IN THE COURT OF APPEAL OF MANITOBA

Coram: Madam Justice Freda M. Steel
Mr. Justice Alan D. MacInnes
Madam Justice Holly C. Beard

B E T W E E N:

HER MAJESTY THE QUEEN	)	***I. N. MacNair***
	)	*for the Appellant*
Respondent	)	
	)	***E. A. Thomson*** *and*
- and -	)	***W. E. Friesen***
	)	*for the Respondent*
CLATO LUAL MABIOR	)	
	)	***D. M. Olson***
(Accused) Appellant	)	*for the Intervener*
	)	
- and -	)	*Appeal heard:*
	)	***February 10, 2010***
CANADIAN HIV/AIDS LEGAL NETWORK	)	
	)	*Judgment delivered:*
Intervener	)	***October 13, 2010***

STEEL J.A.

INTRODUCTION

1 The accused appeals his conviction on six counts of aggravated sexual assault and on one count each of invitation to sexual touching and sexual interference. He was sentenced to a total of 14 years' incarceration.

2 While these six women consented to having sexual intercourse with the accused, they testified that they would not have done so if they had known he was HIV-positive. The Supreme Court of Canada held in *R. v.*

Appeal from 2008 MBQB 201, 230 Man.R. (2d) 184
See 2009 MBCA 93, 245 Man.R. (2d) 81

Cuerrier, [1998] 2 S.C.R. 371, that the failure to disclose one's HIV-positive status, where this creates a significant risk of serious bodily harm to the complainant, constitutes fraud and invalidates any consent to the sexual activity. Consequently, whether the fraud is sufficient to vitiate consent depends on the degree of risk created by the accused's conduct.

3 The principal issue on the appeal is whether the trial judge erred in her application of the test of "significant risk of serious bodily harm" to the particular facts of this case.

4 For the reasons detailed below, I have found that she did so err. The law with respect to aggravated sexual assault and the transmission of HIV, as developed by the Supreme Court of Canada in *Cuerrier*, attaches criminal liability to the failure to disclose one's positive HIV status only when there is a "significant risk of serious bodily harm." That determination will vary depending on the scientific and medical evidence adduced in each particular case. In this case, the scientific evidence indicated that either the careful use of a condom or effective antiretroviral therapy which reduced viral loads to an undetectable level could potentially reduce the level of risk to below the legal test of "significant risk."

5 Whether in fact the accused could be said to have carefully used a condom or had undetectable viral loads in relation to each of the six complainants was a matter to be determined on an examination of the facts relating to each complainant.

BACKGROUND

6 Between February 2004 and December 2005 the accused had sexual relations with the six complainants, one of whom was under 14 years of age at the time. The accused's knowledge of his HIV status, the dates of his medical tests and his treatments are all relevant facts in determining culpability, and therefore the facts are presented in some detail.

7 The accused was medically diagnosed as HIV-positive on January 14, 2004, as a result of a specimen being drawn on December 22, 2003. The evidence showed that he had been fully counselled by doctors and nurses on all relevant aspects of being HIV-positive, including the potential result of unprotected sex. He was advised by public health officials that he was to use latex condoms that had not expired every time he had sexual intercourse and to tell all sexual partners of his HIV-positive status.

8 The trial judge found as a fact that the accused, despite the advice given him, engaged in acts of both protected and unprotected sexual intercourse with the complainants subsequent to learning of his condition without disclosing to any of them that he was HIV-positive. None of the complainants have to date been diagnosed as HIV-positive.

9 The trial judge also found as a fact that five of the complainants would not have engaged in sexual relations with the accused if they had been told by him that he was HIV-positive. The one exception to this was D.C.S., who learned of his medical condition during the course of their sexual relationship.

10 The scientific and medical evidence at trial were provided by Dr. Richard Smith, Ms Katherine McDonald and Ms Jaime Burgoyne, all three of whom were called by the Crown. Dr. Richard Smith testified as an expert in the area of HIV and AIDS on behalf of the Crown. He was qualified as a medical doctor whose primary emphasis of practice was on the diagnosis, treatment and prevention of HIV and AIDS. He provided an expert's report on HIV/AIDS, which was filed and upon which he was examined. As well, although he did not treat the accused, he reviewed and gave his opinion on the accused's medical and public health records, all of which were also filed.

11 Ms McDonald, a public health nurse, was the Coordinator of the Sexually Transmitted Infectious Program, HIV, Hepatitis C for the Assiniboine and Brandon Regional Health Authorities, and Ms Burgoyne is a public health nurse in Brandon who specializes in sexually transmitted infections. Between the two of them, they met and counselled the accused approximately 20 times between December 12, 2003, and December 7, 2004. Besides counselling him, as previously indicated, with respect to medication, support, safety, sexuality and the obligation to disclose his status, they often provided him with a supply of condoms and used a model to explain their proper use.

12 In April 2004 the accused was placed on antiretroviral therapy, and his viral loads were checked every three to four months. Dr. Smith testified, and the trial judge accepted, that the accused had viral loads that were consistent with "probably low but possible infectivity" until October 21, 2004, and then from October 22, 2004, to December 28, 2005, there was a

very high probability that the accused was not infectious and could not have transmitted HIV throughout that period.

13 Although Dr. Smith suggested that it would have been normal practice for the accused's doctors to have told him that his viral load was controlled during the period of time under consideration, Ms Burgoyne testified that, while she briefly discussed viral loads with the accused, she never told him that his viral loads were so low that he could not infect anyone.

14 The trial judge held that a significant risk of serious bodily harm existed even in instances of protected sexual intercourse, that is, with a condom, between some of the complainants and the accused. In addressing the subject of the risk of transmission of HIV when condoms were used, the trial judge referenced, at numerous junctures in her reasons, that condom usage only resulted in an 80 per cent risk reduction or that they were only 80 per cent reliable or effective and therefore a significant risk of transmission remained.

15 The trial judge did not consider the effect of a low viral load on the question of risk where instances of unprotected sex occurred. She held that only where the accused's viral loads were undetectable and a condom was used did the risk of transmission fall below the legal standard of "significant."

16 The accused appealed, arguing that given his low viral loads at the time, together with, in some cases, the use of condoms, the risk of transmission of the virus to the complainants was so low that it did not constitute a "significant risk of serious bodily harm." Thus, he submitted,

the trial judge erred in her application of the factual findings in the case to the legal standard. He also argued that the trial judge misapprehended the evidence related to the reduction of the risk of transmission of HIV by means of the use of a condom.

17 As a separate ground of appeal, the accused submitted that the trial judge erred in making inappropriate findings of fact from the evidence of two of the complainants, M.P. and D.C.S.

18 On appeal, the Canadian HIV/AIDS Legal Network was allowed to intervene. Their intervention was limited to assisting the court by providing any cases and academic comment concerning the public policy considerations enunciated in *Cuerrier* or in subsequent cases. The intervener argued that it was contrary to public policy to criminalize lack of disclosure in situations where there was no "significant risk" of transmission.

19 The Crown's position focussed on the issue of consent. It argued forcefully that this case is not about criminalizing those with HIV, but rather it is about every person's right to have control over their basic bodily integrity. This includes the right to critical information that may affect their decision as to whom they choose to have sexual intercourse with or how they choose to do so. Removing the complainant's ability to make this decision for herself or himself is inconsistent with the respect for sexual autonomy that underlies the law of sexual assault. The fact that an accused uses a condom or takes medication does not address this fundamental issue. People have a right to know the risks they are accepting when they agree to sexual intercourse. The accused withheld this information so that he could

have sex with women who otherwise would not have consented to have sex with him.

20 Alternatively, the Crown submits that there was no or insufficient evidence in this case of the factors necessary to actually reduce the risk of transmission of the virus. So, for example, with respect to condoms, there was no evidence on which to base a finding that condoms were properly used and therefore no basis for a finding that they effectively reduced the risk of transmission in this case.

21 Finally, and again alternatively, the Crown goes further and argues that given the extremely serious nature of the consequences of infection, even a small risk of transmission constitutes a "significant risk of serious bodily harm." Although, when properly used, condoms can reduce the risk of HIV transmission, they do not and cannot eliminate this risk completely. Even the most careful use of condoms, for example, cannot guarantee against the risk of breakage. It is the nature of the possible resulting harm that matters, contends the Crown, not the percentage chance that it might be passed on. Instead, the Crown argues, in this case, neither condoms nor a low viral load lowered the risk sufficiently so as to eliminate the need for the accused to disclose his HIV-positive status.

DID THE TRIAL JUDGE ERR IN HER CREDIBILITY FINDINGS?

22 The accused argues that the trial judge erred in making inappropriate findings of fact from the evidence of two of the complainants, M.P. and D.C.S. He submitted that there were inconsistencies in the evidence of both

complainants and the trial judge did not explain sufficiently why she accepted one version over another, and even if she did, the accused submitted it was unreasonable of her to accept the complainants' evidence given those inconsistencies.

23 It seems as if the accused is alleging grounds of appeal related both to insufficient reasons and unreasonable verdict. In a judge-alone trial, these two grounds of appeal are analytically very similar, and the parties agreed that the standard of review would be one of palpable and overriding error. It is simply not open to an appellate court to disagree with the trial judge's assessment of credibility unless her reasons demonstrate an overriding error in her appreciation of the law or evidence or an insufficiency in those reasons. See *R. v. Gagnon*, 2006 SCC 17, [2006] 1 S.C.R. 621 at para. 24, and *R. v. R.E.M.*, 2008 SCC 51, [2008] 3 S.C.R. 3 at para. 32. However, one must remember that, although they overlap, they are two distinct grounds of appeal. As Professor Janine Benedet points out in her annotation to *Gagnon* (37 C.R. (6th) 209 at 212):

> Although the various grounds for allowing an appeal may overlap, courts should be careful to keep the unreasonable verdict test and the insufficient reasons test distinct because of the different remedies they require. The usual remedy for an unreasonable verdict is an acquittal; insufficient reasons typically demand a new trial.

24 Where the issue is the reasonableness of the decision, this court explained in *R. v. Sinclair (T.)*, 2009 MBCA 71, 240 Man.R. (2d) 135, leave to appeal to S.C.C. granted, [2009] S.C.C.A. No. 456 (QL), and in *R. v. Oddleifson*, 2010 MBCA 44, 256 C.C.C. (3d) 317, that the well-known standard set out in *R. v. Biniaris*, 2000 SCC 15, [2000] 1 S.C.R. 381, no

longer articulates the standard of review for reasonableness in a judge-alone rather than a jury trial. Instead, the focus is on the reasons of the trial judge as opposed to the verdict itself. "... [I]t is the reasons that inform the reasonableness of the verdict" (*Oddleifson*, at para. 5). Moreover, to render a verdict unreasonable, an error about the evidence must go to the "substance rather than to the detail. It must be material rather than peripheral to the reasoning of the trial judge" (*R. v. Lohrer*, 2004 SCC 80, [2004] 3 S.C.R. 732 at para. 2, Binnie J., quoted in *Sinclair*, at para. 97).

25 With respect to the sufficiency of reasons, the reasons must be sufficiently amenable to appellate review and should, for example, explain how and why material pieces of inconsistent evidence were reconciled. However, a functional approach should be used, and appellate review does not require a word-for-word analysis. Rather, an examination should be conducted to determine whether the reasons, taken as a whole, reflect reversible error. See *R. v. R.E.M.*, at para. 25.

26 Where the error alleged relates to an assessment of credibility, one must be particularly careful. As the Supreme Court of Canada stated in *Gagnon* (at para. 20):

> Assessing credibility is not a science. It is very difficult for a trial judge to articulate with precision the complex intermingling of impressions that emerge after watching and listening to witnesses ....

27 In relation to the evidence of both complainants in this case, the key issue is whether, despite the inconsistencies, the core of each complainant's testimony remained the same.

28 M.P. engaged in sexual relations with the accused on 10 or 11 occasions between February 2004 and March or April 2004. The key finding by the trial judge taken from her testimony was that condoms were not used on each occasion of intercourse. The accused argues that the complainant testified that she had alcohol on every single one of those instances, as well as drugs on several occasions. On cross-examination, she fairly responded that she could not remember all the exact details of their first sexual encounter, nor could she remember "with certainty now whether or not condoms were or were not used on each one" of the 10 or 11 occasions of intercourse.

29 In the context of her entire testimony, M.P. recalled certain details and not others. The trial judge acknowledged that it was reasonable, given the passage of time and consumption of alcohol, that the complainant would not remember a lot of details. Indeed, it would be surprising if she did recall the intimate details of each act of intercourse with the accused. The trial judge considered and acknowledged the weaknesses in M.P.'s evidence. But M.P. did remember certain core occasions related to condoms with some clarity:

> Q The very first time you had intercourse was a condom used?
>
> A No.
>
> Q How do you know that?
>
> A Because it was so fast, there was – I don't remember him saying pause or saying hold on or – don't remember hearing any packages, not seeing any packages.
>
> . . . . .

Q During those two days that you were there, of the times when you had intercourse, how many times was a condom used?

A I would say one time. I asked him to use it the second day.

. . . . .

Q What about the other times you had intercourse with him during that first two days? Was a condom used those other times?

A No.

. . . . .

Q How many times total did you have intercourse with K-Dog?

A I'd say 10, 11 times, if not more.

. . . . .

Q Over all the times you had intercourse with him, how many times was a condom used?

A Twice.

Q Twice? You've told us about once when you suggested it. Can you tell us about the other time?

A The second time was at his second place and he brought a condom out. He wanted to use one.

30 So, she did recall having sexual relations with the accused on at least 10 occasions. She remembered the first time a condom was used, when she requested it on the second night they had sex, and she recalled the second time, because he wanted to use one. The details as to when a condom was used specifically stick in her memory, as does the first occasion of unprotected sex. Consequently, the trial judge accepted her evidence that

although there was condom use on several occasions, there was also unprotected sex on a number of occasions.

31 It was open to the trial judge to make those findings, and they were reasonable on the evidence. There was no error in the trial judge's assessment of that evidence. Whether there was a "significant risk of serious bodily harm" arising from those encounters is something that will be addressed later in these reasons.

32 With respect to D.C.S., the accused submits that given the inconsistencies, none of the evidence provided by this complainant should or could have been relied on.

33 D.C.S. was 12 years old at the time of her contact with the accused in 2005 and a ward of Child and Family Services. She had sexual relations with the accused on 10 to 15 occasions over several months. She testified that although she did not want to have sexual relations with the accused, she kept returning to his house because alcohol was always supplied and it was a place to party. The trial judge was alive to the inconsistencies in D.C.S.'s evidence, as well as the discrepancies between her trial testimony and her statements made to the police and at the preliminary inquiry. She stated (at para. 46):

> .... D.C.S. made several admissions during cross-examination, such as the fact that she told the police what she anticipated they wanted to hear. ....

34 In fact, the trial judge was not prepared to conclude that the relationship was of a forced or non-consensual nature given the inconsistencies.

35 However, a judge is entitled to accept all, part or none of a witness's evidence. When considering D.C.S.'s testimony, the trial judge observed that she was a young witness and a common-sense approach had to be utilized in assessing her credibility. The trial judge held that as to whether sexual intercourse took place at all and whether there were condoms used, "she was a believable witness when her evidence was considered in its totality" (*ibid.*). The trial judge further held that "[w]hile her evidence was not, in all the circumstances, consistent or in some respects satisfactory, I have no hesitation in finding that sexual contact occurred" (at para. 156). Her findings in this regard are entitled to deference, and I would dismiss this ground of appeal.

36 Given the dismissal of that ground of appeal, it follows that the accused's appeal of his convictions on the charges of sexual interference and invitation to sexual touching must also be dismissed. The trial judge found that sexual contact occurred on a number of occasions. D.C.S. was under 14 years of age at the time. The trial judge found that the accused not only took no reasonable steps to ascertain her age, but he had knowledge of her age soon after the commencement of their relationship in August 2005. Pursuant to ss. 150.1(1) and 150.1(4) of the *Criminal Code*, D.C.S. could not consent to such sexual activity because of her age.

DID THE TRIAL JUDGE ERR IN APPLYING THE FACTUAL FINDINGS TO THE LEGAL STANDARD OF "SIGNIFICANT RISK OF SERIOUS BODILY HARM"?

37 By which standard is this court to review the issue of whether the trial judge erred in her application of the test of "significant risk of serious bodily harm" to the facts of this case? There are two components to this question. First, the trial judge made certain factual determinations. Those findings are entitled to deference, absent palpable and overriding error. See *R. v. Grant*, 2009 SCC 32, [2009] 2 S.C.R. 353 at para. 129. Second, the application of a legal standard to the facts of the case is a question of law. See *R. v. Shepherd*, 2009 SCC 35, [2009] 2 S.C.R. 527 at para. 20. As a result, absent palpable and overriding error, the facts as found by the trial judge are to be accepted. Whether those facts, as found by the trial judge, amount at law to "significant risk of serious bodily harm" is a question of law and will be reviewed on the standard of correctness.

The Law of Consent in Sexual Assault

38 The accused was convicted of aggravated sexual assault contrary to s. 273(1) of the *Criminal Code*, which states:

> 273. (1) Every one commits an aggravated sexual assault who, in committing a sexual assault, wounds, maims, disfigures or endangers the life of the complainant.

For a conviction, in the context of this case, the Crown was required to prove beyond a reasonable doubt that the accused intentionally applied force to the complainants, that the complainants did not consent to the application

of that force and the accused knew it, that the application of force took place in circumstances of a sexual nature and, finally, that the force endangered the life of the complainants.

39 Although the complainants may have consented to have sex with the accused, they testified that they would not have done so had they known he was HIV-positive. Section 273.1(1) of the *Criminal Code* defines consent as "the voluntary agreement of the complainant to engage in the sexual activity in question." According to s. 265(3), a person's "voluntary" consent, whether to assault, sexual assault or aggravated sexual assault, is vitiated if it was obtained by fraud.

40 Is it criminally fraudulent to lie or fail to disclose one's HIV-positive status to a sexual partner? The Crown says that it is fraudulent based on the principles underlying the law's present treatment of consent in relation to sexual assault. In *R. v. Ewanchuk*, [1999] 1 S.C.R. 330, the Supreme Court of Canada described the role of consent in relation to sexual assault as follows (at para. 28):

> .... Society is committed to protecting the personal integrity, both physical and psychological, of every individual. Having control over who touches one's body, and how, lies at the core of human dignity and autonomy. .... The common law has recognized for centuries that the individual's right to physical integrity is a fundamental principle, "every man's person being sacred, and no other having a right to meddle with it, in any the slightest manner": ....

41 Parliament seems to have reinforced this attitude toward consent in sexual assault by explicitly placing the onus on the accused to take

reasonable steps to ensure the consent of the complainant to the activity in question. See s. 273.2 of the *Criminal Code* and *Ewanchuk*, at paras. 46, 51. Thus, an accused can only rely on a complainant's consent to sexual activity if that consent was clear and unequivocal.

42 The Crown submits that sexual intercourse should not be treated any differently than any other physically invasive procedure. Individuals have a right to know the risks they are accepting when they agree to sexual intercourse. An accused should ensure that a prospective complainant is fully informed of the material risks prior to seeking consent to the acts. The obligation imposed on an accused, it is argued, is relatively minor. He or she is free to have sexual intercourse with anyone he or she pleases so long as their HIV status is disclosed. To hold otherwise removes the ability of a complainant to make any kind of informed decision about his or her own body and is inconsistent with the law of consent in relation to sexual assault.

43 Several judges have agreed with the position taken by the Crown. Approximately one year before the decision in *Ewanchuk*, Justice L'Heureux-Dubé expressed the same views in her minority decision in *Cuerrier*.

44 *Cuerrier* is the leading case with respect to the meaning of fraud in the context of obtaining consent to sexual activity. The accused in *Cuerrier* was charged with two counts of aggravated assault as a result of having unprotected sex with two women while failing to inform them that he was HIV-positive. The second complainant specifically told the accused she was afraid of disease. Both women testified that had they known the accused was HIV-positive, they would not have had sex with the accused. Neither

complainant became infected with HIV. The Crown argued that the women's consent had been vitiated by fraud.

45 While all three judgments in *Cuerrier* held that failure to disclose HIV-positive status could vitiate consent to sex and thus were unanimous as to the outcome, three quite different interpretations of fraud under s. 265(3)(c) of the *Criminal Code* were developed in order to reach this conclusion. Only Justice L'Heureux-Dubé adopted the approach urged upon us by the Crown. She stated that in order to show fraud, the Crown should only be required "to prove beyond a reasonable doubt that the accused acted dishonestly in a manner designed to induce the complainant to submit to a specific activity, and that absent the dishonesty, the complainant would not have submitted to the particular activity" (at para. 16).

46 This approach, held L'Heureux-Dubé J., recognizes that "[t]he essence of the offence [of sexual assault] ... is not the presence of physical violence or the potential for serious bodily harm, but the violation of the complainant's physical dignity in a manner contrary to her autonomous will" (at para. 19).

47 Most recently, Justice Roscoe of the Nova Scotia Court of Appeal, in *R. v. Hutchinson*, 2010 NSCA 3, 251 C.C.C. (3d) 51, adopted a similarly broad approach to the meaning of consent. Now, the *Hutchinson* case is quite distinguishable from the case at bar. It involved a Crown appeal from a directed verdict on a charge of aggravated sexual assault. The immediate issue in that case was whether the directed verdict ought to have been granted and therefore whether the trial judge had properly concluded that there was no evidence on particular issues. The Crown alleged that the

accused endangered the life of the complainant by poking holes in the condoms they used during sexual intercourse, which resulted in her pregnancy and subsequent abortion. The majority of the court granted the appeal and sent the matter back for a new trial, but the panel gave separate sets of reasons for doing so.

48 Justice Roscoe held that the complainant must have consented to engage in the "sexual activity in question" and so the question was not simply whether the complainant had consented to sexual intercourse, but whether she had consented to intercourse without contraception. She arrived at this conclusion by a comparison of s. 265(1)(a) and s. 273.1(1). Since s. 265 applies to all forms of assault, including sexual assault, and s. 273.1 applies only to sexual assaults, the words "voluntary agreement ... to engage in the sexual activity in question" in s. 273.1(1) must mean something more than consent to the application of force. The sabotage of the condoms fundamentally altered the nature of the sexual activity in question, and therefore the complainant's consent could not be found to be reasonably informed and freely exercised.

49 A broad interpretation of fraud in relation to consent to sexual activity seems most consistent with protection of bodily integrity. Moreover, fraud with respect to HIV status does relate to a matter which most people would regard as going to the fundamental nature and quality of the sexual act as opposed to, for example, false representations as to financial or social status. See, for example, the arguments made in support of this approach in Diana Ginn, "Can Failure to Disclose HIV Positivity to Sexual Partners Vitiate Consent? *R. v. Cuerrier*" (2000) 12 Can. J. Women & L. 235, and Isabel

Grant, "The Boundaries of the Criminal Law: the Criminalization of the Non-disclosure of HIV" (2008) 31 Dalhousie L.J. 123 at 176 (but see n. 193, on p. 177).

50 However, it is not the law in Canada. The majority decision in *Cuerrier*, written by Cory J., widened the definition of fraud which vitiated consent in assault cases beyond that of the common law. However, it still required that the dishonesty result in a deprivation consisting of actual harm or a significant risk of serious bodily harm. Justice Cory, in examining the development of the doctrine of criminal fraud, found that it had two constituent elements, namely, dishonesty, which can include non-disclosure of important facts, and deprivation or risk of deprivation. By deprivation, it is meant "proof of detriment, prejudice, or risk of prejudice to the economic interests of the victim" (at para. 113).

51 Justice Cory felt that the above principles, which were developed to address the problem of fraud in the commercial context, could, with appropriate modifications, "serve as a useful starting point in the search for the type of fraud which will vitiate consent to sexual intercourse in a prosecution for aggravated assault" (at para. 117).

52 He rejected the position taken by L'Heureux-Dubé J. on the ground that it "would trivialize the criminal process by leading to a proliferation of petty prosecutions instituted without judicial guidelines or directions" (at para. 131). Instead, he modified the second requirement for fraud, that is, deprivation, in the following manner (at paras. 128-29):

> The second requirement of fraud is that the dishonesty result in deprivation, which may consist of actual harm or simply a risk of

harm. Yet it cannot be any trivial harm or risk of harm that will satisfy this requirement in sexual assault cases where the activity would have been consensual if the consent had not been obtained by fraud. For example, the risk of minor scratches or of catching cold would not suffice to establish deprivation. What then should be required? In my view, the Crown will have to establish that the dishonest act (either falsehoods or failure to disclose) had the effect of exposing the person consenting to a significant risk of serious bodily harm. The risk of contracting AIDS as a result of engaging in unprotected intercourse would clearly meet that test. In this case the complainants were exposed to a significant risk of serious harm to their health. Indeed their very survival was placed in jeopardy. It is difficult to imagine a more significant risk or a more grievous bodily harm. ....

To have intercourse with a person who is HIV-positive will always present risks. Absolutely safe sex may be impossible. Yet the careful use of condoms might be found to so reduce the risk of harm that it could no longer be considered significant so that there might not be either deprivation or risk of deprivation. To repeat, in circumstances such as those presented in this case, there must be a significant risk of serious bodily harm before the section can be satisfied. In the absence of those criteria, the duty to disclose will not arise.

53 As one academic put it:

The majority in *Cuerrier* was particularly concerned that fraud not be defined so broadly that any risk of harm (such as the emotional harm that may result from deceptive sexual practices), could negate consent to sexual activity and give rise to assault charges. They held that the deception must pose a *significant* risk of *serious* bodily harm in order to negate consent. The Court conceptualized the duty to disclose in direct proportion to "the risks attendant upon the act of intercourse": the greater the risk to the complainant, the more likely it is that the accused has a duty to disclose. ....

[Isabel Grant, "Rethinking Risk: The Relevance of Condoms and Viral Load in HIV Nondisclosure Prosecutions" (2009) 54 McGill L.J. 389 at 396]

54 While L'Heureux-Dubé J.'s approach has the attraction of maximizing the individual's right to determine by whom and under what condition he or she will consent to physical contact, it also has the effect of significantly widening the ambit of criminalization in relation to individuals who are HIV-positive and who fail to disclose their status to their sexual partner, which effect raises practical and public policy issues.

55 In this context, no one, including the intervener, the Canadian HIV/AIDS Legal Network, disagrees with charging individuals who intentionally or recklessly infect their partners with a serious disease. The criminal law has a role to play in protecting the public from irresponsible individuals. Nor is there any disagreement that, from an ethical and public health perspective, disclosure is necessary. However, between those two poles, policy considerations should impact on the law so as to produce a more nuanced view of when failure to disclose warrants criminal sanctions. There are other mechanisms for the state to intervene, short of criminalizing the act. Criminal sanctions should be reserved for those deliberate, irresponsible or reckless individuals who do not respond to public health directives and who are truly blameworthy.

56 The majority in *Cuerrier* considered all of these arguments in attempting to determine when the impact of such an individual's actions on the rights or well-being of others justifies recourse to the criminal law. The arguments advanced against criminalization in front of us were the same as those argued in front of the Supreme Court in *Cuerrier*. It is therefore unnecessary to repeat them here. The test developed by the majority in *Cuerrier* represents a compromise position. The threat of criminal sanctions

attaches only to individuals who know that they are HIV-positive, but who neither inform their sexual partners of this fact nor follow guidelines for safe sex.

Significant Risk of Serious Bodily Harm

57 The criminal law definition of commercial fraud applied by Cory J. to sexual assault vitiates consent whenever there is a deception resulting in deprivation. The element of deception is satisfied by failure to disclose. The element of deprivation is satisfied by exposure to a significant risk of serious bodily harm.

58 Inevitably, that test introduces some ambiguity into the nature of the risk of harm. As McLachlin J., as she then was, warned in *Cuerrier* (at para. 48):

> .... Cory J.'s limitation of the new crime to significant and serious risk of harm amounts to making an *ad hoc* choice of where the line between lawful conduct and unlawful conduct should be drawn. ....

And that line will move depending upon the development of the medical science related to HIV/AIDS over the years. Legal assessments of risk in this area should be consistent with the available medical studies. As Justice Fenlon stated in *R. v. J.A.T.*, 2010 BCSC 766 (at para. 21):

> Advances in research and treatment have been made since *R. v. Cuerrier* was decided in 1998. Much has been learned about the nature of HIV, how it is transmitted, and how it should be treated. It is incumbent on the Court to take that knowledge into account in assessing, in any given case, whether the complainant's risk of

> contracting HIV was sufficiently significant to establish endangerment to his or her life. That assessment necessarily includes a consideration of both the nature of the harm involved and the likelihood of its occurrence.

59 Moreover, as Cory J. pointed out in *Cuerrier* (at para. 139):

> The phrase "significant risk of serious harm" must be applied to the facts of each case in order to determine if the consent given in the particular circumstances was vitiated. ....

So, as is true in many areas of the law, the result will vary depending upon the application of the test to the facts of each case.

Serious Bodily Harm

60 AIDS is an acronym for the Acquired Immunodeficiency Syndrome. It is a condition that damages the immune system to such an extent that opportunistic infections will occur.

61 HIV is an acronym for the Human Immunodeficiency Virus, and it is a retrovirus that destroys immune cells and impairs overall immune response. Transmission of the virus may occur when the bodily fluids of an infected person cross the mucous membranes or get into the bloodstream of an uninfected individual. HIV infection is accepted as the precondition for development of AIDS not only in the scientific community, but by all the national and international organizations addressing the AIDS pandemic.

62 In the past, HIV was a lethal condition. Dr. Smith's evidence was that if the HIV infection is left untreated, time from HIV infection to the

development of AIDS averages about eight years. If AIDS is left untreated, the average interval from AIDS to death is less than two years.

63 However, since the development of powerful antiretroviral agents, HIV can be well controlled, although not, as of yet, eradicated. "It is now believed that, with the advances thus far achieved in HIV care, many if not most persons infected with HIV who receive and are compliant with optimal care will die of a non-AIDS cause" (Dr. Smith's report, at p. 4).

64 Nonetheless, I do not think it can be disputed that being infected with HIV subjects an individual to serious bodily harm. Although no longer necessarily fatal if treated medically, HIV is an infection that cannot be cured at this time and is a lifelong, chronic infection. For those who become infected, it is a life-altering disease, both physically and emotionally. Individuals must take medications every day, and the condition is potentially lethal if they do not have access to treatment or fail to take the medications. Even with treatment, HIV infection can still lead to devastating illnesses. Moreover, the emotional and psychological impact of dealing with such a disease is, no doubt, overwhelming. In their factums, both the accused and the intervener acknowledged that acquiring HIV constitutes serious bodily harm.

Significant Risk of Harm – Error of Trial Judge

65 The accused and the intervener argue that the trial judge made two errors when assessing the risk of harm. First, given the nature of the harm that might be suffered, she required that there be no risk of transmission at

all. Second, she misapprehended the evidence as to the risk of transmission of the virus in the case of protected sexual activity, and that misapprehension "play[ed] an essential part in the reasoning process resulting in a conviction" (*R. v. C.L.Y.*, 2008 SCC 2, [2008] 1 S.C.R. 5 at para. 19). I agree with both of those submissions.

66 At various points in her reasons, the trial judge seems to have required proof of no risk at all. For example, she states, "... [E]ven with an undetectable viral load, there remains a risk ..." (at para. 105), and again, "However, the research has not proven that such a situation completely eliminates the risk of transmitting the virus. In such circumstances, I find that the risk constituted a significant risk of serious bodily harm" (at para. 134).

67 The elimination of risk is not the legal test. I do not accept the Crown's argument, which seems to have been accepted by the trial judge and was argued again in front of us on appeal, that given the nature of the serious bodily harm that might occur, <u>any</u> risk of harm is significant. This was the same argument that was made and rejected in the case of *R. v. Jones*, 2002 NBQB 340. In that case, the accused was charged with aggravated assault as a result of having unprotected sexual intercourse while being infected with Hepatitis C. Although the medical evidence was that the risk of transmission through sex was very low, the Crown argued that it was not the risk of transmission that mattered, but rather the serious consequences to one's health after it is contracted. The court rejected this argument, stating (at para. 32):

> I interpret this paragraph [in *Cuerrier*] to mean that the risk referred to by the Supreme Court of Canada is both the risk of contracting the disease and the risk to the health of the person after it is contracted.
>
> [emphasis added]

68 I agree that the nature of the harm can affect the determination of what is considered to be a significant risk. As the magnitude of the harm goes up, the threshold of probability that will be considered significant goes down. However, to have required a complete elimination of risk rather than a significant risk was an error in law.

69 So one must determine what constitutes a "significant risk" of transmission in any particular case. I do agree with the British Columbia Court of Appeal when it stated in *R. v. T. (J.)*, 2008 BCCA 463, 256 C.C.C. (3d) 246 (at paras. 19-20):

> I do not accept that *Cuerrier* set an evidentiary benchmark. Risk is a matter of fact to be assessed on the evidence in each and every case. The remark at paragraph 129 of *Cuerrier* concerning the careful use of condoms merely provides an illustration of what "might" (the word chosen by Cory J.) take the risk below the "significant" level. I think the language acknowledges that it is a question of evidence whether in any given prosecution the risk is significant.
>
> *Cuerrier* laid down a proposition of law: a significant risk of substantial harm will vitiate consent when combined with deceit. It did not, in my opinion, purport to prescribe for all cases what facts will determine the significance of the risk.

70 Second, at numerous points in her reasons, the trial judge held that since the use of condoms only resulted in an 80 per cent risk reduction (or, alternatively, that they were only 80 per cent reliable or effective), there still

remained a significant risk of transmission of the virus. For example (at paras. 65, 72, 104, 116, 125, 129):

> .... Ms. McDonald also commented on a 2007 study which had indicated that condom use resulted in an 80% risk reduction of the transmission of HIV.
>
> .... Dr. Smith's testimony is summarized as follows:
>
> . . . . .
>
> • The success rate with respect to condoms, even if properly used, is 80%;
>
> . . . . .
>
> I am also persuaded that endangerment of life has been proven in those circumstances where protection was utilized. This finding is supported by the evidence of Dr. Smith that condoms are considered to be only 80% reliable. ....
>
> .... In this context, it is important to recall the evidence of Dr. Smith which stated that condoms are only 80% reliable and constitute an 80% reduction in HIV incidence. ....
>
> The fact that the accused's viral load was sufficient for possible infectivity, combined with only 80% of reduction in HIV incidence with condom use, satisfies me that a significant risk of serious bodily harm existed. ....
>
> I find that there was a significant risk of serious bodily harm. This determination is made on the basis of the evidence that the accused's viral loads at the time allowed for possible infectivity, accompanied by the only 80% effectiveness rate of condoms.

71 Although the trial judge quoted the medical evidence of an 80 per cent reduction in risk, she did not go on to consider an 80 per cent reduction "from what." A substantial reduction of an already small number may not necessarily result in a significant risk. As a foundational building block to the legal question of whether a significant risk remains where there is

condom use or reduced viral loads, one must first have a baseline of the rate of transmission of HIV in unprotected intercourse.

Rates of Transmission of HIV

72 In *Cuerrier*, there does not appear to be any information about infectiousness or risk of transmission, not surprisingly given the trial evidence was adduced some 12 to 13 years ago. The court accepted that unprotected intercourse would clearly meet the test of significant risk with respect to the transmission of HIV. Again, in *R. v. Williams*, 2003 SCC 41, [2003] 2 S.C.R. 134, the agreed statement of facts stated that the medical evidence was that a single act of unprotected vaginal intercourse carries a significant risk of HIV transmission.

73 But, as stated above, if we are to attempt to determine what is a significant risk given different facts than *Cuerrier* (that is, the use of a condom) or advances in medical treatment (low viral loads), we must first establish a baseline.

74 Sexual transmission of HIV has been widely studied. The rates of transmission vary considerably from study to study, depending on a number of factors, including the type of sex act, the individual's viral load and any possible co-infection associated with other maladies. Moreover, the risk is cumulative. The risk of transmission increases depending on the number of times that an infected individual has intercourse with his or her partner. See *R. v. T. (J.)*. So transmission probabilities cannot be measured with exact precision. However, medical science has advanced to the point where

transmission rates can be estimated to a degree that distinguishes the trivial from the significant.

75 The most common route of transmission – male to female heterosexual intercourse – has been well documented. Dr. Smith's evidence at trial was rather confusing; however, his written report does contain information on transmission rates for unprotected vaginal intercourse. He states that the risk of HIV transmission per act of unprotected vaginal sex ranges from 0.05 per cent (1 in 2,000) to 0.26 per cent (1 in 384). In her testimony, Ms McDonald, the public health nurse, referred to the Manitoba Health post-exposure protocol. That protocol refers to an average percentage of risk per act that ranged from 0.1 per cent (1 in 1,000) for receptive penile-vaginal intercourse to 0.05 per cent (1 in 2,000) for insertive penile-vaginal intercourse.

76 That coincides, to some extent, with the medical evidence presented in some other recent cases. So, for example, in *R. v. Wright*, 2009 BCCA 514, 256 C.C.C. (3d) 254, leave to appeal to S.C.C. dismissed, [2010] S.C.C.A. No. 22 (QL), the medical evidence was to the effect that "the risk of HIV infection by a woman from vaginal intercourse with a male who is HIV-positive is between 0.1% and 1.0%; so the experts generally say the risk of transmission is 0.5%" (at para. 8). In *R. v. Edwards (J.R.)*, 2001 NSSC 80, 194 N.S.R. (2d) 107, the medical evidence was that the likelihood of infection arising from unprotected vaginal intercourse was 1 in 1,000 or 0.1 per cent.

77 In a systematic review and meta-analysis of 43 publications comprising 25 different study populations, a male to female per act risk of

transmission in high-income countries of 0.08 per cent was identified. See Marie-Claude Boily *et al.*, "Heterosexual risk of HIV-1 infection per sexual act: systematic review and meta-analysis of observational studies" (2009) 9 Lancet Infect. Dis. 118.

Condom Usage and Its Effect on Risk of Transmission

78 In *Cuerrier* and *Williams*, the Supreme Court left open the question of whether a significant risk of harm still existed when the parties engaged in protected sex. However, some of the justices did express opinions on this point. For example, Cory J., writing for the majority in *Cuerrier*, suggested that careful use of condoms might reduce the risk of transmission to below a significant level. See para. 129.

79 Concurring in the result, McLachlin and Gonthier JJ., in *Cuerrier*, stated that in their own approach to fraud, a person who does not disclose HIV-positive status, but does use a condom, does not commit fraud. See paras. 73-74.

80 As a result, six of seven justices in *Cuerrier* explicitly declared that there must be a significant or high risk of HIV transmission before non-disclosure may transform otherwise consensual sex into an aggravated sexual assault, and six of seven justices either suggested (Cory J.) or explicitly declared (McLachlin J.) that condom use might or would suffice to reduce the risk below the significant threshold.

81 Following *Cuerrier*, several Canadian cases have expressly or implicitly accepted that the Crown must establish unprotected anal or

vaginal sex in order to reach the threshold of a significant risk triggering a duty to disclose. The assumption in all of those cases was that protected sex reduced the risk of transmission to below the level of a significant risk. See, for example, *Edwards, R. v. Agnatuk-Mercier*, [2001] O.J. No. 4729 (S.C.J.) (QL), *R. v. Nduwayo*, 2006 BCSC 1972, and *R. v. Smith*, [2007] S.J. No. 116 (Prov. Ct.) (QL).

82 However, in *Cuerrier*, Cory J. merely suggested that careful use of condoms might reduce the risk of transmission to below a significant level. It would depend on the evidence adduced.

83 The medical evidence adduced at trial in this case certainly seems to support the argument that the careful use of condoms reduces the risk of transmission of HIV substantially. In Dr. Smith's report, he stated (at p. 6):

> HIV is unable to pass through good quality condoms. "The proper use of the male or the female condom has been shown to reduce the risk of HIV transmission during vaginal intercourse. There is evidence of transmission due to condom failure, however, so receptive penile-vaginal intercourse with a condom is considered to be 'low risk', not 'no risk'. Condoms are not 100 percent reliable. It is difficult to define a condom failure rate because the information is dependent on the history of study participants. This issue is also a matter of controversy and researchers may bring their own biases. A Cochrane review of condom effectiveness concludes that consistent use of condoms results in an 80% reduction in HIV incidence. The studies used in this review did not report on the 'correctness' of use. Quality control of condom manufacture is now rigorous but is unable to prevent some defective condoms coming to market. There is enough evidence of transmission due to condom breakage or improper use to classify this activity as low (rather than negligible) risk."

In this quote, Dr. Smith's reference to the "Cochrane review" is to Weller SC, Davis-Beaty K. Condom effectiveness in reducing heterosexual HIV transmission. *Cochrane Database of Systematic Reviews* 2002, Issue 1. Art. No.: CD003255. DOI: 10.1002/14651858.CD003255.

84 So, even taking into account condom breakage or improper use, Dr. Smith still describes the activity as "low (rather than negligible) risk." At other points in his testimony, he describes it as "very low risk."

85 In his review of the accused's medical and public health records, he stated (at p. 5): "There is no scientific justification to require HIV status disclosure if a condom is always used."

86 So, assuming the risk of transmission of the virus in unprotected intercourse is approximately somewhere between 0.05 per cent and 0.26 per cent, the consistent and careful use of good quality condoms reduces that risk by 80 per cent. The medical evidence adduced in *Police v. Dalley* (2005), 22 C.R.N.Z. 495 (D.C.), was to the effect that the "risk of an HIV-positive man transmitting the virus when a condom is used and vaginal intercourse takes place is one in 20,000" (at para. 21). The medical evidence in *Wright*, at para. 11, while still within the above-noted range, was to the effect that the use of latex condoms can reduce the risk of transmission to 1 in 10,000 or 0.01 per cent if they are used properly.

87 Given the above, I agree with the accused and the intervener that consistent and careful use of condoms can reduce the risk of transmission, not to zero, but below the level of significance. The word "significant" is not necessarily equated with quantity, but it does imply importance. See *R.*

v. J.A.T. In the case of *R. v. J.A.T.*, the medical evidence indicated that the risk of transmission of HIV during three acts of anal intercourse was 0.12 per cent. The court held that was not a significant risk so as to ground a charge for aggravated sexual assault. In *Jones*, the court held that a risk of transmission of Hepatitis C between 1.0 and 2.5 per cent was "so low that it cannot be described as significant" (at para. 33). I agree with the trial judge in *Hutchinson* (2009 NSSC 51, 275 N.S.R. (2d) 128) when he stated (at para. 42):

> .... In my respectful view, a low risk, a remote risk, the risk indicated by the words "very rare" and "safe", does not meet the requirement of **Cuerrier**.

88 All the evidence in this case refers to the risk of transmission in protected sex as being low. Even acknowledging that there remains a 20 per cent risk of transmission in protected sex, it is 20 per cent of an already small baseline figure. This is perhaps best explained by the following quote:

> A finding of an 80% reduction in HIV transmission does not mean that 80% of people using condoms are protected from HIV while 20% of people using condoms will become infected. Rather, it means that condoms prevent 80% of the transmissions that would have occurred if a condom had not been used. For example, assume a per-act risk of 0.08% for receptive vaginal sex and no other HIV risk factors, in a group of 10,000 women who had unprotected vaginal intercourse once with an HIV-positive man. If all 10,000 did not use a condom, about 8 women would become infected with HIV. If all 10,000 used a condom, 1 or 2 women would become infected with HIV.
>
> [Eric Mykhalovskiy, Glenn Betteridge & David McLay, "HIV Non-Disclosure and the Criminal Law: Establishing Policy Options for Ontario" (Toronto, July 2010) at 32 [a report funded by a grant from the Ontario HIV Treatment Network]]

89 Using Dr. Smith's figures of risk of transmission ranging between 0.05 per cent (1 in 2,000) and 0.26 per cent (1 in 384) for sex without a condom and reducing those figures by 80 per cent, that means the risk of transmission with condom use per act falls into the realm of 0.01 per cent (1 in 10,000) to 0.052 per cent (approximately 1 in 2,000).

Careful Use

90 Although the appropriate use of condoms can reduce the risk of transmission to below a significant level, one must still determine whether, in any particular case, this accused used condoms in a careful and consistent manner.

91 Besides consistent usage and the absence of other risk factors (such as the presence of other infections), Dr. Smith listed a number of factors which he opined were required to achieve the careful and effective use of condoms. Dr. Smith testified the proper use of a condom entails the following:

(1) The condom must be used before the expiry date on the package. If no expiry date is present, then it must be used within five years of the manufacture date.

(2) The condom must be taken out of the package carefully. It should not be opened with teeth or cut open as that may damage the condom.

(3) The condom must be stored in cool temperatures.

(4) The condom must not be squished or sat on.

(5) The condom must be made of latex. Animal membrane condoms allow HIV to pass through.

(6) The condom must be correctly applied, which includes squeezing the air out of the tip of the condom and rolling it completely down the shaft of the penis.

(7) Lubricant made out of specific materials must be used (no petroleum products, Vaseline or oils).

(8) If there are any problems with the condom during intercourse, the condom must be replaced.

(9) When removing the penis from the vagina, the condom should be held around the base of the penis to prevent spillage.

(10) Both parties should be sober as the ability to optimize the use of a condom will be impaired if under the influence of drugs or alcohol.

92 The above list would seem to represent an ideal situation. It seems unlikely that all of the above conditions would be met in most sexual situations. Nonetheless, even accepting that reasonably proper condom use, as opposed to perfect condom use, reduces the risk level to below a significant risk of harm, the question still remains, "Was there proper condom use in this case?" That is an issue that was not raised in the above cases, which simply assumed that if there was evidence that a condom was used, that was the end of the matter. The evidence, which was accepted by

the judge, was that this accused not only had other risk factors, but that he did not utilize condoms in either a consistent or a careful manner.

93 The testimony of the public health nurses was that the accused had been taught proper condom use, which included consistency and manner of application. Both the testimony of the nurses and their notes on file indicated that they often provided the accused with supplies of good quality latex condoms.

94 However, the accused was tested for a number of sexually transmitted diseases during the relevant time period. Not only does the presence of STDs affect the risk of transmission, but it obviously indicates an inconsistent use of condoms. The first time the accused was diagnosed with gonorrhea in December 2003 he did not know he was HIV-positive. However, the second time he was diagnosed with gonorrhea in February 2004 was after he had knowledge he was positive for HIV. Also, on October 8, 2004, he was named as a contact with respect to someone who had Chlamydia, and his medical records indicate that the accused told his doctor that he had had sexual intercourse with the woman in question and the condom broke.

95 Ms Burgoyne, one of the public health nurses who counselled the accused, testified that her department was aware that the accused was not compliant with condom use, as demonstrated by the fact that he had contracted STDs on at least two occasions. Dr. Smith testified that these instances were, in his opinion, evidence of improper condom use by the accused.

96 Again, the use of drugs or alcohol has been shown, not surprisingly, to impair the ability to follow correct condom application procedures. The complainants' evidence was that sexual intercourse was generally preceded by the consumption of alcohol and/or marihuana. In June 2005, for example, the accused's medical records refer to an occasion when he reported having sex, but stated that he did not know if a condom was used or not as he had "passed out." The history of the accused shows a fair amount of recklessness regarding condom use.

97 One of the complainants testified that although condoms were used, they broke on three or four occasions. I acknowledge that even with the most responsible and careful precautions taken, a condom may break. However, in such circumstances, surely the person with HIV must then disclose his HIV status to enable his non-HIV partner to take prophylactic measures. As noted in *R. v. J.A.T.*, at para. 25, a non-HIV partner can successfully be treated with drugs for one month so long as treatment starts within 72 hours. Obviously then, when a condom breaks, immediately disclosing one's HIV status to a non-HIV partner could reduce the risk of harm. Not disclosing would mean that the risk of harm is equal to that of unprotected sex.

Transmission Rates and Antiretroviral Therapy

98 Even if there was no careful use of condoms, there was evidence adduced to show that the accused had a low viral load during much of the relevant period of time. A viral load refers to the number of copies of the virus in a millilitre of body fluid, such as blood, semen or vaginal secretions.

The transmission or infectiousness of an HIV-positive individual is directly proportional to viral loads so that the lower the viral load, the lower the risk of transmission. When the viral load is below approximately 40 copies or "undetectable," HIV transmission is significantly reduced, although not proven to be completely eliminated. Effective antiretroviral treatment is defined as HIV treatment that stably renders the viral load in blood undetectable for at least six months.

99 The trial judge refused to consider the impact of a low viral load in cases of unprotected sex on the question of significant risk of harm. Although she accepted that during those times when the viral load is undetectable in the blood the risk of HIV transmission is reduced, she concluded (at para. 134):

> The testing of a viral load serves to provide only a "snapshot" in time. The evidence demonstrated that other illnesses, STDs, female contraceptives and other factors could affect or "spike" a viral load. Such an occurrence would not be detected unless viral load testing was performed at the time the relevant factor was affecting an HIV-positive individual. ....

100 Again, the trial judge seems to have required evidence of no risk as opposed to the Crown proving the existence of significant risk. For example, she states (at paras. 105-6):

> .... I have found the medical and scientific evidence to be very persuasive that even with an undetectable viral load, <u>there remains a risk of transmission</u> of HIV with resultant endangerment of life. This is particularly so given the medical evidence that other influences or factors such as STDs or the use of female contraception can affect or "spike" a viral load.

> There was a continuing risk that HIV could be passed upon sexual intercourse in all of the circumstances. ....
>
> [emphasis added]

And again (at para. 134):

> .... During those times when the viral load is undetectable in the blood, the risk of HIV transmission is reduced. However, the research has not proven that such a situation completely eliminates the risk of transmitting the virus. In such circumstances, I find that the risk constituted a significant risk of serious bodily harm.
>
> [emphasis added]

101 Therefore, she held that only in cases where the accused had properly used a condom and had a low viral load could it be said that there was no risk and consequently no criminal liability.

102 The accused argues that the trial judge erred in not considering the actual risk factors as established by the factual findings in this case. It is true that various factors might spike a viral load. But what was the actual evidence in this case of viral loads and the presence or absence of other factors? The trial judge's comment that "I am not prepared to consider factors involving the possible implications of the viral load of the accused" (at para. 100) simply because the Supreme Court in *Cuerrier* did not consider them cannot stand.

103 In the decade since *Cuerrier*, a substantial body of scientific evidence has established that successful treatment with antiretroviral therapy can dramatically reduce viral load to levels categorized as "undetectable" by

current testing technologies, with a correspondingly measurable impact on lowering the risk of transmission. As indicated earlier, effective antiretroviral treatment is defined as HIV treatment that stably renders the viral load in blood undetectable (less than 40 copies per millilitre) for at least six months.

104 Since the test in *Cuerrier* is based on a significant risk of serious harm, a trial judge must base his or her decision on what is a significant risk on the evidence adduced in front of him or her, including the medical evidence. The application of the legal test in *Cuerrier* must evolve to account appropriately for the development in the science of HIV treatment.

105 This is the first case that I am aware of where the evidence adduced revealed such detailed viral load testing. In *Wright*, there was no such specific evidence available. Consequently, the court held, and I agree, that (at paras. 32-33):

> The Crown had no knowledge in this case of the level of the appellant's viral load, and it was entitled, in my view, to introduce evidence of an average risk based on average viral loads. This does not mean viral loads are irrelevant to the determination of criminal liability. If the viral load of the accused at the time of the sexual relations is known or can be estimated, then it will be very relevant to determining whether there was a significant risk of serious bodily harm.
>
> After the Crown introduced the evidence of the average risk of HIV transmission, it was open to the accused, if he wished, to introduce evidence about his own viral load. This does not represent a shift in the legal burden of proof but, rather, it was a tactical decision for the accused to make on the basis of his assessment of the Crown's case. The difference between this type of tactical decision and the legal burden of proof was discussed by the Supreme Court of Canada in *R. v. Darrach*, 2000 SCC 46, [2000] 2 S.C.R. 443; 148 C.C.C. (3d) 97:

> [50] There is an important difference between a burden of proof with regard to an offence or an evidentiary burden, and the tactical need to respond when the Crown establishes a *prima facie* case, in order to raise a reasonable doubt about it. "[T]he criminal law does not allocate an evidential burden to the accused to refute the Crown's case and he or she may decline to adduce any evidence. Nevertheless, if the accused decides not to call any evidence, he or she runs the risk of being convicted" (Sopinka, Lederman and Bryant, [*The Law of Evidence in Canada*, 2d ed. (Markham: LexisNexis Canada Inc., 1999], at para. 3.17). Where there is neither a legal obligation nor an evidentiary burden on the accused, the mere tactical pressure on the accused to participate in the trial does not offend the principle against self-incrimination (s. 11(*c*)) or the right to a fair trial (s. 11(*d*)).
>
> Thus, although the introduction by the Crown of the evidence regarding the average risk of HIV transmission may have made it advisable for the accused to introduce evidence about his actual or estimated viral load, the legal burden of proof was not shifted to the accused.

106 In regard to viral testing in this case, Dr. Smith's evidence was to the effect that low viral loads due to antiretroviral drug therapies greatly decrease the chance of heterosexual transmission of HIV. The risk of HIV transmission is low if the viral load is below 1,500 copies and very low if it is undetectable or lower than the viral load test can accurately count. Generally, his testimony in this regard is summarized by the intervener in their factum:

> *Viral load and HIV transmission risk*: On this point, the evidence was that:
>
> . . . . .
>
> - "[I]t's extremely unusual to transmit with a viral load of less than 1500 copies."

. . . . .

- "Q: ... if you meet these three criteria of taking the medicine and the medicine working to making your load levels to the undetectable point and you having no other STIs, then you fit into that category of ... very low risk of infectiousness? A: Certainly very low risk, yes. Q: So ... if that person were to have unprotected sex with somebody, from a scientific perspective, there would be a very low risk of transmission, correct? A: That, that is my strong opinion."

- "A: ... the question is whether it's one in a hundred thousand or one in a million as they have said ... these figures are very small and very difficult ... to prove."

- "In my opinion, there is a very high probability that the accused was not infectious and could not have transmitted HIV throughout this period ... There is no evidence that he had any sexually transmitted infection during this time."

107 In the *Wright* case, the medical evidence was to the effect that if the viral load is undetectable, the risk of transmission goes down between 100 and 1,000 times. In *Police*, the evidence was that with a low viral load, the risk of transmission in unprotected vaginal intercourse is between eight to ten per 10,000 exposures. A Swiss appeal court, with the support of the prosecution, overturned an HIV-positive man's conviction for unprotected vaginal sex without disclosure as, given his viral load levels, the risk was too low to be scientifically quantified. See *"S" v. Procureur General* (23 February 2009), Geneva (Court of Justice (Penal Division)); further appeal dismissed on other grounds: Tribunal Fédéral, Arrêt 6B_260/2009.

108 Now, during the trial, there was much discussion about a report released by Switzerland's Federal AIDS Commission in January 2008, some two to four years after these incidents occurred. The report claimed that

people with HIV do not risk transmitting the virus sexually provided they have had an undetectable viral load for at least six months, are adhering to a strict antiretroviral treatment, which is regularly monitored by the treating physician, and do not have a sexually transmitted disease. If these three criteria are complied with, the report indicated that the risk of transmission in situations of unprotected sex was less than 1 in 100,000, a level of risk considered acceptable in other situations, such as flying in a plane.

109 The report is not relevant for our purposes, nor did the accused argue that it was. While the scientific evidence relied on in the report may be useful, the statement that unprotected sex was acceptable in those circumstances was intended to apply only to couples who were in a stable relationship, who met the three criteria mentioned and then only if that was the choice of the uninfected partner. It is clear that this accused was a person with multiple partners who engaged in casual sex.

110 Whatever the utility or validity of the report may be for public health policy, this court is concerned only with the scientific evidence contained in it for the purpose of determining significant risk. Dr. Smith did testify that since the accused did not meet the criteria listed in the Swiss report (because he had multiple partners), he should have consistently worn a condom. But his reason was not because it affected the risk of transmission to other people, but rather because it affected the accused's own risk. If he did not wear a condom and had multiple partners, even though he was on antiretroviral therapy, he was at risk of getting STDs and would be opening himself to the possibility of exacerbating the course of his own disease by infecting himself with a strain of uncontrolled HIV from another person.

111 With respect to the issue of "significant risk," the World Health Organization and UNAIDS indicated that more research was needed to determine the degree to which the viral load in blood predicts the risk of HIV transmission and to determine the association between the viral load in blood and the viral load in semen and vaginal secretions. Research also needs to consider other related factors that contribute to HIV transmission. For example, Dr. Smith's report indicated (at pp. 4-5):

> In addition to the viral load of the infected partner, other factors have been reported to affect the male to female transmission rate of HIV from men with unsuppressed plasma HIV viral loads, including oral contraceptives, gonococcal cervicitis, candida vaginits [*sic*], genital ulcers, bacterial vaginosis, herpes genitalis, Vitamin A definciency [*sic*], CD4 count <200, oral contraceptives.

112 It is true that the test for a viral load is done for "a moment in time." If a person were to miss a dose of his medication, at some point, after 72 hours, an individual could become resistant to the medication, although it is uncertain how long this might take since it depends on an individual's metabolism. So, it is difficult to know one's viral load at a particular point in time and to ensure it remains undetectable. Common infections, STDs and treatment issues can lead to fluctuations in a person's viral load. HIV-positive people with apparently undetectable viral loads can experience occasional spikes in viral load or may develop viral resistance.

113 Consequently, no comprehensive statement can be made about the impact of low viral loads on the question of risk. Each case will depend on the facts regarding the particular accused, and each case will depend on the

state of the medical evidence at the time and the manner in which it is presented in that particular case.

114 The accused's medical records indicated that his viral loads were tested in May 2004, August 2004, October 2004, December 2004, January 2005, May 2005, September 2005 and December 2005. Dr. Smith reviewed those records. He testified that the initial viral load counts of the accused were around 6,100 to 6,300 copies, which would be consistent with "probably low but possible infectivity."

115 After six months of treatment, Dr. Smith stated (at p. 3 of his review):

> .... In my opinion there is a very high probability that Mr. Mabior was not infectious [that is, he] could not have transmitted HIV throughout this period from 6 months after initiation of antiretroviral treatment in April 2004 ([that is] October 22, 2004 till December 28, 2005 – the last date for which we have a viral load). ....

116 Dr. Smith also testified on cross-examination:

> Q – that if you meet these three criteria of taking the medicine and the medicine working to making your load levels to the undetectable point and you having no other STIs, then you fit into that category of, I believe – what would you say? That would be very low risk of infectiousness?
>
> A Certainly very low risk, yes.
>
> Q So that person, on an individual basis, if he has – if that person were to have unprotected sex with somebody, from a scientific perspective, there would be a very low risk of transmission, correct?
>
> A That, that is my strong opinion.

117 Further, Dr. Smith testified, after some initial hesitancy before the accused realized his drugs would be paid for, that it was likely the accused complied with the antiretroviral regimen because of the consistency in the results of his load tests. While Dr. Smith acknowledged that a spike in viral load was possible, he stated that it was unlikely in this case. Again, his review stated (at p. 3):

> .... There is no evidence that he had any sexually transmitted infection during this time frame.
>
> .... If he had had an STI his viral load might have increased above the level of detection but as he was taking a potent antiretroviral combination throughout this period it seems unlikely that his viral load would have achieved even the low levels that he had in Brandon at the time of his gonoccal [*sic*] urethritis. ....

118 This general evidence with respect to condom use and viral load must now be examined in relation to each complainant.

M.P.

119 The first complainant who had sexual intercourse with the accused after his diagnosis was M.P. M.P. engaged in sexual relations with the accused on 10 or 11 occasions between February 2004 and March or April 2004. I have already indicated that I accept the trial judge's finding that although condoms were used on at least two occasions, there was also unprotected sex on a number of occasions.

120 The accused's viral load counts taken on February 11 and 25, 2004, were 6,100 copies per millilitre and 6,300 copies per millilitre, which,

according to Dr. Smith, indicated that the accused had "probably low but possible infectivity" when these tests were taken. Moreover, the impact of STDs has already been discussed, and the accused tested positive for gonorrhea for the second time on February 13, 2004. Consequently, I agree with the trial judge that a significant risk of harm existed during the instances of unprotected sex with M.P.

K.R.

121 K.R. had sexual relations with the accused from April 2004 until approximately November 2004. She testified that condoms were always used and that she and the accused practised safe sex. However, she indicated that on three or four occasions, the condom broke during sexual intercourse. As a result, sexual activity was stopped and a new condom was applied. This breakage may have resulted from any number of causes – improper application or utilization, simple condom failure or intoxication of the accused. Nonetheless, once the condom broke, the complainant became exposed to the risk of transmission as if the sex was unprotected. She was entitled, at that point in time, to disclosure of the accused's serostatus so that she could, if she chose to, take prophylactic measures. As mentioned earlier, where a condom breaks, the non-HIV partner can be treated successfully so long as treatment starts within 72 hours.

122 The accused's viral load near the beginning of this relationship was less than 500 copies per millilitre, which again was consistent with low, but possible infectivity. His viral load was undetectable for the latter portions of his relationship with K.R. (50 copies per millilitre on August 4, 2004, and

less than 50 copies per millilitre on October 6, 2004). However, given the increased risk factors, including the fact that he had a higher viral load during the first part of his relationship, he was involved with multiple partners (he had sex with K.G. while in a relationship with K.R.) and he was listed as a Chlamydia contact by another woman during this period, I agree with the trial judge that a significant risk of harm existed in relation to this complainant.

K.G.

123 K.G. had sexual relations on one occasion with the accused in June 2004. Although she was intoxicated at the time, she testified that she was "pretty sure" a condom was used. She testified that she normally required the use of a condom during intercourse. The trial judge found the accused guilty, referring to the "only 80% effectiveness rate of condoms" (at para. 129). I have already commented on the error related to the assessment of risk and condom use. Generally, consistent and careful use of good quality condoms reduces risk to below a significant level.

124 In this case, it is true that there was generally much evidence of inconsistent and careless use of condoms by the accused. However, based on the testimony of the complainant herself, with respect to this one sexual encounter, there is no evidence of failed condom use or human error. Even alcohol did not appear to play a factor. The complainant testified that she did not see the accused drinking or using drugs at any time.

125 Given the evidence of the complainant as to the use of a condom in this particular instance and the medical evidence as to the effect of condom use on the risk of transmission, I find that there was no significant risk of serious bodily harm here.

126 When an appeal is allowed with respect to a conviction, an appellate court may direct that a verdict of acquittal be entered or order a new trial. See s. 686(1)(a) and s. 686(2) of the *Criminal Code*. The appeal court should exercise its discretion and enter an acquittal, rather than order a new trial, where it concludes there was no reasonable evidence of an essential element in the crime charged. See *R. v. MacNeil*, 2009 NSCA 46, 244 C.C.C. (3d) 88 at para. 16, and The Honourable Mr. Justice E. G. Ewaschuk, *Criminal Pleadings & Practice in Canada*, 2d ed., looseleaf (Aurora: The Cartwright Group Ltd., 2010) vol. 3 at para. 23:10120. Consequently, I would allow the appeal with respect to this count and substitute an acquittal.

127 With respect to the last three complainants, generally from October 22, 2004, to December 28, 2005, according to Dr. Smith, there was a "high probability" that the accused was not infectious during this period. I do not see how that evidence can support a finding with respect to these complainants that the Crown has proven beyond a reasonable doubt the lack of consent arising from the presence of a significant risk of serious bodily harm. "Significant" means something other than an ordinary risk. It means an important, serious, substantial risk. It is the opposite of evidence of a "high probability" of no infectiousness, especially given the statistical

percentages referred to earlier. However, I will discuss the facts with respect to S.H., D.C.S. and D.H. separately, each in turn.

S.H.

128 Between February 2005 and April 2005 S.H. had a number of sexual encounters with the accused. They were together for approximately one month and engaged in intercourse on a daily basis. A condom was used during the first week of their relationship, after which the complainant asked if the accused had "an STD or if he had anything," to which he replied "No." Since the complainant was on birth control, they engaged in unprotected sex for the remaining three weeks of their relationship.

129 The trial judge acknowledged that at the time of their relationship, the evidence showed that the accused's viral load was suppressed. He was tested in January 2005 and May 2005, both before and after the relationship in question, and given his viral load, Dr. Smith testified there was a very high probability that the accused was not infectious during this period. Moreover, while Dr. Smith acknowledged that "spikes" in viral loads are possible, there was no evidence of it, and unlikely in this case.

130 Nonetheless, the trial judge found him guilty because Dr. Smith testified that the risk was not completely eliminated. As I have already said, this was an error in law. The test is not "no risk," but the presence of significant risk. I would allow the appeal from this count.

D.C.S.

131 D.C.S.'s contact with the accused began in August 2005, at the age of 12. I have already dealt with the accused's appeal on the counts of sexual interference and invitation to sexual touching. The trial judge accepted the complainant's evidence that there was sexual intercourse between the two, albeit not forced activity, as alleged by D.C.S.

132 D.C.S. was a ward of Child and Family Services who was absent from her group home. While the complainant could not remember if condoms were used every time, the trial judge accepted her evidence that they were not used the first time. She is the only complainant who continued to have sex with the accused after she learned from a third party that he was HIV-positive. Given her age, her lack of sophistication and the absence of viable alternatives in her life at the time, this action does not surprise me.

133 However, although there was unprotected sex, the medical records indicated that the accused's viral load was below the level of detection and that once again, according to Dr. Smith, "there is a very high probability that Mr. Mabior was not infectious" during the period of his relationship with D.C.S. He had undetectable viral loads in May 2005 and September 2005. Moreover, shortly before the relationship began (June 21, 2005), he tested negative for gonorrhea and Chlamydia. Thus, the specific evidence with respect to the particular circumstances of the accused showed that he was at a very low risk of transmitting the infection at the relevant time period. I would acquit him of this count as well. However, as indicated earlier, I

would not disturb the convictions for sexual interference and invitation to sexual touching.

D.H.

134 D.H. was one of several underage girls living in group homes who frequented the home on Sherbrook Street, drawn there by the easy access to alcohol and drugs provided by the accused and other men who either lived at that address or were regularly on the premises. Many of these young girls were often absent, by choice, from these homes and looking for a place to stay.

135 D.H. engaged in intercourse several times with the accused when she was 17 years of age. Her testimony confirms the general evidence that the accused's condom use was inconsistent. She testified that, although a condom was normally used at her request, on at least one occasion she recognized that "semen [was] coming out" of her after a trip to the bathroom. On that occasion, he was wearing a condom when they began to have sex, but she later saw a condom on the floor beside the bed which had not previously been there. She also testified that, while she never saw the accused take off the condom, they had "stopped" intercourse for a few seconds.

136 However, once again, although unprotected intercourse occurred, the Crown could not prove that a significant risk of harm existed. The complainant testified that the relationship began around Christmas 2005, but did not last very long:

> A Just the same time, like we weren't going out very long and it was still before Christmas because I started going out with this other guy, like two weeks after that.
>
> Q Christmas 2005 are you still talking about?
>
> A I think so.

137 Once again, the accused was tested on December 28, 2005, with the results being a level of below 50 copies per millilitre. As well, he was tested for gonorrhea and Chlamydia on February 9, 2006, the results of which were again negative. Given this evidence and Dr. Smith's evidence, it cannot be proven beyond a reasonable doubt that there was a significant risk of serious harm around Christmas 2005.

ENDANGERMENT OF LIFE

138 The accused was convicted of aggravated sexual assault. The focus of the accused's appeal was on the question of "significant risk" and its application to the medical evidence adduced in this case. No argument was directed to the question of whether a charge of aggravated sexual assault was appropriate in this type of case. Given the absence of legal argument, it would be inappropriate to rule on that issue.

139 However, I would like to make some *obiter* comments.

140 Aggravated sexual assault, or for that matter aggravated assault, in s. 273(1) of the *Criminal Code* exists when, in committing an assault, an individual wounds, maims, disfigures or endangers the life of a complainant. The fourth consequence – endangering life – is significantly different from

the first three consequences – wounding, maiming or disfiguring. The latter three involve the causing of serious bodily harm, whereas endangering life may occur without any bodily harm actually occurring to the victim. See Gerry Ferguson, "Failure to Disclose HIV-Positive Status and Other Unresolved Issues in *Williams*" (2004), 20 C.R. (6th) 42 at 52.

141 In the *Cuerrier* case, since at that time a diagnosis of HIV was considered akin to an inevitable death sentence, the proof of "endangerment of life" was obvious. As Cory J. stated in that case (at para. 126):

> .... The possible consequence of engaging in unprotected intercourse with an HIV-positive partner is death. ....

And see para. 95.

142 Since that time, Dr. Smith reported that "[i]t is now believed that with the advances thus far achieved in HIV care many if not most persons infected with HIV who receive and are compliant with optimal care will die of a non-AIDS cause" (at p. 4).

143 I do not wish to minimize the terrible physical and emotional consequences of having a lifelong chronic condition. I have already concluded that for the purpose of determining whether consent was vitiated by means of fraud, transmitting the AIDS virus results in serious bodily harm. There is also the issue that treatment may not be available to everyone, nor may all infected individuals react the same way to the medication. Some may be or become resistant to the antiretrovirals. See *Wright*, at para. 9. However, from a legal standpoint, I still wonder whether,

if there is risk of serious bodily harm, does it necessarily follow that there is also endangerment of life? Are the two tests the same?

144 Many of the cases dealing with this issue have so held. Where a "significant risk of serious bodily harm" has been found, these courts have held that also satisfies the requirement with respect to aggravated assault. See, for example, *R. v. J.A.T.*, at para. 76.

145 However, I would suggest that "endangerment of life" and "serious bodily harm" are two different standards. In *Williams*, the Supreme Court of Canada stated that the "aggravation" in aggravated assault comes from the consequences or possible consequences of that assault. See para. 45. To endanger means to put in danger or to incur the risk of death. In the Canadian Judicial Council's Model Jury Instructions, the suggested instruction on endangerment is:

> To "endanger the life" of another person is to put him or her in a situation or condition that could cause that person to die.

Not all serious injuries necessarily put a victim's life in peril or at risk. See *R. v. Harwood-Jones (P.H.)*, 2009 MBQB 313, 247 Man.R. (2d) 184.

146 While that issue may arise in the future, it is not a question addressed by the parties or these reasons. I would leave it for argument in a future case.

CONCLUSION

147 In this case, the Crown proved, and the trial judge correctly accepted, that the accused intentionally applied force to all the complainants in circumstances of a sexual nature. Further, although the accused knew that he was HIV-positive, and despite medical warnings to the contrary, he did not disclose that condition to the complainants, who, with one exception, would not have consented if they had known he was HIV-positive.

148 I can well understand that those complainants feel, in their opinion, that the nature and quality of the sexual act was fundamentally changed by the lack of disclosure of the risk of disease. Certainly this was especially the case with S.H., who was lied to by the accused as to his HIV status after she specifically asked about the presence of disease. From the complainants' points of view, any risk of contracting HIV is too great because any sexual encounter "could be 'the one', whether the odds are 1 in 100 or 1 in 10,000" (*R. v. J.A.T.*, at para. 54). In fact, other judges (L'Heureux-Dubé J. in *Cuerrier* and Roscoe J.A. in *Hutchinson*) and certain academics agree that misrepresentation coupled with reliance should be sufficient to vitiate consent without the necessity of the element of deprivation. In addition, some argue that there are unique issues for women here. "Thus, the reality for women may be that they cannot always take the best precautions available to prevent transmission of HIV/AIDS; rather they must rely on their male partners to cooperate" (Grant, "The Boundaries of the Criminal Law," at p. 159).

149 In *Cuerrier*, a majority of the court expressed concern that to allow a wider definition of fraud when determining when consent to sexual activity was negated might trivialize the issue. Yet, in other areas, courts are well able to determine when a material matter goes to the heart of consent without trivializing the analysis. For example, courts are very familiar with determining whether an informed consent has been obtained from a medical patient. In determining whether disclosure is required in a medical setting, both the degree of probability of risk and its seriousness are relevant factors. The same analysis may be useful in determining whether non-disclosure of a certain risk affected a person's informed consent to sexual activity.

150 So, for example, McLachlin J., as she then was, in *Rawlings v. Lindsay* (1982), 20 C.C.L.T. 301 (B.C.S.C.), stated (at p. 306):

> .... [A] medical person must disclose those risks to which a reasonable patient would be likely to attach significance in deciding whether or not to undergo the proposed treatment. In making this determination, the degree of probability of the risk and its seriousness are relevant factors. Thus an "unusual" or improbable risk should be disclosed if its effects are serious. Conversely, a minor result should be disclosed if it is inherent in or a probable result of the process.

The above comments of Justice McLachlin continue to be cited with approval. See *Harris v. Beck Estate*, 2009 PECA 8, 284 Nfld. & P.E.I.R. 29, and Allen M. Linden & Bruce Feldthusen, *Canadian Tort Law*, 8th ed. (Markham: LexisNexis Canada Inc., 2006) at 185.

151 At the very least, issues of condom usage and viral load raise difficulties of proof perhaps not contemplated or even known when the

Supreme Court developed the test in *Cuerrier*. The scientific evidence provides only general propositions or benchmarks, whereas judicial determination of individual cases is, of necessity, fact-specific. It is the Crown's obligation to prove its case beyond a reasonable doubt. To achieve the goal of careful and consistent condom use, as described by Dr. Smith, involves a complex series of steps. The inquiry as to whether there was careful and consistent use of a condom in a particular instance of sexual activity is likely to be an unrealistic endeavour given that the sexual acts at issue will often have occurred some time ago, in conjunction with the use of drugs and/or alcohol, and the participants may be young and unaware of how to properly use a condom. As an example, where the disclosure of the accused's HIV-positive status occurs some time after the sex act, the actual condom is unlikely to be available for examination and testing, so how is the Crown to prove that it did not meet the standards prescribed by Dr. Smith, particularly where it was the accused who provided and applied the condom?

152 Again, with respect to viral loads, the ability to show that an accused had a common infection or an STD at the time of sex that might have led to a spike in the viral load may very well prove elusive. In light of these concerns and the developments in the science, the Supreme Court may wish to consider revisiting the test in *Cuerrier* to provide all parties with more certainty.

153 At present, however, *Cuerrier* is the law in Canada. The trial judge incorrectly interpreted and applied the test arising from *Cuerrier* and erred in her understanding of the relevant evidence at trial. Specifically, she erred in

ruling that a combination of both undetectable viral load and the use of a condom would be required to escape criminal liability.

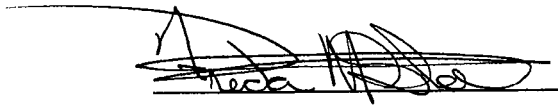
154 The Supreme Court of Canada has held that there must be a significant risk of the transmission of the virus before criminal sanctions will attach to lack of disclosure. The evidence of transmission rates varies considerably depending on the study and will again vary depending on the individual and the number and nature of acts of sexual intercourse. However, it was not seriously disputed in this case that unprotected sexual intercourse with an individual with an unrepressed viral load constitutes a significant risk of serious bodily harm even though, from an absolute statistical point of view, the risk is small.

155 The evidence also showed that, when careful and consistent condom use is present or effective antiretroviral treatment is undertaken, that small but significant risk is reduced to "low" or "very low," statistically to a risk substantially below the 0.7 per cent considered significant in *R. v. Thornton* (1991), 1 O.R. (3d) 480 (C.A.). There is no requirement that there be absolutely no risk of transmission, as the trial judge seems to have held.

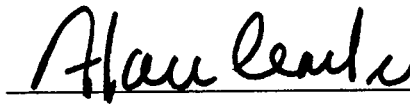
156 I am well aware that respect for one's bodily integrity would favour a legal standard that requires disclosure of facts that so closely impact on one's decision to allow physical intimacies. Everyone would want to be told that a potential partner was HIV-positive. Most people would agree that there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

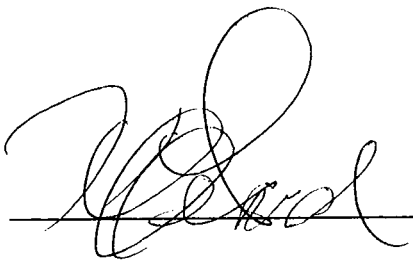
157 However, there are other criminal charges possible when actual harm occurs. See McLachlin J.'s comments in *Cuerrier*, at para. 74, and *R. v. Mercer* (1993), 84 C.C.C. (3d) 41 (Nfld. C.A.). With respect to situations where exposure to risk of harm is at issue, the requirement for a significant risk of serious bodily harm is the legal test, as set out by the Supreme Court of Canada.

158 The appeal is allowed in part. The accused should have a fresh sentencing hearing in the Court of Queen's Bench on the charges for which his conviction has been sustained.



J.A.

I agree:  J.A.

I agree:  J.A.