COURT OF APPEAL FOR BRITISH COLUMBIA

Citation: *R. v. Wright,*
2009 BCCA 514

Date: 20091119
Docket: CA036415

Between:

Regina

Respondent

And

Michael Aaron Wright

Appellant

And

Canadian HIV/AIDS Legal Network and
British Columbia Persons with AIDS Society

Intervenors

RESTRICTION ON PUBLICATION: THESE REASONS FOR JUDGMENT MAKE REFERENCE TO THE DECISION IN [*R. v. J.T.],* 2008 BCCA 463, (18 NOVEMBER 2008) VANCOUVER CA035770, INCLUDING A SUMMARY OF SOME OF THE EVIDENCE INTRODUCED AT THE PRELIMINARY INQUIRY IN THAT CASE. AN ORDER HAS BEEN MADE IN THAT CASE PURSUANT TO SECTION 539(1) OF THE *CRIMINAL CODE* DIRECTING EVIDENCE TAKEN AT THE PRELIMINARY INQUIRY SHALL NOT BE PUBLISHED, BROADCAST OR TRANSMITTED IN ANY WAY PRIOR TO THE END OF THE ACCUSED'S TRIAL.
[AS THE TRIAL IN *R. v. J.T.* ENDED MAY 7, 2010, THIS BAN IS NO LONGER IN EFFECT, BUT AS A SUPPLEMENTAL BAN WAS ISSUED TO INCLUDE THE NAME OF THE ACCUSED IN THE PROHIBITION UNDER S. 486.4 IN THAT PROCEEDING, THE REFERENCE TO THAT CASE IN PARA. 38 OF THESE REASONS HAS BEEN AMENDED.]

RESTRICTION ON PUBLICATION: AN ORDER HAS BEEN MADE IN THIS CASE PURSUANT TO SECTION 486.4(1) OF THE *CRIMINAL CODE* THAT PROHIBITS ANY INFORMATION THAT COULD IDENTIFY THE COMPLAINANT[S] OR WITNESS[ES] BEING PUBLISHED, BROADCAST OR TRANSMITTED.

Before: The Honourable Madam Justice Levine
The Honourable Madam Justice Kirkpatrick
The Honourable Mr. Justice Tysoe

On appeal from: Supreme Court of British Columbia, February 14, 2008
(*R. v. Wright*, Vancouver Docket 24288)

Counsel for the Appellant:	D. M. Layton
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Counsel for the Intervenors:	M. J. Bozic

Place and Date of Hearing:	Vancouver, British Columbia October 21, 2009
Place and Date of Judgment:	Vancouver, British Columbia November 19, 2009

Written Reasons by:
The Honourable Mr. Justice Tysoe

Concurred in by:
The Honourable Madam Justice Levine
The Honourable Madam Justice Kirkpatrick

Reasons for Judgment of the Honourable Mr. Justice Tysoe:

Introduction

[1] The appellant appeals from his conviction by a jury on two of three counts of aggravated sexual assault. The appellant is positive for the human immunodeficiency virus, HIV. It was alleged that he failed to disclose this fact before he had sexual relations with the three complainants and that, as a result, their consent to the sexual relations was vitiated.

[2] The appellant raises four grounds of appeal. For the reasons that follow, I would not give effect to any of these grounds, and I would dismiss the appeal.

Background

[3] The Crown called five witnesses in addition to the police officer who interviewed the appellant. The three complainants, P.S., D.C. and C.N., testified that the appellant had sexual intercourse with them without wearing a condom in the years 2004, 2005 and 2006. They all testified in direct examination that the appellant had not told them he was HIV-positive and that they would not have had sex with him or would not have gone near him or let him near them if they had known he was HIV-positive. However, in cross-examination, C.N., the complainant in the count in respect of which the appellant was acquitted, agreed with the suggestion that she knew he was HIV-positive and had sex with him anyway.

[4] In direct examination, P.S. said that the appellant ejaculated a few times when they had intercourse. When it was put to her in cross-examination that she could not say whether the appellant ejaculated when his penis was inside or outside her vagina, she replied that she got wet a few times and she later agreed that her only basis for saying he ejaculated was that he went to the bathroom, where she assumed he washed or wiped himself off.

[5] D.C. testified that the appellant ejaculated on the one occasion they had vaginal intercourse. She said that she knew he ejaculated because she felt it on her leg. D.C. also said that she pulled a condom out of her bag and put it on the floor beside the appellant and that the condom was still on the floor when they had finished having intercourse.

[6] It was an agreed fact that none of the complainants had tested positive for HIV.

[7] Dr. Talento was the appellant's family doctor for a period of eight years. He testified that he was the one who informed the appellant in February 1998 that the appellant had tested positive for HIV. Dr. Talento did not treat the appellant for this condition and referred him to Dr. Vortel, an infectious disease specialist. Approximately three years later, Dr. Talento

referred the appellant to a neurologist in respect of peripheral neuropathy, a disease causing numbness, tingling and pain in the extremities, which he believed was a side effect of antiviral treatments prescribed by Dr. Vortel.

[8] The most important of the Crown witnesses for the purposes of this appeal was Dr. Conway, a specialist in HIV, and I will set out his testimony in some detail. He explained that HIV is an irreversible virus that is transmitted through blood or sexual contact. The disease weakens the body's immune system over time, resulting in infections known as the AIDS disease, which leads to death. Dr. Conway testified 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%.

[9] Dr. Conway explained that the treatments used for HIV infection are becoming more and more effective, and that the most recent data speaks of a life expectancy approaching 30 years after HIV contraction. In terms of treatment, Dr. Conway said that, in Canada, approximately 5% of infected persons are resistant to many of the drugs used, approximately 15% of infected persons do not take the medication as prescribed and the virus becomes more resistant to the drugs, and approximately 5% to 10% of infected persons get re-infected with the virus from high-risk behaviours and the new strain may be harder to treat. That leaves approximately three-quarters of HIV-infected persons, said Dr. Conway, who should enjoy the maximum benefits of treatment.

[10] A test called a viral-load test, which measures viral sequences in the blood, can be used to determine if a person is infected with HIV. Dr. Conway explained that the peak viral load, or the peak amount of virus in the blood, occurs between two weeks and six weeks after the person becomes infected. The viral load will then fall and reaches a plateau where it can stay for a number of years. The viral load will again increase when the immune system weakens. Dr. Conway said that the viral load can range from 10 to 20 copies of the HIV virus per millilitre of plasma in people who are on treatment to 40 million per millilitre of plasma in people who have just recently been infected and have not received treatment.

[11] Dr. Conway testified that HIV can be passed on vaginal intercourse even if the male does not ejaculate because certain genital fluids are secreted from the penis prior to ejaculation and because there may be sores present on the penis; however, there is less virus present in the cells in these fluids than in semen. Dr. Conway also testified that the use of latex condoms can reduce the risk of transmission to 1 in 10,000, or 0.01%, if they are used properly and do not break, but he cautioned that reporting on condom use is not always reliable.

[12] In cross-examination, Dr. Conway agreed that one of the factors affecting the risk of transmission is viral load. He testified that if the viral load is undetectable, or lower than the viral-load test can accurately count, the risk of transmission goes down between 100 and 1,000 times. He was referred to a Swiss study and agreed it concluded that if the viral load is below 1,000, the risk of transmission is less than 1 in 100,000 (0.001%).

[13] Dr. Conway was asked whether he would be unable to reach any conclusion with respect to the degree of risk of transmission if he did not know all of the factors that may affect the risk. He agreed that was theoretically correct but said that ascertaining those factors in a completely accurate manner was often difficult and the experts have to make generalizations.

[14] In answering a question during cross-examination about the type of information needed by him to give an opinion with respect to the risk of transmission, Dr. Conway explained that information he receives from individuals diagnosed with HIV infection can be denied or minimized, and “I’m cautious of taking people’s sexual history at face value, especially at first visits”. He subsequently came back to his point about people “being notoriously unreliable” and said after people have told him there was genital-to-genital contact “people tend to not be completely reliable as to what happened after that”.

[15] At the conclusion of the Crown’s case, an application for a directed verdict of acquittal was made by the appellant on the basis that there was no evidence as to his viral load. The trial judge dismissed the application. He did not give detailed reasons; he simply indicated that, on the authorities as they then stood, he was not prepared to have a directed verdict.

[16] The appellant testified in his defence. He testified that Dr. Talento and Dr. Vortel told him of the need to tell his sexual partners of his HIV status, and that he had always done so. He specifically testified that he told each of the complainants that he was HIV-positive before he had any sexual contact with them. He said that D.C. gave him a condom, which he put on, but their attempt to have sexual intercourse was not successful and he did not ejaculate.

[17] The appellant gave testimony about his medical situation since testing positive for HIV in 1998. He testified that he began taking anti-viral medications soon after he was diagnosed and had taken them since that time except for a period of approximately one and one-half years (which covered the times he had sexual contact with each of the complainants). The appellant testified that he saw an HIV specialist other than Dr. Vortel, whose name he could not recall, who told the appellant that he did not need to take anti-viral drugs at that time because his viral load could not be seen on a blood screen.

Issues on Appeal

[18] The appellant asserts that the trial judge erred in the following respects:

(a) the judge should not have dismissed the application for a directed verdict;
(b) the judge should have instructed the jury that, if it had a reasonable doubt as to whether the appellant wore a condom during his sexual intercourse with D.C., it was required to acquit him in respect of that count;
(c) the judge should have instructed the jury to disregard Dr. Conway's testimony about the unreliability of reports from HIV-infected persons in assessing the appellant's credibility; and
(d) the judge should not have effectively told the jury that Dr. Conway was of the opinion that any exposure to the HIV virus through sexual contact created a significant risk of serious bodily harm.

(a) Directed Verdict

[19] There is no dispute between the parties with respect to the test to be applied in considering an application for a directed acquittal verdict. The test is whether or not there is any evidence upon which a reasonable jury, properly instructed, could return a guilty verdict: see *R. v. Charemski*, [1998] 1 S.C.R. 679, 123 C.C.C. (3d) 225 at para. 2. The test is the same whether the evidence is direct or circumstantial but, if the evidence on an element of the offence is circumstantial, the judge must engage in a limited weighing of the evidence to determine what may be reasonably inferred from the evidence: see *R. v. Arcuri*, 2001 SCC 54, [2001] 2 S.C.R. 828, 157 C.C.C. (3d) 21 at paras. 22-23.

[20] The live issue at trial related to consent. There was no dispute that the complainants consented to having sexual intercourse with the appellant. The issue was whether it was effective consent or whether the consent was vitiated by fraud because the appellant had not informed the complainants that he was HIV-positive.

[21] The issue of consent in the present context was addressed by the Supreme Court of Canada in *R. v. Cuerrier*, [1998] 2 S.C.R. 371, 127 C.C.C. (3d) 1. Prior to that decision, the law provided that fraud did not vitiate consent unless it related to the nature of the act or the identity of the accused. Fraud relating to the possibility of contracting a disease did not vitiate consent. In *Cuerrier*, the Supreme Court of Canada decided that the law should be changed.

[22] Madam Justice L'Heureux-Dubé believed that any deceit inducing consent to sexual touching should be sufficient to vitiate consent. Madam Justice McLachlin (as she then was) and Mr. Justice Gonthier considered that consent should only be vitiated if there is deception as to the presence of a sexually transmitted disease giving rise to a serious risk or probability

of infecting the complainant. The majority of the Court chose a middle ground and adopted a modified version of the commercial meaning of fraud.

[23] The test for fraud in the commercial context is whether there is proof of dishonesty and deprivation. Dishonesty will be proven if the accused deliberately deceived the complainant respecting his HIV-positive status or failed to disclose his HIV-positive status prior to the sexual act. Mr. Justice Cory discussed the aspect of deprivation as follows:

> [128] 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.

Thus, consent will be vitiated if the accused is dishonest regarding HIV-positive status that has the effect of exposing the complainant to a significant risk of serious bodily harm. This involves a consideration of the appellant's HIV-positive status, bearing in mind that the Crown has the onus of proving the lack of consent beyond a reasonable doubt.

[24] In his factum, the appellant argued that, in view of Dr. Conway's evidence, a directed acquittal verdict should have been given in the absence of any evidence regarding the appellant's viral load. The appellant modified his argument at the hearing of the appeal. He points to the evidence of Dr. Conway that 75% of HIV-infected persons are treated with antiviral medication, and the evidence of Dr. Talento that he believed the appellant's peripheral neuropathy was a side effect of antiviral treatments. The appellant says that this evidence suggests that there was a reasonable possibility that his viral load was at the low end of the range given by Dr. Conway (i.e.,1 in 100,000 to 1 in 200 or 0.001% to 0.5%), and an acquittal had to follow because the evidence raised a reasonable doubt that the complainants were exposed to a significant risk of serious bodily harm.

[25] In my view, the appellant's argument is predicated on an interpretation of Dr. Conway's evidence that is far from certain. The argument is based on the premise that the high end of the range given by Dr. Conway (1 in 200 or 0.5%) applies only to HIV-infected persons who have not received treatment and that the risk of transmission from an infected person receiving treatment must be lower.

[26] My understanding of Dr. Conway's evidence is that the figure of 0.5% given by him is a composite average taking into account all of the factors that can affect the risk of transmission, including the factor of treatment. Dr. Conway testified as follows during cross-examination:

> Q But that 0.5 percent is derived from studies that could or could not have had ejaculation as part of the genital contact.
> A That's accurate. It's a -- it's a composite of a number of things, but it's the average risk that most experts in the field would quote when they're asked that specific question.
> Q And it's an average risk that takes into account that ejaculation has occurred.
> A Well, if ejaculation occurred, some people might say it's a bit higher. So when I quoted -- when I was initially asked the question, I said it's somewhere between 0.1 and one percent. And just to, let's say, keep things simple, most of us will quote a middling risk of 0.5 percent to take into account a whole series of -- of circumstances.
>
> [Emphasis added.]

[27] The cross-examination then turned to the Swiss study that showed, if the viral load is below 1,000, the risk of transmission is less than 1 in 100,000. It was put to Dr. Conway that the viral load is something that one needs to know before any conclusion can be drawn with respect to the risk of transmission. He answered as follows:

> A Well, it plays in context, and with genital-genital sex it plays in the way -- in the figures that I've described. But I -- if I misheard you, I apologize, but I thought I heard you say that the Swiss Cohort Study said that it was safe, but they didn't say that.
>
> [Emphasis added.]

Hence, low viral loads achieved by treatment were one of the circumstances included in the 0.5% average given by Dr. Conway, and it is not necessary to know the viral load of the infected person before an expert can give an estimate of the risk of transmission. Even if I am mistaken in my interpretation of Dr. Conway's evidence, it is an interpretation that the jury could reasonably have given to his evidence.

[28] When the application for a directed acquittal verdict was made, it was not the function of the trial judge to weigh the evidence and make findings of fact and to then decide whether a reasonable doubt as to the appellant's guilt existed on the basis of those findings. The test on such an application is whether there was any evidence upon which a reasonable jury, properly instructed, could return a guilty verdict: *Charemski*. In my opinion, there was such evidence.

[29] The jury had the evidence of Dr. Conway that the average risk of transmission is 0.5%. That evidence was sufficient for a jury to have been satisfied beyond a reasonable doubt that the risk of HIV transmission represented a significant risk to the complainants of serious bodily harm. The jury was entitled to rely on that figure as an average risk in the absence of specific

evidence with respect to the appellant's viral load because the figure was a composite average taking into account the wide range of viral counts of all infected persons included in the group from which the average risk was derived.

[30] The appellant points to the fact there was evidence in the Crown's case that he was receiving treatment because Dr. Talento testified that he believed the condition of peripheral neuropathy he observed in the appellant in or about 2001 to be a side effect of antiviral treatments. However, even if the jury accepted that the appellant had received treatment up to 2001, it was not required to conclude that the appellant was still receiving treatment three to four years later when he had sexual relations with the complainants. There was evidence that the appellant was having unprotected sex with the complainants in 2004 and 2005, and it was open to the jury to conclude that at that time the appellant was part of the risk-taking group comprising approximately 15% of HIV-infected persons who Dr. Conway said do not take their medications as prescribed.

[31] The intervenors argue that ignoring the relevance of viral load would considerably widen the scope of potential criminal liability of HIV-infected persons beyond what was contemplated by the Supreme Court of Canada in *Cuerrier*, and the appellant and intervenors argue that the Crown's position improperly shifts the onus on the accused to prove that the level of his viral load is below a level representing significant risk of serious bodily harm. I do not agree.

[32] 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.

[33] 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:

> [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, *supra*, 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.

[34] In my opinion, therefore, there was some evidence introduced during the Crown's case upon which a reasonable jury, properly instructed, could have concluded that it had been proven beyond a reasonable doubt that the risk of HIV transmission from the appellant to each of the complainants represented a significant risk of serious bodily harm. The trial judge did not err in dismissing the appellant's application for a directed verdict.

(b) Use of Condom

[35] In arguing that the trial judge was required to instruct the jury to acquit him of the count involving D.C. if it had a reasonable doubt as to whether he wore a condom, the appellant points to Dr. Conway's evidence and a paragraph from *Cuerrier*.

[36] Dr. Conway's evidence was to the effect that the proper use of a latex condom could reduce the risk of HIV transmission by a hundredfold or more, and he referred to a risk of 1 in 10,000 or 0.01%. However, he also pointed out that many people do not follow all of the proper steps in using condoms and a number of things like breakage and condoms falling off tend to reduce the efficacy of condoms. He gave an example that 20% of pregnant women claim to have been using condoms when they became pregnant.

[37] The passage from *Cuerrier* relied upon by the appellant is the following paragraph from the reasons of Cory J.:

> [129] 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.
>
> [Emphasis added.]

I do not regard this passage as establishing that use of a condom will preclude a finding of a significant risk of serious bodily harm. Mr. Justice Cory did not say that careful use of a condom would in all cases be found to reduce the risk below the standard of a significant risk of serious bodily harm. He simply said that it might. Indeed, Dr. Conway also testified that

while sheepskin condoms prevent pregnancies, they do not protect against HIV at all.

[38] I find support in my view in the decision of this Court in [*R. v. J.T.*], 2008 BCCA 463, (18 November 2008) Vancouver CA035770. In that case, an epidemiologist testified at the accused's preliminary inquiry that the risk of HIV transmission from unprotected anal intercourse in a situation where the insertive partner was HIV-negative and the receptive partner was HIV-positive was about 6 infections in 10,000 exposures. The epidemiologist agreed during cross-examination that risk of HIV transmission was about the same for protected anal intercourse in the reverse situation where the insertive partner was HIV-positive and the receptive partner was HIV-negative. The accused, who had been the receptive partner, challenged his committal to trial on the basis that the risk of HIV transmission was the same as it would have been if he had been the insertive partner and had used a condom, and *Cuerrier* held that risk fell below the level that should attract criminal liability.

[39] This argument was rejected by the Court. Mr. Justice Donald reasoned as follows:

> [19] 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.
>
> [20] *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.

Thus, it is a question of fact in each case for the trier of fact to determine whether the use of a condom has reduced the risk of HIV transmission to a level that does not represent a significant risk of serious bodily harm.

[40] In the present case, the trial judge left it to the jury to determine whether the potential use of a condom in the sexual intercourse with D.C. raised a reasonable doubt as to whether there had been a significant risk of serious bodily harm. In my view, he did not err in that regard.

(c) Reporting Unreliability

[41] The appellant says that it was evident from Dr. Conway's testimony that he was of the opinion that HIV-positive people are often unreliable and lacking in credibility when reporting their sexual behaviour. This should have prompted the trial judge, says the appellant, to instruct the jury that it should disregard Dr. Conway's comments in this regard when assessing the appellant's credibility.

[42] The appellant points to three sets of comments made by Dr. Conway. The first was during cross-examination when Dr. Conway was asked whether the type of sexual relations was one of the factors that affected the risk of HIV transmission:

> Yeah, with the caveat that when we ask -- speaking of individuals who I diagnose with HIV infection, and when I ask them, oftentimes at first or even at second visit the -- a lot of contacts are denied or minimized. So I -- before I'm convinced of the information that I'm being -- that's being shared with me, I wait two or three different times before I draw a conclusion. Some people tell me everything the first time and some people say, "I have no idea how I became infected because I was always safe and I was always this and I was" -- well, that's what you say but three visits later the story changes. So I'm cautious of taking people's sexual history at face value, especially at first visits.

[43] The second is Dr. Conway's answer when asked in direct examination what can be done to ensure that the virus is not passed:

> Well, first, to state the obvious, one could avoid genital-genital contact and form -- choose other forms of -- of gratification, let's say, that carry less risk. But if one is intent on that form of contact, the use of condoms significantly reduces transmission by -- by a hundredfold or more in terms of the risk of transmission.
>
> That being said, we need to remember that 20 percent of women who show up being pregnant claim to have been using condoms 100 percent of the time. So obviously at some point the condom didn't work or the person I wouldn't say is being untruthful, they're just, let's say, thinking in a wishful manner. So when people tell us that they are using condoms all the time, it's a piece of information that we need to interpret in context.

[44] Third are comments made by Dr. Conway when he was being questioned about the effect of withdrawal before ejaculation:

> Then I come back to the point of people are being notoriously unreliable. Beyond telling me that genitals contacted genitals, people tend to not be completely reliable as to what happened after that.
>
> * * *
>
> If I was there with a camera watching everything and could document every second of what happened, I might think different. But short of that, relying on human beings telling me what happened during sex, I default to the 0.5 percent.
>
> * * *
>
> But we know in clinical medicine and the type of research that we do that once genital-genital contact has been initiated and has occurred, beyond that, people's recollections of what happened or their descriptions of specifically what happens tends to not be reliable. And that's not any specific person or a specific character, it's even lawyers and doctors.

[45] In my opinion, there was no need for the trial judge to give a cautioning instruction with respect to this evidence. No reasonable juror would have interpreted Dr. Conway's comments to suggest that the appellant would not be reliable or credible in giving his testimony because he was HIV-positive.

[46] The first set of Dr. Conway's comments addressed the reaction of people when they receive the devastating news that they have contracted the HIV virus. It is understandable that people in that context would tend to minimize their culpability. The comments do not suggest that an accused person, testifying long after being diagnosed and under an oath to tell the truth, would be unreliable in giving evidence about his sexual encounters several years after his diagnosis.

[47] A reasonable juror would not conclude from the second set of comments that HIV-infected persons are unreliable when reporting on condom use. Dr. Conway was commenting on condom use generally, and he used pregnant women as an example. Dr. Conway went on to explain there are a number of things that tend to reduce the efficacy of condoms, including improper use and breakage. One would not conclude from his comments that pregnant women, much less HIV-positive persons, are unreliable witnesses.

[48] The third set of comments was, again, directed at all people. That is best illustrated by the comment made by defence counsel after Dr. Conway finished making his comments:

> In the heat of the moment, all of us are probably not very good historians with respect to what occurred.

No reasonable juror would have interpreted Dr. Conway's comments as a suggestion that the appellant would be any less reliable or credible than any other person when giving evidence about the details of his sexual relations with the complainants.

[49] It is noteworthy that defence counsel at trial did not request the special instruction that the appellant now says should have been given by the trial judge. Defence counsel had the opportunity to make the request at a pre-charge conference and after the charge was given. Although the lack of objection to an aspect of the judge's charge at trial is not determinative, it is significant because it illustrates that the defence counsel at trial, who was present when Dr. Conway made his comments and in the best position to assess their potential effect on the jury, was not concerned that the comments would have adverse ramifications on the jury's determination of the appellant's credibility or the reliability of his testimony: see *R. v. Jacquard*, [1997] 1 S.C.R. 314 at para. 38, 113 C.C.C. (3d) 1.

[50] I conclude that the trial judge did not err in failing to give the jury a special instruction with respect to Dr. Conway's comments about the reliability of reports concerning the potential sources of HIV infection, the use of condoms and details of sexual activity.

(d) Erroneous Description of Dr. Conway's Opinion

[51] As has been discussed, *Cuerrier* established the proposition that consent will be vitiated

if there is dishonesty and deprivation consisting of a significant risk of serious bodily harm. Section 273(1) of the *Criminal Code* provides that a sexual assault is an aggravated sexual assault if the accused, in committing a sexual assault, wounds, maims, disfigures or endangers the life of the complainant. In the context of this case, it was alleged that the appellant endangered the lives of the complainants. The trial judge defined the term "endangerment" to mean a significant risk of serious bodily harm, which is the same meaning given to deprivation for the purpose of determining whether consent is vitiated. The appellant does not take issue with the judge's definition of endangerment.

[52] The appellant's complaint is that the trial judge mistakenly indicated in the following portion of his charge that Dr. Conway was of the opinion that any exposure to HIV through sexual contact constituted a significant risk of serious bodily harm:

> Dr. Conway agreed that the risk may be very, very low, depending on the factors. His view was that any exposure to the virus through sexual conduct, whether it be sexual intercourse, anal intercourse or oral sex, creates some risk, some endangerment to life. For oral sex, a tremendous variation depending on the presence of sores. We don't have that evidence. Similarly, a very low viral count can reduce the risk of infection markedly. So can wearing a condom.
>
> A very important reason for [recording malfunction] on this approach, as far as he was concerned, was the nature of the risk. That HIV is incurable, that it leads to AIDS often with horrible suffering and premature death. He did not agree that the risk of HIV from oral sex, or from intercourse without ejaculation, was too little to constitute a risk of serious bodily harm.
>
> Now, that was his view. You are not here to decide based on his view of what was a significant risk. It is for you to decide, beyond a reasonable doubt, what, if any, sexual activity took place, and whether taking everything into account it amounted to a serious -- a significant risk of serious bodily harm. You are not bound by the expert's view of it.
>
> [Emphasis added.]

[53] The appellant submits that because the jury had been told that "endangerment" was commensurate with a significant risk of bodily harm, the import of the above portion of the charge was that Dr. Conway expressed the opinion that there existed a significant risk of serious bodily harm on the facts of this case.

[54] The short answer to this argument is that the trial judge did not say that Dr. Conway expressed the opinion that any exposure to the HIV virus through sexual conduct creates a significant risk of serious bodily harm. He said any exposure creates "some risk, some endangerment to life".

[55] The judge did not misstate Dr. Conway's opinion. In testifying about the various factors affecting the risk of transmission, Dr. Conway spoke about reduction of the risk but he never said the risk was eliminated. When discussing the Swiss study during his cross-examination,

Dr. Conway took issue with the suggestion that a low viral load meant that sex was safe, and he agreed with defence counsel's follow-up comment that nothing but abstinence is 100% safe.

[56] In addition, a reasonable juror would not have understood the judge to have equated some risk to a significant risk, especially in view of the following portion of the judge's charge dealing with risk of harm:

> The risk must be more than an ordinary risk. The Crown must prove on each count, beyond a reasonable doubt, that Mr. Wright had a kind of sexual activity that created a significant risk of serious bodily harm to the complainant. It is not necessary to establish – I am going to repeat this – it is not necessary to establish that as a result of the sexual contact the complainant was infected by the HIV virus. That didn't happen here. They did not, as far as they know, catch the AIDS virus, or the HIV virus. Deprivation or loss is satisfied by showing beyond a reasonable doubt that there was an endangerment to life or, as I've said before, a significant risk to the complainant of a serious bodily harm.

[57] As with the previous ground of appeal, it is significant that defence counsel did not object to the portion of the charge in question, either at the pre-charge conference or after the charge was given.

[58] In my view, the judge did not misdirect the jury with respect to Dr. Conway's opinion.

Conclusion

[59] I would dismiss the appeal.

"The Honourable Mr. Justice Tysoe"

I agree:

"The Honourable Madam Justice Levine"

I agree:

"The Honourable Madam Justice Kirkpatrick"