Legislation to Authorize Forced Testing of Federal Prisoners for HIV: An Unjustified Violation of Human Rights

A submission to the Minister of Public Safety and Emergency Preparedness Canada

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About the Canadian HIV/AIDS Legal Network

The Canadian HIV/AIDS Legal Network (www.aidslaw.ca) promotes the human rights of people living with and vulnerable to HIV/AIDS, in Canada and internationally, through research, legal and policy analysis, education, and community mobilization. The Legal Network is Canada's leading advocacy organization working on the legal and human rights issues raised by HIV/AIDS.

The Legal network has over 200 members across Canada, the majority of whom are front-line, community-based organizations working in the field of HIV/AIDS or related fields. The Legal Network has been involved in extensive government, community and international consultations regarding legal and policy issues related to HIV/AIDS. Law and policy related to HIV testing and disclosure have been central to the Legal Network's research and analysis for many years. In 1998, we released *HIV Testing and Confidentiality: Final Report*, containing an extensive analysis of various aspects of Canadian law and policy in this area. In 2000, we produced *Rapid HIV Screening at the Point of Care: Legal and Ethical Questions* that addressed numerous questions related to the introduction and use of rapid HIV test kits in Canada.

We have also undertaken extensive work on the issue of compulsory HIV testing. In 2001 we produced *Testing of Persons Believed to Be the Source of an Occupational Exposure to HBV, HCV, or HIV: A Backgrounder*,[1] and in 2002 we published *Occupational Exposure to HIV and Forced HIV Testing: Questions and Answers* to assist policy-makers, service-providers, the media, and the general public in understanding this issue.[2] In February 2002, the Legal Network appeared before the House of Commons Standing Committee on Justice and Human Rights to discuss then Bill C-217, the proposed "Blood Samples Act," and presented written and oral submissions highlighting the serious human rights issues raised by the legislation. On the Standing Committee's recommendation, the Bill did not proceed.

[1] *Testing of Persons Believed to Be the Source of an Occupational Exposure to HBV, HCV or HIV: A Backgrounder*, Canadian HIV/AIDS Legal Network, 2001 (online via www.aidslaw.ca/testing). A copy of the *Backgrounder* accompanies these submissions. Unless otherwise indicated, data and studies referenced in this brief are drawn from that document. Please refer to the *Backgrounder* for citations to the original sources. (Legal Network materials regarding HIV testing are also available in French via www.aidslaw.ca/test.)

[2] *Occupational Exposure to HIV and forced HIV Testing: Questions and Answers*, Canadian HIV/AIDS Legal Network, 2001 (online via www.aidslaw.ca/testing).

Introduction

The Canadian HIV/AIDS Legal Network (Legal Network) understands that the Minister of Public Safety and Emergency Preparedness Canada has received at a proposal from the Union of Canadian Correctional Officers (UCCO) encouraging it to amend the *Corrections and Conditional Release Act* so as to authorize the forced testing of inmates for HIV and other infectious diseases. The Legal Network wishes to take this opportunity to comment on this subject and, in particular, the legislation proposed by UCCO.[3] The UCCO proposal, if passed into law, would permit the forced testing of a prisoner in a situation where a correctional officer has been exposed to the prisoner's blood or other bodily fluid. It would also permit the testing of a prisoner where no other person has been exposed to that prisoner's blood or bodily fluids. With respect to the latter, the UCCO proposal goes far beyond any other forced testing legislation proposed or enacted in Canada.

Throughout this submission we will refer to "forced testing" legislation since this phrase accurately describes the ultimate purpose of such legislation -- to compel a person to undergo a medical test without that person's consent. Obtaining a "blood sample" pursuant to a judicial order is the means to that end. It is also important to note that where a test is ordered under such legislation, the results of that test – the person's private medical information – are disclosed to numerous people.

As a matter of human rights, including the right to safe working conditions as recognized in international law,[4] the Legal Network supports measures to prevent or reduce the occupational risk of infection with bloodborne pathogens such as HIV for health care workers, emergency responders (police, firefighters, paramedics), and correctional officers. (This has included, for example, support for legislation that would mandate the use of safety-engineered needles in healthcare settings, which account for by far the greatest number of occupational exposures.) The Legal Network also supports access to quality HIV testing and counselling, and access to care, treatment and support, for those who may be exposed to the risk of HIV infection, whether occupationally or otherwise. Finally, we support measures that respect and protect the rights of people living with HIV/AIDS and those vulnerable to HIV infection.

This submission explains why legislation authorizing the forced testing of federal prisoners for HIV, hepatitis B virus (HBV) and hepatitis C virus (HCV) should not be introduced or supported by the Government of Canada. Briefly stated, legislation authorizing the forced testing of people (i.e., without the individual's informed consent) does not represent an appropriately balanced policy response to the issue of correctional officers' potential or actual occupational exposures. Forced testing legislation remains a flawed approach that does not adequately respect and protect human rights.

Forced testing legislation is an example of a situation where a legislative "quick fix" is not the best solution to a complex problem. Any consideration and assessment of proposed legislation should be informed by scientific and medical information about the transmission of bloodborne pathogens and by a commitment to respecting and protecting human rights. This means that workers who risk exposure to bloodborne pathogens such as HIV, HBV and HCV deserve a considered, effective response from employers, policy-makers and legislators that will fulfill workers' right to safe and healthy working conditions by providing real protections for workers. Ensuring access to adequate information, counselling, support and treatment in the event of an occupational exposure is a more constructive and useful alternative, and is more beneficial to correctional officers as a group. To date, this is the approach that has been followed by the Correctional Service of Canada (CSC), which has put in place a detailed protocol for managing exposure to blood and other bodily fluids, applicable to both CSC staff

[3] Union of Canadian Correctional Officers, *An Act to amend the Corrections and Conditional Release Act (blood samples)* ["UCCO proposal"].

[4] The right to just and favourable conditions of work, including safe and healthy working conditions, is set out in the *International Covenant on Economic, Social and Cultural Rights*, Article 7(b). Canada has ratified this treaty.

and prisoners.[5] There is inadequate justification, from a legal or occupational health perspective, for departing from this well-considered approach.

This submission is organized as follows:

- Part 1 sets out the context of the UCCO proposal.
- Part 2 analyzes the available scientific evidence regarding occupational exposure to, and post-exposure management of possible infection with, HIV, HBV and HCV.
- Part 3 considers the arguments presented for forced testing and the limited benefits of the information gained through forced testing.
- Part 4 analyzes the serious human rights and other legal issues raised by forced testing of prisoners.

[5] Correctional Service Canada. Managing Exposure to Blood and/or Body Fluids. Commissioner's Directive 821-1 (24 March 2004).

1. The UCCO forced testing proposal

1.1 The context

As a result of a media reports in April and May of 2006, the Legal Network learned that UCCO had been urging the Government to amend the CCRA to permit the forced testing of prisoners for infectious diseases such as HIV and hepatitis.[6] Because we were not immediately able to obtain a copy of the UCCO proposal, we wrote to the Hon. Stockwell Day, Minister for Public Safety and Emergency Preparedness, expressing our opposition in principle to such legislation. We subsequently obtained a copy of the UCCO proposal (see Appendix A).

As a result of information provided to us by PEPSC and CSC pursuant to requests under the federal *Access to Information Act*, we learned that UCCO has been successful at getting the issue of this proposed legislation on the table as part of an ongoing negotiation process running parallel to the protracted (i.e., over three year) collective bargaining process.[7] Treasury Board authorized CSC to discuss various operational aspects directly with UCCO with a view to reaching an agreement. There has been no official avenue for prisoner rights advocates or other interested parties (e.g., the Office of the Correctional Investigator, John Howard Society, Canadian Association of Elizabeth Fry Societies, civil liberties organizations) to provide input into this process in which operational issues are being discussed and decisions taken. Many of the operational issues being negotiated involve prisoner rights and entitlements. The forcible collection of blood samples to conduct medical tests is one such issue.

According to internal government documents, UCCO is concerned about the physical and psychological impact of exposure to contaminated blood and believes that universal precautions are not enough. Thus, UCCO "wants their members to be able to have all personal information about an inmate when a Correctional Officer is exposed to contaminated blood." CSC recognizes that the issue has privacy and other implications under the *Canadian Charter of Rights and Freedoms*. CSC is working on an agreement with the Union "to implement a further proactive protocol whereby offenders will be approached and asked for their informed consent to allow the sharing of pertinent medical information between medical professionals when staff members have been exposed to blood or bodily fluids." Furthermore, internal government documents reveal that the CSC Commissioner entered into discussion with the Public Health Agency of Canada "to ensure that all medical aspects are fully understood."

The UCCO legislative proposal seeks to amend the *Corrections and Conditional Release Act* to permit the forced testing of prisoners in two distinct situations:

1) in the event of an occupational exposure of a staff member to the bodily substance of a prisoner;

2) pre-emptively, where there is a significant risk that a staff member might come in contact with the bodily substances of a particular prisoner.

[6] K Harris. Jailers seek safeguards. *Ottawa Sun* 30 April 2006, page A4; J Pursaga. Convicts attack with nasty bodily fluids. *Winnipeg Sun*, 7 May 2006: p. A3.

[7] K Coulter. *Briefing note to the Minister of Public Safety and Emergency Preparedness Canada*, 27 February 2006; K Coulter. *Briefing note to the Minister of Public Safety and Emergency Preparedness Canada*. 8 March 2006. The new collective agreement between the Treasury Board and UCCO provides in Article 18.01: "The Employer shall make reasonable provisions for the occupational safety and health of employees. The Employer will welcome suggestions on the subject from the Union, and the parties undertake to consult with a view to adopting and expeditiously carrying out reasonable procedures and techniques designed or intended to prevent or reduce the risk of employment injury."

1.2 Forced testing of prisoners following occupational exposure

The UCCO proposal would permit a CSC staff member to apply to a justice of the peace or provincial court judge for a warrant authorizing the taking of a sample of blood from a prisoner.[8] The justice or judge must hold a hearing at which the parties must be present.[9] Before the justice or judge can issue a warrant, he or she must have reasonable grounds to believe that a number of conditions have been met.[10] Practically speaking, it falls to the staff member to provide evidence that such conditions have been met. The staff member must demonstrate that he or she has come into contact with the prisoner's bodily substance during the execution of his or her duties, and as a result may be infected with HBV, HCV or HIV.[11] The staff member must submit a medical report prepared by a qualified medical practitioner to establish that the analysis of the prisoner's blood sample is necessary to *decrease or eliminate the risk* to the health of the staff member.[12] The justice or judge must also believe, on the basis of an opinion offered by a physician, that the taking of a blood sample would not endanger the prisoner's life or health.[13]

The UCCO proposal states that a peace officer is responsible for the execution of the warrant authorizing the taking of a blood sample. "Peace officer" has the same meaning as in the *Criminal Code*, and includes not only a police officer or constable, by those employees of CSC who have been designated as "peace officers" under the *Corrections and Conditional Release Act* — effectively all CSC institutional staff.[14] Presumably, the CSC staff member who has obtained the warrant would enlist the services of the same physician who prepared the original report supporting the application to take the blood sample or to supervise the taking of the blood sample by a technician. The physician must be satisfied that the taking of the blood sample would not endanger the life or health of the prisoner.[15] The proposal immunizes from criminal and civil liability those people who participate in the forced taking of the blood sample.[16] Finally, the UCCO proposal contains provisions which prohibit the use of the blood sample and results of its analysis for purposes other than that for which they were obtained,[17] with penalties for unauthorized use or disclosure of the blood sample or information derived from its analysis.[18]

These occupational-exposure related provisions of the UCCO proposal will be analyzed in detail in Parts 3 and 4 of this submission.

1.3 Pre-emptive forced testing of prisoners

The UCCO proposal also provides for pre-emptive forced testing of prisoners for HBV, HCV and HIV, in the following terms:

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[8] UCCO proposal, section 57.01(2).

[9] UCCO proposal, section 57.02.

[10] UCCO proposal, section 57.03(1).

[11] UCCO proposal, section 57.03(1)(a), (b).

[12] UCCO proposal, section 57.03(1)(e), (f).

[13] UCCO proposal, section 57.03(1)(d).

[14] UCCO proposal, section 57.01(1).

[15] UCCO proposal, section 57.04. The proposal specifically protects the right of a physician to refuse to take or supervise the taking of a blood sample (s. 57.05).

[16] UCCO proposal, section 57.06.

[17] UCCO proposal, sections 57.08(3), 57.09, 57.10.

[18] UCCO proposal, sections 57, 11, 57.12.

The warrant described in subsection (1) may also be issued by a provincial court judge before whom the parties have appeared where the applicant establishes that

(a) he believes on reasonable grounds that the inmate is infected with a designated virus;

(b) there is a significant risk that staff members could come into contact with a bodily substance of the inmate and as a result become infected with a designated virus;

(c) this risk is preventing staff members from properly and safely exercising their duties; and

(d) a qualified medical practitioner is of the opinion that the taking of blood samples would not endanger the inmate's life or health.[19]

This section of the UCCO proposal is without precedent in Canadian law. No Canadian jurisdiction has passed legislation or put in place regulations or policy that permits the forced testing of a person for HBV, HCV or HIV where there has not first been an occupational exposure.

The constitutional and other legal issues raised by this aspect of the UCCO proposal are analyzed below in Part 4.

[19] UCCO proposal, sections 57.03(3) [emphasis added].

2. Risks and management of occupational exposures

Appropriate post-exposure management of occupational exposures to blood and other bodily fluids is an important element of workplace safety. Assessing the actual risk involved when a worker is exposed to blood or another bodily fluid is the crucial first step in appropriate post-exposure management.

It has become apparent over the years — including in testimony in 2001 and 2002 before the House of Commons Standing Committee on Justice and Human Rights that ultimately recommended against proceeding with forced testing via amendments to the *Criminal Code* — that there remains a great deal of misinformation about HIV, the risks of transmission through occupational exposures, and what should be done in the event of such exposures. A proper understanding of the basic scientific facts of transmission of HIV, HBV and HCV is vital not only when managing cases of exposure, but also when assessing whether legislation authorizing forced testing for HIV and other blood-borne viruses is warranted or justified.

Significant exposure to HIV, HBV or HCV may arise when certain bodily fluids capable of transmitting one of these virus comes into contact with:

- tissue under the skin (e.g., through a needle stick or a cut), which is called a *percutaneous* exposure;
- mucous membranes (e.g., through a splash to the eyes, nose, or mouth), which is called a *mucocutaneous* exposure; and
- non-intact skin (e.g., when the skin is chapped, scraped, or afflicted with dermatitis).

Contact with intact skin is not a significant exposure, but the larger the area of skin exposed and the longer the time of contact, the more important it is to verify that all the relevant skin area is intact. Contact with clothing is not a significant exposure.

The types of bodily fluids capable of transmitting HBV, HCV, or HIV include:

- blood, serum, plasma, and all biologic fluids visibly contaminated with blood;
- laboratory specimens, samples, or cultures that contain concentrated HBV, HCV, and HIV;
- organ and tissue transplants;
- pleural, amniotic, pericardial, peritoneal, synovial, and cerebrospinal fluids;
- uterine/vaginal secretions or semen (unlikely to transmit HCV); and
- saliva (saliva alone transmits only HBV; if saliva is contaminated by blood, it may also transmit HCV and HIV).

It should be noted that HIV, HBV and HCV are not transmitted by feces, nasal secretions, sputum, tears, urine and vomit unless these bodily substances are visibly contaminated by blood. Saliva that is not contaminated by blood cannot transmit HIV or HCV.[20]

[20] Complete references regarding HIV, HBV, and HCV transmission are provided in *Testing of Persons Believed to Be the Source of an Occupational Exposure to HBV, HCV or HIV: A Backgrounder*, *supra* note 1 at page 5ff.

2.1 HIV

Risk of transmission

Almost all available data on the risks of occupational transmission of HIV comes from exposures in health-care settings. The available evidence indicates the very small risks of transmission question:

- Direct, under-the-skin exposure to contaminated blood presents the most significant danger for transmission of HIV. Even then, the U.S. Centers for Disease Control and Prevention and the B.C. Centre for Excellence in HIV/AIDS have estimated that the risk of infection from a single *percutaneous* exposure (i.e., under the skin through a needle stick or cut) to HIV-infected blood is approximately 0.3% (1 in 300). In other words, 99.7% of such exposures do not lead to infection.

- The risk of infection is lower in the case of *mucocutaneous* exposures to HIV-infected blood (i.e., to mucous membranes through a splash to eyes, nose or mouth), at just under 0.1% (1 in 1000).

- The risk of transmission from an exposure to intact skin is estimated to be even lower than 0.1% (less than 1 in 1000).

If the HIV-positive source person is taking anti-retroviral drugs, the chance of infection is lowered further, because the drugs reduce "viral load" — the amount of virus in their blood (even to the point where the virus is clinically undetectable in some cases). If the HIV status of the source person is unknown, statistically the chance of infection from any exposure is lower still. (The risk for transmission after exposure to fluids or tissues other than HIV-infected blood has not been quantified, but is thought to be considerably lower than for blood exposures.)

Given these very low risks, it is not surprising that there have been only two probable cases, and one definite case, of occupational transmission of HIV in Canada since the beginning of the (known) epidemic more than 25 years ago. The two probable cases involved laboratory workers working with contaminated blood, one in the early 1980s (before HIV was identified) and one working with cultured virus during research activities. The one definite case was that of a health-care worker not wearing gloves who sustained a puncture wound involving a patient in the late stage of AIDS (when bodily fluids have elevated concentrations of HIV) and who did not seek post-exposure treatment with antiretrovirals.

There is little data on occupational exposures to HIV among emergency responders (e.g., firefighters, ambulance attendants, police and correctional staff). However, the available evidence helps put the risks at issue here into perspective. One study of police officers in the United States found that one-third of exposures reported by police officers were "significant." These exposures were rarely percutaneous or mucocutaneous exposures to blood (most exposures were to non-intact skin), but when they were, they occurred in circumstances where precautions were not an option or would not have been effective. Of the identified source persons, 94% consented to HIV testing. None of the police officers in the study were infected.[21]

Further evidence regarding the lack of cases of occupational transmission of HIV was provided in 2001 by Ontario's then Chief Medical Officer of Health to a committee of the Ontario legislature. Dr. Colin D'Cunha testified that there have been no documented cases of "emergency services workers"

[21] R Hoffman et al. *Occupational exposure to human immunodeficiency virus (HIV)-infected blood in Denver, Colorado police officers*. American Journal of Epidemiology 1994; 139(9): 910-917.

(meaning police officers, firefighters and ambulance attendants) acquiring blood-borne pathogens occupationally in Ontario or in Canada.[22]

Management of exposure

Following an occupational exposure to HIV, it will be up to the exposed worker, in consultation with a health care professional, to determine if further steps need to be taken to prevent potential infection. In circumstances where there has been a significant exposure to HIV, **post-exposure prophylaxis** (sometimes referred to as PEP) may be indicated. PEP consists of treatment with two to four HIV anti-retroviral medications for a recommended period of four weeks.[23] There are currently five classes of anti-retroviral medications used to treat HIV infection; medications from four of these classes are recommended for use as HIV post-exposure prophylaxis.[24]

Ideally, PEP should be initiated as soon as possible after exposure. Animal studies suggest that PEP probably is substantially less effective when started more than 24 to 36 hours after an exposure. However, for humans, the interval after which no benefit is gained from PEP is undefined. Available data indicate that PEP in the non-occupational setting is less likely to be effective if initiated more than 72 hours after an exposure.[25]

Side effects have been reported by persons taking HIV anti-retroviral medications for post-exposure prophylaxis. The most common side effects reported is nausea, followed by malaise and fatigue; headache and diarrhea have also been reported. According to the US Centers for Disease Control and Prevention, these symptoms can often be managed with anti-nausea or anti-diarrhea medications that target these symptoms, and the antiretroviral regimen need not be changed. In other cases modifying the dose interval (i.e., administering a lower dose more frequently) may help with adherence to the regimen. Finally, the US Centers for Disease Control and Prevention recommends that selection of medications for PEP should be heavily influenced towards those that are tolerable for short-term use. However, not all side effects can be adequately mitigated; PEP may result in time off work. Adverse side effects usually cease when treatment is stopped.[26] There have been a total of 6 reports worldwide of occupational HIV infection despite PEP.

[22] Dr Colin D'Cunha, Chief Medical Officer of Health for Ontario. Submission to the Standing Committee on Justice and Social Policy, Legislature of Ontario, 4 December 2001.

[23] U.S. Centers for Disease Control and Prevention. Updated US Public Health Service Guidelines for the Management of Occupational Exposures to HBV, HCV and HIV and Recommendations for Postexposure Prophylaxis, *MMWR* 2001; 50 (No. RR-11) (29 June 2001) ["Updated CDC Guidelines"]; U.S. Centers for Disease Control and Prevention. Updated US Public Health Service Guidelines for the Management of Occupational Exposures to HIV and Recommendations for Postexposure Prophylaxis, *MMWR* 2005; 54 (No. RR-9) (30 September 2005) ["Updated CDC HIV Guidelines"], online via www.cdc.gov/mmwr/.

[24] See, generally, Updated CDC HIV Guidelines, *supra* note 23.

[25] US Public Health Service (Centers for Disease Control and Prevention). Antiretroviral Postexposure Prophylaxis After Sexual, Injection-Drug Use, or Other Non-occupational Exposure to HIV in the United States, *MMWR* 2005; 54 (No. RR-2) (21 January 2005) ["CDC Non-Occupational HIV Guidelines"], online via www.cdc.gov/mmwr/.

[26] All information in this paragraph is taken from Updated CDC HIV Guidelines, *supra* note _ at pp. 4, 5.

2.2 Hepatitis B

Risks of transmission

A preventive vaccine for HBV is available, and those vaccinated are at virtually no risk of infection. All CSC staff should be offered this vaccine as a truly protective measure against an occupational hazard. Many members of the general public have also received this vaccine or have developed a natural immunity to HBV as result of exposure.

Management of exposure

If the exposed person has not been vaccinated before the exposure, the post-exposure prophylaxis will consist of hepatitis B vaccine and possibly hepatitis B immune globulin (HBIG), which have been demonstrated to be highly effective in preventing HBV infection.[27] HBV vaccination is safe, and reports of any serious adverse effects receiving HBIG have been rare.[28] In addition to helping prevent HBV infection if the person has been exposed, vaccination benefits the exposed person in the event of future exposures.

2.3 Hepatitis C

Risk of transmission

There is no preventive vaccine for HCV. However, according to the US Centers for Disease Control and Prevention's most recent guidelines on managing occupational exposures, HCV "is not transmitted efficiently through occupational exposures to blood."[29] The risk of infection from a single percutaneous exposure to HCV-infected blood – the highest degree of occupational exposure – is estimated to be 1.8%. The risk of infection following mucocutaneous exposure is not known exactly but is believed to be very small.

Management of exposure

Unfortunately, there is no post-exposure prophylaxis for exposure to HCV at this time.

[27] U.S. Centers for Disease Control and Prevention. Prevention and Control of Infections with Hepatitis Viruses in Correctional Settings, *MMWR* 2003; 52 (No. RR-1) (24 January 2003), online via www.cdc.gov/mmwr/, at p. 11.

[28] Updated CDC Guidelines at p. 5.

[29] Updated CDC Guidelines at p. 6.

2.4 Existing CSC protocol for managing exposure to blood and/or bodily fluids: Commissioner's Directive 821-1

On 24 March 2004, the Correctional Service of Canada put in place an updated, comprehensive protocol for managing exposure to blood and/or bodily fluids.[30] Its objective is "[t]o protect the health and safety of people through prompt and consistent response to staff, inmates, and offenders residing in the CCC, who have had exposure to the blood or bodily fluids of another person."[31] Commissioner's Directive 821-1 was developed by a number of branches within CSC, at the NHQ, regional and institutional levels, and with input on the final version from the relevant trade unions.

Commissioner's Directive 821-1 defines "significant exposure" and sets out responsibilities of various parties in the event of an exposure to blood or bodily fluids. Among other responsibilities placed upon the operational unit head, he or she is responsible for ensuring arrangements have been made with a nearby health care facility to ensure implementation of the protocol, including availability of post-exposure prophylaxis (i.e., HIV anti-retroviral medications). Every operational head is also responsible for ensuring that a CSC staff member who has suffered an occupational exposure is offered appropriate Employee Assistance Program and other support mechanisms. The institutional nurse or officer-in-charge is responsible for arranging for an exposed staff member to be transported without delay to the health care facility and for reception of the exposed staff member by the health care facility.

Commissioner's Directive 821-1 also addresses the issue of the infectious disease status of the person who was the source of the blood or bodily fluids:

> 11. If a nurse is on-site and if there is documented serological status of the source person, the nurse will notify the attending physician of the serological status of the source person.
>
> 12. If the serological status of the source person is unknown, every effort should be made to encourage the source person to be tested for HIV, Hepatitis B and Hepatitis C. Testing of the source person cannot be done without their informed consent.

It is evident that in arriving at Commissioner's Directive 821-1, CSC considered the issue of occupational exposure from a wide range of perspectives — staff, prisoners, health services, workplace health and safety, human resources management, legal and operations — and arrived at a well-articulated policy for addressing the needs of staff and prisoners. Commissioner's Directive 821-1 should not be superseded by fundamentally flawed legislation to authorize the forced testing of federal prisoners in the event of occupational exposure. CSC has followed the correct course of action and there is no evidence indicating the need to revisit the issue.

[30] Commissioner's Directive 821-1.

[31] Commissioner's Directive 821-1, section 1.

3. Benefits of information obtained by forced testing in the case of occupational exposure are limited

There are three benefits for people exposed to the risk of infection with HIV, HBV or HCV that are said to flow from legislation such as the forced testing law proposed by UCCO. Information about the source person's HIV, HBV or HCV status is said to benefit the exposed person because it can be used:

1. to inform the exposed person's decisions about post-exposure prophylaxis;

2. to inform the exposed person's decisions about precautions to prevent secondary transmission to others (e.g., sexual partners); and

3. to alleviate anxiety about the possibility of infection.

Each of these is an important consideration and exposed persons need accurate information and support following occupational exposures. However, the purported benefits of forced testing legislation in these three areas are subject to important qualifications. These qualifications must be taken into account balancing the benefits and harms that such legislation carries. Furthermore, "knowing" a prisoner's HBV, HCV, or HIV status as a result of forced testing is not a replacement for ensuring CSC staff are given appropriate counselling and information to make decisions about their health.

3.1 Limited number of circumstances in which forced testing legislation would offer any potential benefit

The benefits of legislation authorizing compulsory testing only exist in those circumstances where:

- there has been a significant exposure to the risk of infection;
- the source person's status is unknown;
- the source person is available to be tested; and
- the source person does not consent to testing.

It should be remembered that most of those who are likely to be occupationally exposed to HBV have likely already received a very effective preventive vaccine. This means there will be few cases in which an occupational exposure to bodily fluids containing HBV will carry any significant risk of the exposed person being infected. In the case of HCV and HIV, it would only be those cases of occupational exposure to blood (and not fluids such as saliva, sputum, urine, etc) that could be considered a significant exposure. This means that it is a much smaller subset of cases of occupational exposure where there might be a great enough concern about the risk of infection to even consider testing the source person.

Furthermore, in the overwhelming majority of cases of occupational exposure, the source person consents to testing.[32] The study previously mentioned of exposures among US police officers reported that 94% of source persons consented to testing. The House of Commons Committee that examined Bill C-217 in 2001-2002 heard testimony from an Alberta physician specializing in infectious diseases that in the case of exposures to health care workers in hospitals approximately 99% of patients consent to being tested, leading him to point out that if the only exposures were occupational in the

[32] This information was presented by various parties to the House of Commons Standing Committee on Justice and Human Rights with regard to Bill C-217, including by the Member of Parliament who introduced the bill. E.g., see: Hon. Chuck Strahl, Member of Parliament. Evidence to the House of Commons Standing Committee on Justice and Human Rights, 12 December 2001.

health care setting, he would not be in favour of this type of legislation.[33] In the first six months of study by the Canadian Needle Stick Surveillance Network, 83% of known source persons agreed to be tested.[34] Elsewhere it has been reported that in one hospital in British Columbia with over 1,700 significant exposures in the hospital and in emergency rooms, all but two people agreed to be tested; in Ontario, none of 2,600 refused to be tested.[35]

There is no evidence that source persons are frequently unwilling to provide a blood sample for testing. The available evidence is to the contrary. It may well be that in some cases the person refuses, but we submit that stronger evidence of a significant problem should be required before we step onto the slippery slope of passing legislation that authorizes testing people for HIV without their consent, particularly when there are limited benefits to the exposed person (as is discussed more fully in the following sections).

3.2 Making decisions about post-exposure prophylaxis

HIV

While the effectiveness of post-exposure prophylaxis for HIV has yet to be fully proven, there is good indirect evidence and theoretical support for its use in appropriate circumstances. A person who has been occupationally exposed to HIV must make a decision as to whether to initiate post-exposure prophylaxis. This decision should be based on the significance of risk associated with the exposure to another person's blood or bodily fluids. *One of the factors* relevant to determining the risk is whether the person who was the source of the exposure is known to be infected with HIV. *Other, equally important factors* include the type and amount of bodily fluid involved, and the presence or absence of a route of entry for the virus. Where the person's HIV status is not known or the person does not consent to an HIV antibody test, the relevant legal and policy question becomes: ***Does testing a source person for HIV offer such a benefit to the exposed person that it justifies overriding other important rights of the source person, with the attendant harms?***

Current guidelines recommend that post-exposure prophylaxis for HIV be initiated within a matter of hours after the exposure. Forced testing legislation is ill-considered and unworkable on this count. The UCCO proposal envisages an administrative system for issuing and executing a warrant which would likely never result in a warrant for forced blood testing issuing within a few hours. Given the requirement of a medical report, a hearing before a justice or judge, the issuing and execution of the warrant, the analysis of the blood sample, and the dissemination of the report of the analysis to various parties, it would likely take days before the prisoner's HBV, HCV or HIV status was known to the CSC staff member. It must be remembered that the administrative and procedural safeguards are contained in the UCCO proposal have been included in an attempt to comply with the requirements under section 8 of the *Charter* — they cannot be set a side on the basis of expediency alone.[36])

Even if these results were to be obtained within a matter of a few hours – either through some extremely expedited process or the use of "rapid tests" on-site – we must remember that testing the source person provides only some of the information needed to answer the exposed person's question about whether or not they are at risk of infection and should initiate post-exposure prophylaxis. With

[33] Dr Steven Shafran, Professor of Medicine, Director of Infectious Diseases Division, University of Alberta Hospital. Evidence to the House of Commons Standing Committee on Justice and Human Rights, 14 June 2000.

[34] S Onno. Oral presentation at the 9th Annual Conference of the Canadian Association of Nurses in AIDS Care, 2001. For discussion, see *Backgrounder*, at 7.

[35] Dr Chris Archibald, Chief, Division of HIV/AIDS Epidemiology and Surveillance, Department of Health. Evidence to the House of Commons Standing Committee on Justice and Human Rights, 27 February 2002. Dr Archibald was testifying before the committee in relation to then Bill C-217, the proposed federal "Blood Samples Act."

[36] See e.g., *R v Dyment*, [1988] 2 SCR 417 at 438.

respect to rapid tests, it should also be noted that these are *screening* tests only – the use if a single rapid test does not provide the confirmed test results currently available using laboratory procedures that consist of repeated testing using different kinds of tests. While the World Health Organization has concluded that a testing procedure that combines the use of three rapid tests (using different principles or antigens) can be as sensitive and specific as the standard HIV diagnostic technique (i.e., combining EIA and Western blot tests),[37] there are currently only two rapid tests licensed for use in Canada.[38]

Therefore, UCCO is proposing to authorize compulsory HIV testing when, in the short period of time during which it might be of any possible benefit, the information resulting from the test would be of limited reliability. The exposed person would still be confronted with decisions about post-exposure prophylaxis. If the source person were to test HIV-positive on one of these rapid tests, obviously this might encourage the person to decide he or she definitely needed to take the post-exposure prophylaxis regimen. Who, upon receiving that initial positive result, which could very well be an inaccurate or false positive result, would want to take the risk of forgoing the drug regimen if there has been what they consider a significant exposure?

As has been noted, some people choose to discontinue post-exposure prophylaxis if the source person tests HIV-negative. Even if the source person tests HIV-negative, while this provides some reassurance, it does not rule out the possibility that the source person (and by extension the exposed person) might still be HIV-infected. The source person might be within the "window period," during which time a person who has been infected may not yet register as such on an HIV-antibody test. The vast majority of infected adults (95%) will develop HIV antibodies within 6 months of infection. The exposed person needs to understand the meaning of, and lack of certainty surrounding, HIV test results in light of the window period. The window period is particularly relevant if the source person had recently engaged in high-risk activities, such as sharing drug injection equipment or having unprotected sex, both of which activities occur in Canadian federal prisons — the former in part because prisoners are denied access to sterile injection equipment. Concern about a possible "false negative" test result would be greatest in the case of a recent potential infection of the source person.

HBV

Given the availability of a highly effective preventive vaccine, and post-exposure prophylaxis that carries no appreciable risk of harm, knowing the person's HBV status is not necessary for making treatment decisions. Therefore, this is not a compelling rationale for compulsory testing of the source person for HBV.

HCV

There is no preventive vaccine against HCV, nor is there any known effective post-exposure prophylaxis. In the absence of such medical options, testing the source person cannot assist with decisions about stopping or starting post-exposure prophylaxis, meaning this is not a compelling rationale for compulsory testing of the source person for HCV.

[37] World Health Organization. HIV Assays: Operational Characteristics (Phase 1) – Report 14: Simple/Rapid Tests. Geneva: WHO, 2004, online http://www.who.int/diagnostics_laboratory/publications/hiv_assays_rep_14.pdf.

[38] E Calero et al. *Rapid HIV-1 Diagnostic Algorithms fore Use in HIV Infection Screening*, Poster 3091, XIV International AIDS Conference, Barcelona, 7 -12 July 2002. As of October 2006, there are two rapid HIV-antibody tests licensed for sale in Canada. Biolytical Laboratories' INSTI HIV-Antibody Test is the only test licensed by Health Canada for use in a point of care setting, such as a physician's office or hospital, using whole blood, serum or plasma. Medmira Laboratories' Rapid HIV Test is approved only for laboratory use, using serum or plasma.

3.3 Preventing secondary transmission

HIV

Persons exposed to HIV should be counselled about avoiding activities that pose a risk of transmission (e.g., sharing needles, unprotected sex) — with accurate information that puts the risk, likely very small in almost all circumstances, into perspective. Women should avoid becoming pregnant until reasonably sure they are not infected (based on a negative HIV test result at 3 months, or 6 months at the outside); if already pregnant, women should be advised of the use of antiretroviral therapy and other interventions to considerably reduce the chance of transmitting the virus to their child during gestation or labour/delivery. If relevant, women should also be counselled about the risks of breast-feeding and advised about alternatives. The exposed person should refrain from donating blood, plasma, organs, tissue or semen. All of these represent temporary modifications to behaviour and can be undertaken whether or not the source person's HIV status is known.

HBV & HCV

Persons exposed to blood infected with HCV or HBV should be counselled about avoiding activities that pose a risk of transmission, again with accurate information about the actual risk of infection in the circumstances. While sex is the predominant mode of HBV transmission, it is rare that HCV is transmitted sexually; in any event, following an exposure, an exposed person should practice safer sex. Women should avoid becoming pregnant until they are reasonably sure they are not infected. The exposed person should refrain from donating blood, plasma, organs, tissue or semen.[39] Knowing the source person's HCV or HBV status is not necessary to take any of the above steps. Preventing secondary transmission is, therefore, not a compelling rationale for compulsory testing the source person for HCV or HBV.

3.4 Alleviating anxiety of the exposed person

A person who has experienced a significant occupational exposure to blood (and potentially blood-borne pathogens) will no doubt experience anxiety. This anxiety is likely to persist until he or she is outside the window period and has tested negative for HBV, HCV or HIV. As the Legal Network's *Backgrounder* indicates, there are various kinds of tests available for these three viruses:[40]

- Nucleic acid tests (which test directly for virus) can detect HBV in the exposed person as early as 23 days following infection, HCV as early as 12 days after infection, and HIV as early as 11 days after infection.

- Antibody tests can detect HBV infection 60 days after infection, HCV as early at 70 days after infection, and HIV as early as 22 days after infection.

Since the *Backgrounder* was published in 2001, there have been a number of advances in testing technology.[41] Such advances are capable of reducing the window period during which the tests may not detect infection, meaning that the time the exposed person must wait before being tested to determine if they are "in the clear" is also potentially shortened.

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[39] Updated CDC Guidelines, at 23.

[40] For a description of different testing technologies available for HIV, HCV and HBV see *Backgrounder*, at 15 -18.

[41] See e.g., S Stramer et al. Detection of HIV-1 and HCV infections among anti-body negative blood donors by nucleic acid-amplification testing. *New England Journal of Medicine* 2004; 351(8): 760-768; J Barletta. Lowering the detection limits of HIV-1 viral load using real-time immuno-PCR for HIV-1 p24 antigen. *American Journal of Clinical Pathology* 2004; 122(1): 20-27; F Hecht et al. Use of laboratory tests and clinical symptoms for the identification of primary HIV infection. *AIDS* 2002; 16(8):1119-1129.

The majority of people who become infected with HIV do so within the first few weeks or first 3 months following exposure. Ninety-five percent will have seroconverted within 6 months following exposure. Given the very small risks of occupational infection even in cases of percutaneous exposure to blood known to be contaminated with HIV (i.e., an estimated 0.3% chance of infection) — the situation of greatest risk — if the exposed person has not seroconverted by 6 months following the exposure, the chances of them seroconverting beyond that point are evidently exceedingly small.

There is no question that receiving a source person's *negative* test results for any of HBV, HCV or HIV can relieve some of the exposed person's anxiety about possible infection, as it means it is statistically even less likely that they have been infected as a result of the exposure.[42] (Of course, as already noted, it is possible that the negative result is a "false negative" if the source person is in the window period before HIV is detectable by standard tests.)

Knowledge of the source person's HIV test result, while having some value for decisions about post-exposure prophylaxis, may be a double-edged sword with respect to the anxiety felt by the exposed person as they wait for their own test results following an exposure. In cases where the source person tests *positive* for HIV, this information will only *increase* the exposed person's anxiety during the waiting period. The point is simply that, as with the other benefits said to flow from knowing the source person's status, the claimed benefit of alleviating anxiety is a qualified one. The fact that the benefit to be gained from knowing a source person's HIV status is limited must be kept in mind in considering whether the human rights violations inherent in forced testing can be justified.

Ensuring that appropriate counselling and information is provided to the exposed person is as important as testing in achieving the goal of relieving the exposed person's anxiety. This can and should be done without resort to compulsory testing. There have been too many reports of exposed police officers, fire fighters, health care workers or Good Samaritans believing that they are at much higher risk of infection than the circumstances of their exposure indicate, or not fully understanding the extent of time required for follow-up testing during which they may still test positive. This is a tremendous source of anxiety that is fully avoidable, which should be addressed through ensuring access to accurate, quality information. With respect to HIV, awareness of the truly small nature of the risk of infection — and in industrialized countries the very small number of emergency responders (zero in Canada) or health care workers (1 definite, 2 probable in Canada) who have been infected through occupational exposure — is information critical to relieving the anxiety of exposed persons.

[42] In the case of the exposed person already vaccinated against HBV, providing adequate information to the exposed person about the effectiveness of the preventive vaccine should go some considerable distance toward alleviating concern following exposure, meaning the anxiety-alleviating value of knowing the source person's HBV test result is much less significant.

4. Legal and ethical concerns about forced testing legislation

The qualified benefits offered by forced testing must be weighed against ethical principles Canadians consider important and which have been enshrined in law because of their significance. In this regard, the Canadian HIV/AIDS Legal Network raises three concerns regarding the UCCO proposal for forced testing of prisoners. In our view, the proposal:

- disregards the ethical and legal principle of informed consent to medical procedures;
- unjustifiably infringes of rights guaranteed under the *Canadian Charter of Rights and Freedoms*; and
- is internally inconsistent from a public policy perspective, insofar as it imposes forced testing on prisoners but not CSC staff, including correctional officers.

4.1 Ethical principle and legal doctrine of informed consent

Forced testing violates the ethical principle and legal requirements of informed consent. The ethical imperative of respect for persons requires that people not be treated merely as means to the ends of others. The legal doctrine of informed consent reflects the fundamental ethical principle of respect for persons and their autonomy, by protecting bodily and psychological integrity. The Supreme Court of Canada has repeatedly recognized that a person cannot be subjected to medical procedures without his or her informed consent.[43] This requirement has also been codified into statute in many provinces, and forms a part of the codes of ethical conduct for all health care professionals. The legal principle of informed consent also includes an aspect of the right to privacy respecting personal medical information. (Privacy rights are examined in section 4.2, below.)

The ethical and legal requirement for informed consent has been well established in policy discussions in Canada regarding the management of occupational exposures. In 1995, Health Canada convened a national conference that established a consensus on guidelines for a protocol to notify emergency responders when they may have been exposed to an infectious disease.[44] In 1996, Health Canada convened a meeting establishing a protocol for managing exposure to HBV, HCV and HIV among health-care workers.[45] Both reiterated that informed consent must be obtained for testing the source person.

The legal principle of informed consent is particularly important in upholding the right of prisoners to bodily integrity. The centrality of the principle of informed consent in prison settings recognizes that serious and persistent human rights abuses have historically been inflicted on prisoners as a means of control, as well as under the guise of medical treatment and scientific experimentation. The requirement of and informed consent, and the underlying respect for bodily integrity, are recognized in the *CRRA*, the Regulations under that Act, and Commissioner's Directives in various contexts:

- the use of X-rays to search for ingested contraband;[46]
- the conduct of cavity searches contraband;[47]

[43] *Reibl v Hughes*, [1980] 2 SCR 990; see also: *Hopp v Lepp*, [1980] 2 SCR 192; *Ciarlello v Schacter*, [1993] 2 SCR 119; *Malette v Shulman* (1990), 37 OAC 281 (CA); *Fleming v Reid* (1991), 82 DLR (4th) 298 (Ont CA); *Videto v Kennedy* (1981), 33 OR (2d) 497 (CA).

[44] Health Canada. A national consensus on guidelines for establishment of a post-exposure notification protocol for emergency responders. *Canada Communicable Disease Report* .1995; 21(19): 169-175.

[45] Health Canada. An integrated protocol to manage health care workers exposed to bloodborne pathogens. *Canada Communicable Disease Report* 1997; 23 (Suppl 23S2): 1-14.

[46] *CCRA*, section 51(a); Commissioner's Directive 566-7.

- the initiation or continuation of medical treatment and for all medical procedures;[48] and
- the prohibition on force-feeding a fasting prisoner.[49]

While urinalysis is permitted under the *CCRA*, a prisoner can never be forced to provide a urine sample.[50] The prisoner may be charged and found guilty of disciplinary offence for failing to provide a sample when requested to do so, but CSC authorities have no lawful power to physically compel a prisoner to provide a urine sample.[51]

4.2 Human rights concerns under the *Charter*

Prisoners do not lose their human and civil rights merely because they have been convicted of a crime and are prisoners of the state. The *CCRA* explicitly recognizes that prisoners retain the rights and privileges of all members of society, except those rights and privileges that are necessarily removed or restricted as a consequence of the sentence.[52] Furthermore, the *Canadian Charter of Rights and Freedoms* contains specific protections applicable to those involved in the criminal justice system and those who are imprisoned.[53] As the majority of the Supreme Court stated in *Sauvé*, in which federal prisoners won the right to vote in federal elections, "*Charter* rights are not a matter of privilege or merit, but a function of membership in the Canadian polity that cannot lightly be cast aside."[54]

To the best of our knowledge, legislation in Canada permitting forced testing for HIV and other communicable diseases has never been reviewed or interpreted by a court. Forced testing legislation such as the UCCO proposal raises numerous human rights concerns under the Charter. Privacy is an important value underlying the *Charter* section 7 guarantees of liberty and security of the person and the *Charter* section 8 guarantee against unreasonable search and seizure.[55] Since there have been no court decisions, it is uncertain whether courts would find forced testing legislation unjustifiably infringe these sections of the Charter.

In our submission, the state violates the *Charter* if it authorizes HIV testing without consent. In particular, it infringes the rights to liberty and security of the person (section 7) and the right to be free from unreasonable search and seizure (section 8). In the remainder of this part we highlight the ways in which the UCCO proposal runs counter to the principles and values that underpin sections 7 and 8 of the *Charter*.

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[47] *CCRA*, section 52; Commissioner's Directive 566-7.

[48] *CCRA*, section 88; Commissioner's Directive 803.

[49] *CCRA*, section 89.

[50] *CCRA*, sections 54 to 57.

[51] *CCRA*, section 40(l).

[52] *CCRA*, section 4(e).

[53] See the "legal rights" contained in sections 7 to 14 of the *Charter*.

[54] *Sauvé* v. *Canada (Chief Electoral Officer)*, 2002 SCC 68 at para. 14.

[55] *R* v. *Sharpe* [2001] 1 SCR 45; *R* v. *Mills* [1999] 3 SCR 668; *R* v. *Edwards* [1996] 1 SCR 128; *Hunter* v. *Southam* [1984] 2 SCR 145.

Liberty and security of the person

In *Morgentaler*, the Supreme Court emphasized that the *Charter* section 7 guarantee of security of the person protects the human body from interference by the state.[56] As stated by then Chief Justice Dickson, "the rights guaranteed in the Charter erect around each individual, metaphorically speaking, an invisible fence over which the state will not be allowed to trespass" such that a person has "the right to make fundamental personal decisions without interference from the state." [57]

Forcibly subjecting a person to a medical procedure, without his or her consent, amounts to an infringement of the person's liberty and security of the person. The UCCO proposal permits physicians to enlist the aid of peace officers to compel testing in the face of a refusal to comply with the court's order.[58] Peace officers are entitled to use reasonably necessary force to enforce the law. The infringement of both liberty and security of the person are evident. If the state is to exercise its coercive power in this way to infringe basic human rights, it must have a strong justification for doing so. The Supreme Court has recognized that while there may well be valid reasons for interfering with the liberty or security of the person, section 7 of the *Charter* requires that such interference conform to the principles of fundamental justice. The state's potential justification for forced blood testing is examined below.

Physical privacy

It is important to bear in mind that the leading Supreme Court cases on privacy rights, and the reasonable limits placed on such rights, have been decided in criminal and other law enforcement contexts. In such contexts, the Court has recognized that "the public's interest in being left alone by government must give way to the government's interest in intruding on the individual's privacy in order to advance its goals, notably those of law enforcement."[59]

However, the governmental interest in forced testing for occupational health and safety purposes — the essence of the UCCO proposal — is not as significant as the governmental interest in law enforcement. The UCCO proposal authorizes medical testing and the disclosure personal medical information of a prisoner without his or her consent and without any requirement that there be at least *prima facie* case of wrongdoing on the part of the prisoner. Under the UCCO proposal, forced testing could be ordered for a prisoner who has not been arrested or charged with any criminal or institutional offence related to the occupational exposure. The exposure could have been purely accidental and not involve any wrongdoing on the part of the prisoner. Under the UCCO proposal forced testing can also be ordered pre-emptively — in the absence of any exposure whatsoever — where "there is a significant risk that staff members *could* come into contact with a bodily substance of the inmate." [60]

The Supreme Court stated in the leading case interpreting section 8 of the *Charter*, and has reiterated many times since, that the function of the *Charter* "is to provide…for the unremitting protection of individual rights and liberties"[61] and that a major purpose of the constitutional protection against unreasonable search and seizure is the protection of the privacy of the individual before such interests are infringed. Furthermore, that right "must be interpreted in a broad and liberal manner so as to secure the citizen's right to a reasonable expectation of privacy against governmental encroachments."[62]

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[56] *R* v. *Morgentaler*, [1988] 1 SCR 30, at para 16, per Dickson CJ, writing for himself and Lamer J.

[57] *Morgentaler*, at para 226, per Dickson CJ.

[58] UCCO proposal, section 57.03(1).

[59] See the line of cases following on *Hunter* v. *Southam Inc*, *supra* at pp.159-60 (per Dickson J).

[60] UCCO proposal, section 57.03(3)(b) [emphasis added].

[61] *Hunter* v. *Southam*, *supra* at p. 155.

[62] *Dyment*, *supra* at 426. In the earlier case of *R* v. *Pohoretsky*, [1987] 1 SCR 945, the Court stressed the seriousness of a violation of the sanctity of a person's body as an affront to dignity.

The Supreme Court of Canada has held that, generally speaking, there is a heightened privacy interest associated with the taking of bodily samples due to the intrusive nature of such seizures and the affront to human dignity they entail.[63] In *Colarusso*, the Court stated that, "physical integrity, including bodily fluids, ranks high among the matters receiving constitutional protection, there is no doubt…"[64] In *Dyment*, the Court stated that:

> the use of a person's body without his consent to obtain information about him invades an area of personal privacy essential to the maintenance of human dignity... [T]he protection of the *Charter* extends to prevent a police officer, an agent of the state, from taking a substance as intimately personal as a person's blood from a person who holds it subject to a duty to respect the dignity and privacy of that person."[65]

In *Dyment*, police had obtained, without the patient's consent, a sample of free-flowing (not drawn) blood obtained by a physician treating a man involved in an automobile accident. The Supreme Court ruled this was an unlawful seizure in breach of section 8 of the *Charter*, and that the violation of the man's privacy interests was not minimal.

The *Charter* rights to physical privacy and bodily integrity are not absolute. When analyzing an alleged breach of section 8,[66] the court must determine whether a person has a reasonable expectation of privacy, and if so, whether the limits placed on that privacy are reasonable. The Supreme Court has stated that for a search to be reasonable: (a) it must be authorized by law; (b) the law itself must be reasonable; and (c) the manner in which the search was carried out must be reasonable.[67]

Recently, two judges of the Supreme Court held that compelling a convicted person to undergo blood tests as part of a probation order "would be far too intrusive and would breach s. 8 absent a statutory framework consistent with the standards of the *Charter*" (which framework did not exist in the case before it).[68] Taking bodily samples without consent is clearly the exception in Canadian law. Indeed, the *Criminal Code* only allows it in two carefully limited circumstances: (1) testing for alcohol when there are reasonable grounds to believe an offence of impaired driving has been committed, and (2) for the purpose of DNA analysis relating to a prosecution for certain designated serious offences. In both those cases, the infringement of privacy has been deemed justified in the interests of law enforcement once reasonable grounds exist for believing a person has engaged in criminal wrongdoing.

In the 25 years since the beginning of the AIDS epidemic, there have been two reported judgments in Canada directly considering the question of whether a court may order HIV testing of a person without consent, with test results provided to a person claiming to have been exposed to a risk of infection.[69]

- In *Beaulieu*, a woman sought a court order compelling the man accused of sexually assaulting her to provide a blood sample for HIV testing.[70] The Québec trial court expressly referred to

[63] *Dyment*, *supra*; *R* v. *Stillman*, [1997] 1 SCR 607.

[64] *R* v. *Colarusso*, [1994] 1 SCR 20 at 53.

[65] *Dyment*, *supra*, at para. 28.

[66] The Supreme Court has indicated that when a section 7 and a section 8 challenge based on the constitutional privacy interest are levelled against the same law or practice, it is appropriate to conduct the *Charter* analysis under section 8. In the Court's words, "a reasonable search and seizure is consistent with the principles of fundamental justice." See *Mills*, *supra* at para. 88; *R v Rodgers*, 2006 SCC 15, at paras 23, 24.

[67] *R v Collins*, [1987] 1 SCR 265 at page 278; *Stillman*, *supra* at para. 25.

[68] *R v Shoker*, 2006 SCC 44, at para 42 per LeBel and Bastarache JJ (the only justices to consider the *Charter* section 8 issue).

[69] There have been other cases in which the accused has consented to, or not opposed, testing (e.g. in the case of Paul Bernardo, *DC* v. *371148 Ontario Ltd (c.o.b. Forest Manor)*, [1997] OJ No. 2367 (QL)). Obviously, the issue of the constitutionality of forced HIV testing has not been judicially considered in those cases.

[70] *R* c. *Beaulieu*, [1992] AB No. 2046 (Cour du Québec – Chambre criminelle).

the Supreme Court's decision in *Dyment* in noting that forced testing raises serious *Charter* concerns. The court refused to issue the requested order, finding that it had no authority under the *Criminal Code* or otherwise to do so.

- In *JPB*, a 14 year old girl sought an order from the court that the male young offender convicted of sexually assaulting her undergo an HIV test.[71] On the facts of the case, the young offender had consented to providing a blood sample. Nonetheless, acting on the basis of the discretion granted under the *Young Offenders Act* and citing some undefined "valid moral policy," the judge ordered the young offender to provide a blood sample for the purposes of HIV testing, the results of which were to be communicated to the victim. The judge did not assess the constitutionality of the order sought and instead focused his analysis on U.S. case law and case law under the *Young Offenders Act*.

Prisoners and convicted persons retain *Charter* privacy rights

It is well established in law that prisoners retain all the rights that are not taken away expressly or by necessary implication as a result of their incarceration.[72] Prisoners retain a reasonable expectation of physical privacy in certain circumstances and thus are protected from unreasonable searches and seizures under section 8 of the *Charter.* Given the significant privacy interests that people have in their bodily substances, and the concomitant protection afforded by the Supreme Court, prisoners have a reasonable privacy interest in their blood and the information contained therein in certain circumstances. The Supreme Court has found that since individuals have different expectations of privacy in different contexts and with regard to different kinds of information, it follows that the standard of review of what is a "reasonable" search in a given context must be flexible. [73] Thus, where to draw the constitutional line of "reasonableness" is a function of both the importance of the state objective and the degree to which the individual's privacy is invaded.[74] As set out above, when balancing other public policy objectives against the infringement of *Charter* rights, CSC's interest in forced testing for occupational health and safety purposes is not as significant or weighty as the government's interest in enforcing the criminal law.

While the CCRA permits urinalysis, that context is clearly different from the forced taking of a blood sample to determine a prisoner's HIV, or hepatitis virus status. Urinalysis is more akin to the frisk search and cell patrols considered by the Supreme Court in the *Weatherall* case to be part of the "surveillance, searching and scrutiny" inherent in the prison environment the purpose of which is to provide for the security of the institution, the public and prisoners.[75] The UCCO proposal departs from the normal "surveillance, searching and scrutiny" inherent in the prison environment. In the case of an occupational exposure, a blood sample is taken from one individual to find out medical information for use by another individual in making treatment decisions — not for institutional security purposes under legislation intended "to contribute to the maintenance of a just, peaceful and safe society."[76] Pre-emptive forced HIV

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[71] *R* v. *JPB*, [1992] NWTJ No 207 (Northwest Territories Youth Court).

[72] *Corrections and Conditional Release Act,* S.C. 1992, c. 20, s. 4; *Raymond v. Honey,* [1982] 1 All ER 756 at 759; *Standard Minimum Rules for the Treatment of Prisoners,* UN Doc. A/CONF/611 (1955), amended UN Doc. E/5988 (1977); Basic Principles for the Treatment of Prisoners, UN General Assembly Resolution 45/111, UN Doc. A/45/49 (1990); World Health Organization. *WHO Guidelines on HIV Infection and AIDS in Prisons.* Geneva: WHO, 1993.

[73] *Rodgers*, *supra*, at para 26.

[74] *Ibid.* at para. 27.

[75] *Weatherall* v. *Canada (Attorney General)*, [1993] 2 SCR 872. The constitutionality of the urinalysis provisions of the CCRA have never been considered by the Supreme Court. See also *Mazzei* v. *British Columbia (Director of Adult Forensic Services)*, 2006 BCCA 321, regarding the reduced expectation of privacy of a person incarcerated in a forensic facility, given the need for institutional security.

[76] *CCRA*, section 3.

testing, as envisioned by the UCCO proposal, is arguably relevant to institutional security or, at a minimum, occupational safety. Leaving aside whether such differential treatment would be discriminatory in the legal sense, it is possible to envisage a situation in which CSC staff would take extra precautions to avoid exposure to the bodily substances of prisoners known to be HIV, HBV, or HCV positive. The important question is whether infringing a prisoner's fundamental rights for this putative disease prevention purpose is reasonable or justified. This question is addressed below, under the Charter section 1 analysis.

There are two other important differences between the existing power to demand a urine sample under the CCRA, and the proposed power to force a person to provide a blood sample. First, a prisoner can refuse to provide a urine sample, whereas under the UCCO proposal it must be assumed that a prisoner cannot refuse to comply with the warrant since there is no provision that provides for a penalty for refusing to provide a blood sample. Second, the procedure used to obtain a blood sample from a prisoner would necessarily be physically invasive (involving the puncturing of the skin), whereas the method used to obtain a urine sample is not (urinating into a container).

Informational privacy

Two years after the *Dyment* decision, the Supreme Court ruled in *Duarte* that the *Charter* protects the right of an individual to determine for himself or herself when, how, and to what extent to release personal information.[77] There are good reasons why a prisoner may not wish to be tested for HIV. The loss of confidentiality about something as significant as HIV status can produce a whole range of negative consequences. Stigma and discrimination related to HIV/AIDS remain a reality in Canada.[78]

The law permits the taking of a blood sample for the purposes of DNA analysis for certain purposes — under the DNA warrant provisions of the *Criminal Code* in the case of investigation, and under similar provisions in the *DNA Identification Act*, in concert with provisions in the *Criminal Code*, once a person has been convicted of an enumerated criminal offence. Both types of provisions have been found to be constitutional by the Supreme Court.[79] The privacy interest at issue was determined to be limited because it related solely to a person's identity, since forensic DNA analysis does not reveal any medical, physical or mental characteristics. The Supreme Court drew an analogy with the practice of fingerprinting accused persons subsequent to arrest, which it has also found to be constitutionally valid.[80] In contrast, the privacy interest raised by the UCCO proposal goes well beyond the prisoner's identity. The very purpose of the UCCO proposal is to permit the seizure of sensitive medical information, namely the prisoner's HIV, HBV and HCV status.

Given the prison "grapevine" through which information about prisoners is shared among staff, as well as UCCO's publicly-stated position that correctional officers need to know every prisoner's HIV (and other infectious disease) status in order to protect their health and safety,[81] it is likely that a prisoner's HIV status will quickly become common knowledge within an institution. Many prisoners are reticent to get tested for HIV in prison because they fear their HIV status will not remain confidential. It is difficult to imagine that the UCCO proposal's prohibition on unauthorized disclosure will be effective in

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[77] *R v Duarte*, [1990] 1 SCR 30 at 46.

[78] See: (1) Series of info sheets on "HIV/AIDS and discrimination"; (2) T de Bruyn. *HIV/AIDS and Discrimination: Final Report*. Canadian HIV/AIDS Legal Network. 1998; (3) T de Bruyn. *A Plan of action for Canada to reduce HIV/AIDS-related stigma and discrimination*. Canadian HIV/AIDS Legal Network. 2004. All documents are available on-line via http://www.aidslaw.ca/Maincontent/issues/discrimination.htm.

[79] *R v SAB*, 2003 SCC 60; *R v Rodgers*.

[80] *R v Beare*, [1988] 2 SCR 387.

[81] See, for example, comments of UCCO President Sylvain Martel, *The Current*, CBC Radio One, 27 October 2004, where he stated that "Correctional officers when there is an incident happening have a right to find out has the inmate has any infectious disease." He also stated, "We have to find out who they are and what they have."

protecting the confidentiality of the prisoner forcibly tested for HIV, especially when one considers the likely difficulty of proving an unauthorized disclosure in an environment characterized by professional collegiality. One can also understand the desire on the part of correctional staff to share information with one another, and with family and friends to whom the fact of the initial exposure has likely already been disclosed. Those people will, in turn, likely discuss this information with others, with the result that a prisoner's HIV-positive status is likely to become much more widely known. The invasion of the prisoner's privacy and resulting consequences would be particularly acute given that prisons are relatively small "communities" and are often located in small communities.

Psychological integrity

The violation of physical privacy and bodily integrity is compounded by a violation of psychological integrity. While the UCCO proposal effectively allows the source person to decide whether or not to be informed of his or her test results depending on whether he or she consults with their physician,[82] it nonetheless removes the option to decide whether and when to get tested. The prisoner may have refrained from undergoing an HIV test for valid personal reasons, including the fear of discrimination and violence should it be known within the prison that he or she was HIV positive. There is no requirement in the proposal that the prisoner receive pre- and post-test counselling, in the absence of which the prisoner may not understand the significance of the HIV test result.

Rights violations cannot be justified under section 1 of the *Charter*

In the leading case of *Oakes*,[83] the Supreme Court has set out the requirements for justifying state action that infringes *Charter* rights under the provisions of section 1 of the *Charter*:

- the objective to be served by the measures infringing the right must relate to concerns that are "pressing and substantial in a free and democratic society";
- the measures must be fair and not arbitrary, carefully designed to achieve the objective in question, and rationally connected to that objective;
- the measures should impair the *Charter* right as little as possible; and
- there must be proportionality between the effects of the limiting measure and the objective - the more severe the infringement of the right, the more important must be the objective.

We agree that protecting people against occupational exposures to blood-borne pathogens, and helping them deal with the aftermath of such an exposure, are pressing and substantial concerns. This is why the Canadian HIV/AIDS Legal Network supports, as a matter of workers' human rights, measures to prevent or reduce the risks of occupational exposures in the first place, and workers' right to receive prompt and adequate information, counselling, support, accommodation and treatment in the event that exposures do occur.

However, we submit that the UCCO proposal fails each of the remaining three steps in the *Oakes* test that it must satisfy, under section 1 of the *Charter*, to pass constitutional muster.

[82] UCCO proposal, section 57.08(1).

[83] *R v Oakes*, [1986] 1 SCR 103.

(1) "Rational connection"

The UCCO proposal is not rationally connected to, nor does it achieve, the legislative objectives. Neither pre-emptive nor post-exposure testing of prisoners for HIV can prevent CSC staff from being exposed to prisoners' potentially infectious bodily fluids. Pre-emptive testing does not necessarily make workplaces safer environments in the way that universal precautions do. In addition, post-exposure testing provides information of limited use in making a decision concerning post-exposure prophylaxis. Providing CSC staff with a procedure to test a prisoner for HIV does not ensure that the prisoner's HIV status can be definitively determined during the time in which this information is crucial for making a decision about post-exposure prophylaxis (ideally a matter of hours).

However, there are logical and proven ways to address the post-exposure anxiety faced by CSC staff without infringing *Charter* rights. CSC staff should be provided with accurate information about HIV transmission and the risks involved in different types of exposures, and with appropriate counselling and support. Commissioner's Directive 821-1 is already in place and presents a protocol which includes a rational response to such anxiety focussing on support for the exposed staff member. Various leading associations of health professionals have criticized legislation that authorizes forced taking and testing of blood samples as "not warranted" or "unjustified,"[84] and the Chief Medical Officer of Health for Ontario, while supporting the intention behind such legislation, considers that it does not realize its goals.[85] We have noted in detail above and in the enclosed *Backgrounder* that the rationale for authorizing compulsory testing for HCV and HBV is not well supported by evidence.

(2) "Minimal impairment"

We submit that the UCCO proposal also impairs *Charter* rights in considerably more than a minimal fashion. The UCCO proposal would:

- authorize the application of physical force to conduct a medical procedure without consent;
- authorize the invasion of physical, psychological and informational privacy represented by compulsory testing;
- not sufficiently respond to the practical impossibility of legislating adequate protection for the confidentiality of the test results of the person subject to compulsory testing, or of creating any effective remedy once the damage of testing without consent has been done;
- likely result in discrimination and other negative consequences against a prisoner who tests positive (particularly for HIV) as a result of compulsory testing; and
- not offer any greater protection for CSC staff than existing alternatives for preventing and managing occupational (and non-occupational) exposures that seek to address many of the concerns and needs of exposed persons without infringing the constitutional rights of source persons, including the use of universal precautions and the Commissioner's Directive 821-1.

Workers who risk exposure to blood-borne pathogens such as the HBV, HCV and HIV deserve a more considered, comprehensive response from legislators, a response that would help fulfill the human right to safe and healthy working conditions by offering real protections and support for workers. Moreover, ensuring access to adequate information, counselling, support and treatment in the event of an exposure is more beneficial to CSC staff and represents more a constructive and useful alternative in terms of workplace health and safety.

[84] As set out in the *Backgrounder*, *supra* at pp.25-31, such groups include the Canadian Nurses Association, the Canadian Association of Nurses in AIDS Care, and the Canadian Medical Association.

[85] Dr Colin D'Cunha, Submission to the Standing Committee on Justice and Social Policy, Legislature of Ontario, *supra*.

(3) "Proportionality"

Finally, we submit that the requisite proportionality between objectives and the infringement of *Charter* rights is not adequately demonstrated. The UCCO proposal would invoke the physically coercive power of the state to, if necessary, strap an individual down, take their blood and then communicate private medical information about that person to others. Such treatment by the state violates human rights — liberty, security of the person, and privacy (including freedom from unreasonable search and seizure) — that are held to be so fundamental that they find expression in the country's highest law and Canadian courts have consistently stressed their importance. Such infringement is imposed when unnecessary to achieve the legislative objectives and when it can provide at most a limited benefit, in a small subset of cases and in the face of evidence demonstrating the risk of transmission in almost all cases to be very small, and when the knock-on effect of further violations of privacy (through further disclosure of private medical information) is highly likely. Given this calculus of at-most limited benefit, and very real harms, we submit that the UCCO proposal is not constitutionally justifiable.

4.3 Consistency in the law: an important policy consideration

Finally, the UCCO proposal also raises the issue of consistency in the law, which is desirable as a matter of public policy. The UCCO proposal authorizes the compulsory testing of a prisoner in the event that a CSC staff member is exposed to a prisoner's bodily substance. It does not authorize the compulsory testing of a staff member where a prisoner comes into contact with the staff member's bodily substances. The same rationales for obtaining information to make post-exposure prophylaxis decisions, prevent secondary transmission, and to alleviate anxiety would surely apply to a prisoner who is significantly exposed to a CSC staff members blood or bodily substance capable of transmitting HBV, HCV, or HIV. This asymmetry is not warranted or justifiable. This question was raised by representatives of Justice Canada before the House of Commons Standing Committee with respect to an earlier proposal for using state power to coerce blood sampling and testing following occupational exposure — Bill C-244, the precursor to Bill C-217 that the Committee ultimately recommended in 2002 not proceed.[86] It remains a question with respect to the UCCO proposal and similar legislation.

Conclusion

The forced blood testing of prisoners under the UCCO proposal is an unjustifiable infringement of prisoners' *Charter* rights to privacy and to be secure against an unreasonable search and seizure. The UCCO proposal also raises serious concerns about the privacy of prisoner's medical information and the potential for discriminatory treatment of prisoners known to CSC staff to be living with HIV or hepatitis B or C. Moreover, in light of CSC's existing protocol for responding to exposure to blood and bodily fluids as set out in Commissioner's Directive 821-1, forced testing is unnecessary. There is no evidence that the existing protocol is ineffective or does not adequately protect the occupational health and safety of CSC staff. Nor is there any evidence that the UCCO proposal, were it to become law, would result in increased workplace safety for CSC staff. **For all of the foregoing reasons, we submit that the Government of Canada should not introduce or support forced testing legislation applicable to federal prisoners.**

[86] Yvan Roy, Senior General Counsel, Criminal Law Policy Section, Justice Canada. Evidence to House of Commons Standing Committee on Justice and Human Rights, 13 June 2000.

APPENDIX A: UCCO proposal

An Act to amend the Corrections and Conditional Release Act (blood samples)

1. The *Corrections and Conditional Release Act* is amended by adding the following after section 57:

57.01 (1) In this section and sections 57.02 to 57.12:

‘‘analyst’’ has the same meaning as in subsection 254(1) of the *Criminal Code*.

‘‘designated virus’’ means the hepatitis B virus or the hepatitis C virus or a human immunodeficiency virus.

‘‘justice’’ means a justice of the peace or a provincial court judge.

‘‘peace officer’’ has the same meaning as in section 2 of the *Criminal Code*.

‘‘physician report’’ means a report made by a qualified medical practitioner who is informed in respect of matters related to occupational and environmental health and all protocols and standards of practice in respect of blood-borne pathogens, which report assesses the risk to the health of an applicant described in subsection (2) as a result of the applicant coming into contact with a bodily substance of an inmate.

‘‘provincial court judge’’ has the same meaning as in section 2 of the *Criminal Code*.

‘‘qualified medical practitioner’’ has the same meaning as in subsection 254(1) of the *Criminal Code*.

‘‘qualified technician’’ has the same meaning as in subsection 254(1) of the *Criminal Code*.

(2) A staff member may apply to a justice for a warrant authorizing the taking of a sample of blood from an inmate, in order to determine whether that person carries a designated virus, where the applicant believes on reasonable grounds that

(*a*) while in the execution of his duties, the applicant has come into contact with a bodily substance of the inmate;

(*b*) the applicant may have become infected with a designated virus as a result of coming into contact with the bodily substance; and

(*c*) by reason of the lengthy incubation periods for diseases caused by the designated viruses and the methods available for ascertaining the presence of such viruses in the human body, an analysis of the applicant's blood would not accurately determine, in a timely manner, whether the applicant had become infected with a designated virus as a result of coming into contact with the bodily substance.

57.02 A justice who receives an application under section 57.01 shall cause the parties to appear before the justice.

57.03 (1) A justice before whom the parties have appeared may issue a warrant authorizing a peace officer to require a qualified medical practitioner to take, or to cause to be taken by a qualified technician under the direction of the qualified medical practitioner, such samples of the blood of the inmate as in the opinion of the person taking the samples are necessary to enable a proper analysis to be made in order to determine whether the person carries a designated virus, where the justice is satisfied that there are reasonable grounds to believe that

(*a*) while in the execution of his duties, the applicant has come into contact with a bodily substance of the inmate;

(*b*) the applicant may have become infected with a designated virus as a result of coming into contact with the bodily substance;

(*c*) by reason of the lengthy incubation periods for diseases caused by the designated viruses and the methods available for ascertaining the presence of such viruses in the human body, an analysis of the applicant's blood would not accurately determine, in a timely manner, whether the applicant had become infected with a designated virus as a result of coming into contact with the bodily substance;

(*d*) a qualified medical practitioner is of the opinion that the taking of blood samples would not endanger the inmate’s life or health;

(*e*) the applicant has submitted to the justice a physician report on the applicant made within 7 days after the applicant came into contact with the bodily substance; and

(*f*) having regard to the physician report mentioned in clause (e), the analysis of the samples of the blood of the inmate is necessary to decrease or eliminate the risk to the health of the applicant as a result of the applicant coming into contact with the bodily substance.

(2) A qualified medical practitioner who makes a physician report required under subsection (1) may require the applicant to submit to an examination or treatment for the purpose of making the report.

(3) The warrant described in subsection (1) may also be issued by a provincial court judge before whom the parties have appeared where the applicant establishes that

(*a*) he believes on reasonable grounds that the inmate is infected with a designated virus;

(*b*) there is a significant risk that staff members could come into contact with a bodily substance of the inmate and as a result become infected with a designated virus;

(*c*) this risk is preventing staff members from properly and safely exercising their duties; and

(*d*) a qualified medical practitioner is of the opinion that the taking of blood samples would not endanger the inmate's life or health.

57.04 Blood samples may be taken from an inmate only pursuant to a warrant issued under section 57.03, and only by or under the direction of a qualified medical practitioner, provided that the qualified medical practitioner is satisfied that the taking of such blood samples does not endanger the life or health of the inmate.

57.05 (1) No qualified medical practitioner or qualified technician is guilty of an offence only by reason of a refusal to take blood samples from an inmate for the purposes of this Act.

(2) No qualified medical practitioner is guilty of an offence only by reason of a refusal to cause a qualified technician to take blood samples from an inmate for the purposes of this Act.

57.06 No qualified medical practitioner by whom or under whose direction blood samples are taken from an inmate pursuant to a warrant issued under section 57.03 and no qualified technician acting under the direction of a qualified medical practitioner incurs any criminal or civil liability for anything necessarily done with reasonable care and skill in the taking of such blood samples.

57.07 (1) On completion of the taking of the samples of blood of an inmate by a qualified medical practitioner or a qualified technician, pursuant to a warrant issued under section 57.03, the qualified medical practitioner shall give to the peace officer responsible for executing the warrant, or to another peace officer in his stead, a copy of a certificate

(*a*) stating

(i) that the qualified medical practitioner took the blood samples from the inmate mentioned in the warrant,

(ii) that, before the samples were taken, the qualified medical practitioner was of the opinion that the taking of blood samples would not endanger the life or health of the inmate, and

(iii) the time and place where the blood samples were taken; or

(*b*) stating

(i) that the qualified medical practitioner caused the samples to be taken by a qualified technician under his direction from the inmate mentioned in the warrant, and

(ii) that, before the samples were taken, the qualified medical practitioner was of the opinion that the taking of the blood samples would not endanger the life or health of the inmate.

(2) On completion of the taking of the samples of blood from the inmate pursuant to the warrant issued under section 57.03, the qualified technician shall give to the qualified medical practitioner who caused him to take the samples and to the peace officer responsible for executing the warrant, or to another peace officer in his stead, a copy of a certificate stating

(*a*) that the qualified technician took the samples of blood;

(*b*) the time and place where the samples of blood were taken; and

(*c*) that the blood samples were taken directly from the inmate mentioned in the warrant.

57.08 (1) On completion of the analysis of the samples of the blood of an inmate pursuant to the warrant issued under section 57.03, the analyst shall

(*a*) make reasonable attempts to deliver a report on the results of the analysis to the physician of the inmate from whom the sample was taken;

(*b*) make reasonable attempts to deliver, to the inmate from whom the sample was taken, a notice that the analyst delivered the report mentioned in clause (a) if the analyst succeeded in delivering the report under that clause;

(*c*) make reasonable attempts to deliver a report on the results of the analysis to the physician of the applicant; and

(*d*) make reasonable attempts to deliver to the applicant

(i) a notice that the analyst has made reasonable attempts to deliver a report on the results of the analysis to the physician of the applicant, and

(ii) a recommendation in writing that the applicant consult his or her physician for a proper interpretation of the results of the analysis.

(2) On completion of the analysis of the samples of the blood of an inmate pursuant to the warrant issued under section 57.03, the analyst shall give to the peace officer responsible for executing the warrant, or to another peace officer in his stead, a copy of a certificate stating

(*a*) that the analyst completed the analysis of the samples of blood; and

(*b*) that the analyst made reasonable attempts to deliver the reports and notices described in subsection (1).

(3) An analyst who receives a sample of blood for analysis pursuant to a warrant issued under section 57.03

(*a*) shall ensure that the sample is not used for any purpose other than the analysis and the reporting of results described in this section;

(*b*) shall not release the sample to any person other than for the purpose of this section or the retention of the sample by a person acting on behalf of the analyst as long as no person other than the analyst has access to the sample;

(*c*) shall not disclose the results of the analysis to any person other than in accordance with this section.

57.09 (1) The samples of the blood of an inmate obtained pursuant to a warrant issued under section 57.03 shall not be used for any purpose other than the purpose for which they were obtained.

(2) A sample of blood taken from an inmate pursuant to a warrant issued under section 57.03 shall not be analysed for any purpose other than the purpose specified in the warrant.

57.10 Except as expressly authorized by this Act, no person shall disclose to any other person the name of or any other information that will or is likely to identify

(a) a staff member in respect of whom an application or physician report is made under section 57.01 or section 57.03; or

(*b*) an inmate in respect of whom a warrant is issued under section 57.03.

57.11 Every one who contravenes subsection 57.08(3), section 57.09 or section 57.10 commits an offence punishable on summary conviction.

57.12 The results of the analysis of blood samples obtained pursuant to a warrant issued under section 57.03 and all certificates, reports or notices provided for in sections 57.07 and 57.08 shall not be received in evidence

(*a*) in a civil proceeding; or

(*b*) in a criminal proceeding except in a proceeding under section 57.11.