance required to establish deprivation. As the magnitude of the harm goes up, threshold of probability that will be considered significant goes down. The word significant is not necessarily equated with quantity, but it does imply importance.

121 Deprivation is defined as a significant risk of bodily harm. In the context of this case, it is a significant risk of transmission of the HIV virus. However, it cannot be any risk or a trivial one. It is important to note that the elimination of risk is not the legal test.

122 The test is a question of fact to be determined in each case.

123 In the present case, the Court finds that there was one incident of unprotected anal and vaginal intercourse, and two incidents of intercourse with condoms. The Court accepts the evidence of the complainant in this regard. She provided the condoms on the other two occasions when they had relations. She specifically recalled and recollected the distinction. Notwithstanding her memory problems and other personal issues, of this she could not have been mistaken. Therefore, no reasonable doubt has been raised on this fact. There was clearly an act of unprotected sex.

124 Therefore, the decision in the present case turns on whether the viral load of the defendant would have been at the low end of the range, resulting in a low risk of transmission and, therefore, no substantial or significant risk of harm.

125 Since Cuerrier, courts have recognized that there are other factors, beyond condom use that may reduce the risk of transmission to a point where it is so minimal or insignificant that disclosure is not required. For example, if an individual has an undetectable viral load, then the risk of transmission is not significantly sufficient to trigger a disclosure requirement and vitiate consent.

126 In the present case, however, the defendant does not have an undetectable, but only a low viral load.

127 However, there is caselaw supporting the proposition that there is no need for the Crown to lead evidence of the defendant's viral load to establish significant risk of harm.

128 In R. v. Wright (2009), 256 C.C.C. (3d) 244 (B.C.C.A.), an expert testified that the viral load of a carrier can significantly reduce the transmission rate of HIV, as can the use of condoms. Notwithstanding this, in the circumstances of this case, the defendant was still convicted. On appeal, he argued that no evidence of his actual viral load had been led. The appeal Court, however, rejected this argument and found that the expert evidence established that a low viral load was included in his calculation of the average rate of transmission. In other words, the Court was entitled to rely on figures of average risk in the absence of specific evidence of the defendant's viral load, because the figure was a composite average, taking into account the wide range of viral counts of all infected individuals included in the group from which the average risk was derived. The Court then commented on the specific use that can be made of evidence of the defendant's actual viral load. Such evidence is relevant to the assessment of risk, but there is no requirement that the Crown lead evidence of same. The trier of fact is, therefore, entitled to rely on figures of the average rate of transmission.

129 In the present case, although the defendant did not introduce any evidence himself to show that his particular risk of transmission was below the average, there is Crown evidence of the defendant's actual viral load at the relevant times which can be weighed and evaluated in the analysis.

130 It would appear that the transmission of HIV is a "moving target" often discussed by scientists in averages or ranges.

131 Furthermore, there appears to be consensus that the science is not perfect. These estimates do not necessarily, but can take into account such variables as age; whether or not one is circumcised; ejaculation versus non-ejaculation; condom use; sloppy condom use; and missed antiretroviral medication.

132 Advances in science appear to have changed HIV/AIDS from being a "death sentence" into a chronic one. HIV is now a more manageable disease, allowing those with it to continue a normal life.

133 The application of the legal test in Cuerrier, therefore, must evolve to account for the developments in the science of the treatment of HIV.

134 Therefore, given this shift, the legal question becomes whether even finding a risk of serious bodily harm necessarily means that there is also endangerment of life? In other words, perhaps not all serious bodily harm puts a victim's life in peril.

135 The Cuerrier analysis did not address this. The required threshold was merely once a significant risk of bodily harm had been found, this also satisfied the requirement with respect to aggravated assault. This is likely because at the time the case was decided, the diagnosis of HIV was con-

sidered akin to an incurable one, in which case proof of endangerment from engaging in unprotected intercourse was obvious.

136 Although the J.A.T., case, at para. 76, seems to restate that the two standards are the same, there is obiter in the slightly more recent case of R. v. Mabior, [2010] N.J. No. 308, at para. 145, suggesting that endangerment of life and serious bodily harm are two different standards. To endanger means to put in danger or to incur the risk of death. Therefore, not all actual or risk of serious bodily harm necessarily puts one's life in peril.

137 This argument is attractive. However, the decision in the present case does not turn on this possible distinction. Rather, it turns on whether the Crown has proven significant risk of bodily harm.

138 The analysis in J.A.T. is instructive. The defendant had unprotected anal sex with the complainant on three occasions. Expert evidence disclosed that the defendant had viral loads between 17,000 and 30,000 particles of HIV per millilitre of plasma during the relevant period (which the Court considered as being a significant level). The complainant did not contract HIV. The expert estimated a 4 in 10,000 risk of transmission of HIV for each incident of unprotected anal intercourse. (note that the defendant in this case was the receptive partner, while the complainant was the insertive partner). The Court noted unprotected anal sex posed a high risk of HIV transmission. Nonetheless, the defendant was acquitted of aggravated sexual assault and the included offence of sexual assault, because the less than 1% risk that these incidents would have resulted in the transmission of HIV was too small to be considered endangerment. Therefore, this minimal risk was not material enough to vitiate the complainant's consent. Although this case is not a binding authority, it is of persuasive value.

139 The Mabior analysis is also helpful. It is an appellate decision from the province of Manitoba. The defendant appealed his six convictions of aggravated sexual assault. None of the complainants contracted HIV. Expert evidence at trial established that the defendant's viral load for HIV was so low that he was not considered as infectious. Nonetheless, the trial Court did not consider the effect of a low viral load on the question of risk where there were instances of unprotected intercourse. Rather, the Court only considered that where the viral load was undetectable and where a condom was used the risk of transmission would fall below the legal standard of significant. The appeal was allowed in part. As part of its analysis, the appeal Court found that the trial Court erred in holding that the defendant failed to completely eliminate the risk of transmission.

140 In the present case, it is hard to resist the urge to convict. The defendant did little, if any, to help himself or to demonstrate that he had the complainant's best interests in mind.

141 The Court finds that the defendant did not wear a condom, having been informed by Dr. Moore that this was the best way to minimize transmission; was not on any antiretroviral medication at the relevant time, even though it had been prescribed; and that he did not disclose his illness to the complainant.

142 The only proactive step he did take was to not ejaculate. At least he complied with the complainant's wishes in this regard.

143 The only other significant factor, which he may or may not been aware of, is that he was carrying a low viral load.

144 Should he now, therefore, be entitled to be the beneficiary of his still reckless and irresponsible behaviour?

145 Put another way, if having unprotected sex is still a high-risk activity akin to "Russian Roulette", does the evidence in this case amount to there being a "bullet" in the chamber, or was it merely a "blank"?

146 On the totality of the evidence, the Court cannot be satisfied that the defendant's viral load count and the chance of transmission of the HIV virus to the complainant meets the legal test of either significant risk of bodily harm, or endangerment of life. A reasonable doubt has been raised for the following reasons:

1. The risk of transmission must take into account the number of times there was unprotected intercourse. It was only once. In J.A.T., there was still an acquittal with three incidents.
2. The evidence is insufficient as to whether there was any exchange of bodily fluids or pre-ejaculate. The Court finds, however, that there was no ejaculation.
3. It is not enough to accept Dr. Moore's opinion that unprotected anal intercourse is still a "high-risk" activity, and to conclude that the legal test has been met. This is a relative term, to be understood in the context of meaning a higher risk compared to other forms of sexual activity.
4. The defendant's viral load (2,426 as of June 18, 2009) is low. Dr. Ostrowki's opinion is that individuals with less than 5,000 copies per millilitre of plasma would be considered as having a low viral load. Granted, he also opined that on the basis of at least one study a viral load of less than 1,500 copies would reduce the risk of transmission to insignificant. Therefore, although the defendant's "numbers" do not place him in the category of insignificant risk, neither do they place him at the significant risk level.
5. Dr. Ostrowski's opinion in both his report, and in his oral evidence, was not particularly definitive. With no criticism of him, this is likely because the various studies are not definitive either. Nonetheless, it would appear that his opinion of the risk of transmission of anal intercourse being 1 in 400, and 1 in 769 for vaginal intercourse, or if the two are combined, 1 in 333, can only be reduced, having regard to the variables of the defendant being circumcised, and being in an age group, which for some unknown scientific reason, benefits him.

147 Against the background of uncertainty and variability, the Court is not satisfied that the risk of transmission is material enough to establish deprivation.

148 While the risk might be too high for the complainant, from a subjective standpoint, viewed objectively, the probability of infection in this case has not reached the required threshold to convict.

149 Accordingly, the Court has not proven all the essential elements of the offence beyond a reasonable doubt. The charge is, therefore, dismissed.

S.R. CLARK J.

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