
The System is Broken



Audit of Australia's Mandatory Disease Testing Laws

napwha national association of
people with HIV australia

 **HIV JUSTICE
NETWORK**

Published by the National Association of People with HIV Australia

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First published: September 2019

Suggested Citation: Cameron, S. The System is Broken: Audit of
Australia's Mandatory Disease Testing Laws to Test for HIV, HIV
Justice Network and the National Association of People with HIV
Australia, 2019.

We gratefully acknowledge the financial contribution of the Robert
Carr Fund for civil society networks.

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Executive Summary

In Australia, informed consent is required for HIV testing in all but rare circumstances. In fact, it is these “principles of voluntary testing, informed consent and confidentiality [that] have underpinned the improvements in testing coverage achieved in Australia to date” (Department of Health, 2018).

Five states have legislation that allows for mandatory testing of a person whose bodily fluids come into contact with police and/or emergency service personnel. In Victoria, these laws sit under public health legislation. In Queensland, they are framed around the testing of a person accused of sexual assault or a serious offence, although they can be used in relation to other persons who may have been exposed to bodily fluid during or soon after the commission of the offence, which could include first responders. A recent push by police unions and member organisations has resulted in the introduction of new laws specifically relating to assaults against emergency services personnel in South Australia and Western Australia (2015), and in the Northern Territory (2016). Notably, all these laws are uniformly focused on the rights and health of the person who has come into contact with bodily fluids, not the person being tested.

This report does not seek to trivialise the risks and trauma faced by emergency services workers who regularly encounter difficult and confronting situations. We do not condone assaults against emergency services personnel in any form, including spitting or biting, and condemn any intentional application of bodily fluids during an assault against an emergency services worker, regardless of HIV risk. We also note that, this is not an issue of ‘us’ and ‘them’. The community of emergency service personnel is part of our community, and we are part of theirs (Bambridge & Stardust, 2018).

The adoption of new laws in this area is both perplexing and problematic, given existing criminal laws that can

be applied against a person who assaults police or other emergency services workers, but particularly when considered through the lens of modern HIV treatments. Although violence against emergency services workers may be increasing, risk of HIV transmission is not. If anything, effective treatments mean that the majority of people living with HIV in Australia have a low or undetectable viral load, making transmission unlikely or impossible in the types of circumstances covered by these laws. Should a person actually be exposed to HIV, post-exposure prophylaxis (PEP) has a high success rate, preventing HIV from establishing itself in a person’s body so that they do not become HIV-positive. Further, in the context of modern treatment, the implications of living with HIV have been transformed, with the long-term health and quality of life of people living with HIV now drastically improved. Antiretroviral therapies have been so successful at preserving health and extending life that a person recently diagnosed with HIV who commences effective treatment will have an equivalent life expectancy to that of the HIV-negative general population (Barré-Sinoussi et al., 2018).

Unlike many occupations, policing and other emergency response work inherently involves engaging in difficult and dangerous situations in order to protect the health and safety of others. Despite that, the odds of a first responder being exposed to HIV during their ordinary working lives are extraordinarily low. Fewer than 0.1% of the Australian population is living with HIV and HIV is not easily transmitted. There is no possibility of HIV transmission via contact with the saliva of an HIV-positive person (including biting or spitting); no possibility of HIV transmission via contact with the saliva of an HIV-positive person where the saliva contains a small quantity of blood (including biting or spitting); and negligible to no possibility of HIV transmission from biting where the HIV-positive person’s saliva contains a significant quantity of blood, **and** their blood comes into contact with a mucous membrane

or open wound, **and** their viral load is not low or undetectable (Barré-Sinoussi et al., 2018).

This means that in effect, almost all emergency services officers will never come into contact with HIV in the course of their careers and, if they do, the chance of HIV transmission is either impossible or vanishingly small. Further, if against all the odds transmission of HIV was to occur, modern prevention treatments administered according to best practice in a timely manner would prevent seroconversion. Put simply, the risk of an emergency service officer becoming HIV positive through occupation-related spitting or biting is so small as to be almost impossible in real world scenarios.

HIV prevalence is extremely low in Australia so emergency services workers will seldom come into contact with a person with HIV during their regular work. The odds of being exposed to bodily fluids are far lower still. And the possibility of acquiring HIV as a result of an exposure - much reduced again. The availability of PEP, which can stop HIV in its tracks, makes the possibility of HIV transmission through occupational exposure quite remote. That explains why emergency services workers are not getting HIV through occupational exposures.

The risk of HIV transmission from an occupational exposure involving other bodily fluids is also extremely low, as evidenced by the fact that there has not been a notification of HIV transmission in any occupational setting since 2002 (and even in this case, the occupational nature of the exposure is not certain). It is important to note that despite extensive investigation over many years, the combined efforts of many HIV service and research organisations have not been able to identify a case of HIV transmission to a police officer, ever.

National surveillance data show there has not been a notification of HIV transmission in any occupational setting since 2002. In fact, there has never been a recorded case of occupational HIV transmission to a police officer in Australia, ever.

This national audit of Australian mandatory disease testing laws was undertaken as a means to better understand the use of these laws to test for HIV. It included a scoping of

current laws and guidelines; a literature review; requests for information from the state governments of Northern Territory, Queensland, South Australia, Victoria and Western Australia; and discussions with clinicians and other health care workers.

The results of the audit are concerning. Our investigations reveal that mandatory testing laws are at odds with national HIV testing policy, and are operating outside the structured and highly successful HIV responses managed by clinicians and departments of health. The audit found that in many instances, the laws, their implementation, and monitoring include numerous structural failures, usually occurring in multiple states. Issues include:

1. The threshold/trigger for mandatory testing is set too low:

Mandatory HIV testing is an invasive procedure that is contrary to national testing policy and illegal unless specifically allowed by legislation. Yet, in most cases, testing may be ordered based on the supposition of a person who is not a medical expert who believes that a person may have been exposed to bodily fluids, including saliva. That is, they may have been exposed to bodily fluids, not they have been, exposed to bodily fluids that don't necessarily include a risk of HIV transmission. Mandatory testing can therefore be ordered where there is no risk of HIV transmission at all. Where this happens it is the perceived risk of transmission (where none actually exists), informed by stigma and not science, that is driving the decision.

2. Decision-making has been delegated to non-experts:

In the Northern Territory, South Australia and Western Australia, a decision to undertake mandatory testing is made by a senior police officer unless the person is a child or person lacking capacity to consent. Decisions made before a court require a higher burden of proof, however, whether or not expert medical evidence is provided is case dependent. In Western Australia, decisions about whether testing proceeds eventually turn on the opinion of the individual police officer who believes they have been put at risk, with the law specifically allowing them to overrule an expert assessment by a clinician on whether testing is necessary or advised. In Western Australia, mandatory tests have been ordered hundreds of times by senior police since 2015. Specialist HIV clinicians, the people most

qualified to identify where HIV/blood borne virus (BBV) transmission is a possibility, are largely excluded from the decision making process. This means that under the current system, decisions to test for HIV/BBV are particularly vulnerable to stigma and not informed by the latest medical knowledge.

3. Decision-making does not routinely allow for procedural fairness:

In the Northern Territory, South Australia and Western Australia, most people would be subject to mandatory HIV testing orders approved by senior police (as adult, non-protected persons), without the means to present a defence or for that defence to be considered by an independent party to decide whether such intervention by the state is warranted.

4. Use of force is allowed:

All states allow force or reasonable force to be used to enforce an order. In Queensland, South Australia and Victoria, use of force requires a court order, while in the Northern Territory or Western Australia, the law does not require a court order unless the person is a child or otherwise not able to give consent. (See note re: Western Australia at point 6. below). Three states allow healthcare practitioners to ask for assistance and also to use force. This is despite the fact that obtaining a blood draw using force is neither simple nor safe.

5. Hefty criminal penalties apply:

In the Northern Territory, South Australia and Western Australia, failure to consent to a disease test order is a criminal offence with hefty penalties attached, including fines of more than \$15,000 and up to 2 years' imprisonment. Whether or not penalties are applied, they represent a forceful instrument to coerce compliance with an order rather than obtain agreement or consent to be tested. In South Australia, agreement to comply circumvents the process being undertaken before a magistrate.

6. There is a disconnect between laws, guidelines and practices:

The audit revealed numerous instances where the law could not be implemented easily/effectively or the law and guidelines appeared contradictory. For example, in Western Australia, the law allows ongoing detention and use of force if a person is unwilling to comply while police Standing Operating Procedures state that if a person is not willing to comply, they are to be informed they have

committed a criminal offence, issued a summons to court, and released immediately. In numerous states where mandatory testing laws required the drawing of blood by healthcare practitioners, clinicians said they would not undertake mandatory testing (see below). Further, our investigations showed that despite vulnerable people being compelled to undergo testing, the system is so tenuous that they were not always able to receive their test results.

7. Laws may not be implementable in a clinical context:

The mandatory testing laws have been drafted requiring the drawing and testing of blood without a person's consent. However, numerous healthcare practitioners were clear that they would not agree to test a person who refuses to consent, particularly where use of force is involved, given restraining a person to undertake a blood test is not necessarily possible or safe, may not be for the benefit of the patient, and goes against ethical codes of medical practice. Concerns remain, however, that by the time a person is being tested, processes of coercion relating to mandatory testing orders may not be transparent to the person taking the blood sample.

8. States have minimal or no monitoring processes in place:

Where laws are located outside health departments, there are minimal to no monitoring mechanisms in place to assess the use, effectiveness (or lack thereof) or any unintended consequences of the mandatory disease testing laws. This lack of structure suggests a disinterest in the experience of persons who are subject to mandatory testing, a lack of genuine interest in the usefulness of mandatory testing to improve the welfare of officers and other staff, a lack of understanding of the complexity of mechanisms routinely integrated into HIV health management, programming and monitoring systems, and a disregard for cost or cost/benefit of the mandatory testing systems. Cost is certainly an issue in Western Australia where hundreds of tests have been conducted, 32% (125 of 387 cases) of which were conducted in regional areas where, in addition to costs associated with testing, police are required to arrange transport and police guards to and from specific testing locations. Notably, the Western Australian system did not include collection of data on whether those being tested were of Aboriginal or Torres Strait Islander background, although the Police Commissioner noted that this data was to be collected from 2019.

9. States systems lack transparent and accessible mechanisms: At no point was NAPWHA able to identify a key entry point to make enquiries or gain information about the use of mandatory disease testing laws in any state. Despite making FOI requests and approaching police and other state government departments directly (where staff were uniformly courteous and helpful), no states provided information about who had ordered that tests be undertaken, or about the means of alleged HIV exposure related to each test. In two states, it was not possible to discover whether or not the laws had been used. Generally, staff were unclear where requested information might be held.

10. States systems lack a successful interface between health and police: Although the delivery of test results is managed by individual clinicians through standard procedures located in the health sector, and departments of health otherwise retain responsibility for Australia's HIV response, departments of health appear to have been largely locked out of processes regarding implementation of the mandatory testing laws (with the exception of Victoria). There is no requirement or infrastructure for reporting data on mandatory testing to health department staff, nor clearly designated officers in health or police to enable an effective interface between the departments on this issue. Further, conversations with numerous clinicians revealed they were either unfamiliar with processes and responsibilities under the legislation or had concerns about how their organisations could/would respond to mandatory testing orders.

11. Laws are being used and their use does not appear justifiable: Unfortunately, data was not available for Northern Territory or Queensland but the audit revealed mandatory testing relating to incidents involving emergency services workers has not been used in Victoria, but had been used seven times in South Australia in the 15 month period, February 2017 to May 2018. In Western Australia, mandatory testing laws have been used almost 100 times/year since their introduction in 2015. In Western Australia at least, it seems highly unlikely that the majority of incidents would have included any risk of HIV transmission given the conditions required for HIV transmission to be possible.

Unfortunately, at the conclusion of the audit, we remain unable to provide clear data outlining the use of mandatory testing laws to test for HIV. In two states, it was not possible to access any information on the number of times mandatory HIV testing had been carried out. No states provided information on the reasons mandatory testing had been conducted (type of exposure) or in what circumstances testing had been conducted, and it is unclear whether this type of information is being collected.

The system does not include a mechanism to assess whether people are testing positive for HIV: accused or police. That structural failure means the system cannot be effectively monitored and evaluated. It is therefore, unaccountable. We cannot know if the system is working because the very reason it exists cannot be measured. This also raises larger questions, including why these systems continue if police are unable to ascertain whether anyone is testing HIV positive. We know they're not.

It was also not possible to ascertain whether any person subjected to mandatory testing had tested positive for HIV in any state. It appears that in the (commendable) interests of ensuring the confidentiality of health records, police have delegated responsibility for identifying and notifying cases of HIV to individual doctors, and consequently, there is no collection or recording of the results of tests as they relate to mandatory testing. It is unclear whether any state governments have systems in place to record data in this area.

Similarly, police departments do not keep records of HIV diagnosis resulting from an occupational incident (i.e. whether a police officer has tested HIV positive) so they were not able to provide data on this point. However, our queries to the Kirby institute identified an important fact. National HIV surveillance data reveals that there have been no national HIV notifications for the years 2003-2017 following HIV diagnosis in Australia with a reported occupational exposure risk¹. That is, we know from HIV surveillance data that there have been no cases of HIV transmission to emergency services personnel as a result.

¹ Correspondence with Kirby Institute based on national surveillance data, 16 May 2019.

of occupational exposure since any of the legislation has been introduced.

That information would also be held by state health departments in their surveillance data. It is unclear whether that is well known outside health, and whether police, emergency services organisations and associated unions have mechanisms in place to find and analyse that data and to consider whether this legislation is benefiting their personnel or alternatively, causing their employees/members to endure needless concern about impossible HIV transmission.

It is an absolute priority for our organisations that people who fear they may have been exposed to HIV do not undergo undue stress regarding the likelihood of HIV transmission or are not allowed to labour under erroneous, outdated and stigmatised misconceptions of what it means to live with HIV today. Mandatory testing for HIV perpetuates HIV-related stigma, exacerbating fear among emergency services workers. The media push for mandatory testing, led by police member organisations, has consistently used highly emotive language and case studies that have uniformly ramped up fear of HIV transmission in cases where transmission was not possible (Foster, 2014; Morri, 2019; Quedsted, 2019), including reporting a police officer who feared he may have been exposed to HIV was now afraid to kiss his loved ones (Foster, 2014).

HIV is not easily transmissible and it is now a chronic, manageable health condition. Treating it as anything other in media discourse or in legislation is stigmatising and irresponsible. Instead, scaling up the provision of clear, accessible information on the science of HIV through targeted education is crucial, as is the delivery of support services for emergency workers who fear they may have been exposed to HIV.

Mandatory testing laws ignore the collective knowledge and expertise informing Australia's national HIV strategy and world leading, successful HIV response.

The National Association of People with HIV Australia and the HIV Justice Network recommend consideration of the following:

1. Repeal of all mandatory testing laws used to test people for HIV following a possible exposure of a person to another's bodily fluids, given only a remote possibility

of transmission and the availability of post-exposure prophylaxis to prevent HIV acquisition. These laws criminalise behaviour that is already criminalised. They cannot prevent HIV transmissions where no risk exists.

2. Immediate review of current systems regarding use of mandatory testing laws given clear overuse in some locations, use to test for 'all' possible diseases regardless of risk events, lack of a successful interface with clinicians and health departments, disregard for the welfare of persons being tested, and a lack of mechanisms scrutinising the use and effectiveness of these laws

3. Amendment of mandatory testing laws so that all mandatory/forced testing requires the order of a judge and the affirmative recommendation of a qualified medical specialist, with police officers prevented from ordering mandatory tests, to ensure the tests cannot be misused as extra-judicial means of punishment.

4. Amendment of mandatory testing laws to communicate consent (or the absence of consent) and the means by which consent was gained be recorded and communicated to staff undertaking pathology and delivering results.

5. Amendment of mandatory testing laws to include robust monitoring requirements (factors to be monitored), with a condition that results of monitoring be published annually.

6. Amendment of mandatory testing laws to restrict mandatory testing for any transmissible infection to situations where there has been a real risk of transmission (as confirmed by a medical specialist) of that specific infection.

7. Review of clinical and other support procedures, including application of occupational PEP guidelines, to ensure effective treatment of emergency services workers who fear they have been put at risk of HIV transmission.

8. Scaling up of education targeting emergency services workers' organisations and media regarding current science on HIV risk and treatments to alleviate fears of occupational HIV exposure and transmission and to enable a better understanding of the realities of living with HIV.

1. Background

Compulsory testing of a person for any disease infringes the principle of personal autonomy fundamental to biomedical ethics: the same principle that forms the basis of systems of voluntary informed consent for medical procedures, and the right to privacy and confidentiality of personal medical information. This audit is specifically focussed on the use of mandatory testing for HIV; testing which may be achieved through coercion or the use of force.

Mandatory/forced HIV testing is contrary to basic legal principles, constituting both criminal assault and battery under civil law where there is no consent or other lawful authorisation, noting that HIV testing requires the subcutaneous (skin penetrating) drawing of blood. Further, forced HIV testing is inconsistent with human rights, civil liberties and public health strategy, and is opposed by expert international bodies including UNAIDS and the WHO:

Mandatory, compulsory or coerced testing is never appropriate, regardless of where that coercion comes from: health-care providers, partners, family members, employers, law enforcement officials or others (WHO & UNAIDS, 2017).

Consequently, mandatory disease testing regimes exist in a contested space at odds with human rights, bodily autonomy, and public health. The significance of their potential impact on human rights means they should be consistently challenged to ensure the public health justification for them is sufficient to justify the incursion on the right to bodily autonomy that they represent. In short, mandatory disease testing is not to be taken lightly.

In Australia, informed consent is required for HIV testing in all but rare circumstances. In fact, given that an effective HIV response requires high uptake of testing, it is these “principles of voluntary testing, informed consent and confidentiality [that] have underpinned the improvements in testing coverage achieved in Australia to date”

(Department of Health, 2017).

The *National HIV Testing Policy* outlines the key principles guiding HIV screening and diagnostic testing. These include the requirement that HIV testing is voluntary and performed with informed consent. Moreover, the principles require that HIV testing is conducted ethically and is beneficial to the person being tested (Australasian Society for HIV Medicine, 2017).

Systems of ‘compulsory screening’ operate in circumstances where people may not participate in certain activities or access particular services unless they agree to be screened. These include blood, tissue and organ donation (Australasian Society for HIV Medicine, 2017), health checks for certain visa subclasses (Australian Government, 2019), enlistment or service in the armed forces (Australian Government Department of Defence and Australasian Society for HIV Medicine, 2012), or purchasing certain types of insurance (Brady et al., 2013). Importantly, while refusal to undergo a blood test to confirm HIV status denies access to these activities or services, the right to give or refuse consent remains intact. Compulsory screening is not the focus of this report.

Mandatory testing refers to situations where a person is denied the right to refuse consent and, consequently, blood is forcibly drawn to be tested, with the blood then tested to confirm whether a person has a specific condition or disease. The rare circumstances in which compulsory testing is legal include a forensic or coronial inquiry or where a legal order has been made to allow mandatory testing. Australian laws allowing mandatory testing generally cover a number of diseases, with HIV, hepatitis B and hepatitis C among them.

This report concerns the use of mandatory testing laws to test for HIV directly associated with risk of transmission to

emergency services personnel (particularly police).² Given its focus, it is important to state at the outset that this report does not seek to trivialise the risks and trauma emergency services workers face. Here we reiterate our previously articulated position (Australian Federation of AIDS Organisations & National Association of People with HIV Australia, 2018): acknowledging the difficult and confronting situations that emergency services workers regularly encounter, including responding to violent incidents, making arrests, carrying out rescues, and providing medical assistance. In particular, we do not condone violence against emergency services personnel in any form, including spitting or biting, and condemn any intentional application of bodily fluids during an assault against an emergency services worker, regardless of HIV risk. Indeed one of our purposes is to aid emergency services personnel to avoid unnecessary worry about HIV transmission where no risk of transmission exists. It is important to note that existing criminal laws can be applied against a person who assaults police or other emergency services workers. We also note an important point, initially raised in ACON's 2018 position paper: this is not an issue of 'us' and 'them'. The community of emergency service personnel is part of our community, and we are part of theirs (Bambridge & Stardust, 2018).

To paraphrase the NSW Government's *Options Paper – Mandatory Disease Testing*, use of mandatory testing laws relate to exposure to bodily fluids that emergency services workers experience as a part of their regular work. Unfortunately, that work inherently involves engaging in difficult and dangerous situations in order to protect the health and safety of others (Department of Justice, 2018). That is, unlike many other occupations, exposure to bodily fluids is part of the job. Nevertheless, the odds of HIV being transmitted to an emergency services worker during their ordinary work are extremely low. Fewer than 0.1% of the Australian population is living with HIV and HIV is not easily transmitted.

Laws in all states name blood or bodily fluids capable of transmitting disease. In the Northern Territory, Queensland and Western Australia, saliva is specifically named as a bodily fluid that may trigger a testing order despite the fact

that saliva cannot transmit HIV (Cresswell et al, 2018; Barré-Sinoussi et al., 2018), and transmission through exposure to other bodily fluids is certainly not inevitable (Barré-Sinoussi et al., 2018). HIV transmission requires specific elements to be present, and these elements are usually absent during incidents involving emergency services workers.

As noted in the Expert Consensus Statement on the Science of HIV in the Context of Criminal Law (Barré-Sinoussi et al., 2018), authored by 20 of the world's leading HIV scientists:

- There is no possibility of HIV transmission via contact with the saliva of an HIV-positive person, including through kissing, biting or spitting.
- There is no possibility of HIV transmission from biting or spitting where the HIV-positive person's saliva contains no, or a small quantity of, blood.
- The possibility of HIV transmission from biting where the HIV-positive person's saliva contains a significant quantity of blood, **and** their blood comes into contact with a mucous membrane or open wound, **and** their viral load is not low or undetectable varies from none to negligible.

The Expert Consensus Statement supports an earlier Australian Consensus Statement on the same issue (Boyd M et al., 2016).

The risk of HIV transmission from an occupational exposure involving other bodily fluids is also extremely low, evidenced by the fact that there has not been a notification of HIV transmission in an occupational setting since 2002 (and it is unclear whether this case occurred in, or outside, a hospital setting).

Emergency services personnel are not acquiring HIV through occupational exposure, with no recent examples identified anywhere in Australia. Further, the likelihood of HIV transmission to emergency services personnel during an incident involving exposure to bodily fluids is decreasing. Treatments have greatly improved life expectancy and quality of life for people living with HIV but they have also had a marked impact on HIV transmission risk, with risk radically decreased (often to 'no risk') when a person has a suppressed viral load (Cohen et al., 2011; Cohen et al., 2016). National surveillance

² For a table of those covered by those laws, see Appendix A.

figures from 2017 estimate 74% of people living with HIV had a suppressed viral load (Kirby Institute, 2018). This percentage is only likely to increase as Australia tracks toward ambitious 95-95-95 UNAIDS targets to achieve 95% of all people living with HIV diagnosed, 95% of all people diagnosed on antiretroviral therapy, and 95% of all people receiving therapy having a suppressed viral load. (UNAIDS, 2014).

Even working hypothetically, in the event of an occupational exposure to bodily fluids of a person of HIV-positive or unknown status, national guidelines (Australasian Society for HIV Medicine, 2016b) recommend that consideration be given to the use of post-exposure prophylaxis (PEP): short-term use of antiretroviral treatment by an HIV-negative person after an exposure to HIV. If started within 72 hours of exposure and taken for 28 days with good adherence, PEP significantly reduces the likelihood of the person becoming HIV-positive because it can stop HIV from establishing itself in a person's immune cells even after the virus has entered a person's body (Schechter, 2004; Pinkerton et al., 2004). High rates of success have been reported: up to 100% among patients using newer treatments (Poynten et al, 2007). Importantly, to maximise effectiveness, initiation of PEP needs to occur as soon as possible after the event (with 72 hours being the upper limit). Although rapid HIV tests can deliver results with reasonable reliability, accurate testing takes some days so cannot be used to inform commencement of PEP.

HIV transmission through occupational exposure is extremely unlikely

The likelihood of HIV transmission is actually decreasing as more people living with HIV take effective treatment

If an emergency services worker is exposed to HIV and a doctor assesses a genuine possibility of transmission, PEP offers a high likelihood of preventing HIV

Emergency services personnel are not acquiring HIV through occupational exposure

The national guidelines state that the use of PEP should be decided on a case-by-case basis, and it is recommended that an expert is always consulted. That guideline is in place because frequently there is no or negligible risk of HIV transmission from an occupational exposure to bodily fluids. Of course, PEP is available to emergency services workers who may have been exposed to bodily fluids, with the guidelines also applicable to them, however, PEP should be started as soon as possible following an incident, so testing the person who may have a blood borne virus is irrelevant as treatment must be started before the results are returned. That is, standard procedures operate regardless of the (impending) test result.

It should also be noted that the person subject to a mandatory test may test negative for HIV, despite being HIV positive, if they have recently acquired HIV and are in the window period, during which HIV antibodies cannot be detected. This means that even if test results could be returned immediately they cannot be used to inform PEP commencement in the emergency services worker and any reassurance derived by the worker from that test result is illusory.

Antiretroviral therapies dramatically reduce HIV-associated disease progression so that people recently diagnosed with HIV have life expectancy and quality of life comparable to their HIV-negative peers. AIDS-defining illness is now so rare in Australia that the national HIV surveillance report no longer reports on it.

Unfortunately, a focus on mandatory testing is a distraction from the need to ensure emergency services personnel are well educated on both transmission risk and what HIV infection could mean. That work is vital, because persistent misconceptions exaggerating the harms of HIV infection influence application of the law (Barré-Sinoussi et al., 2018). Further, emergency services personnel appear to be undergoing undue stress when there is no risk of HIV transmission, unaware that living with HIV has been transformed during the last decade.

The media push for mandatory testing, led by police member organisations, has consistently used highly emotive language and case studies that have uniformly ramped up fear of HIV transmission in cases where transmission was not possible (Foster, 2014; Morri, 2019; Qusted, 2019). Media reports of a Western Australian police officer offer

a sobering glimpse of the unnecessary trauma experienced after an incident in which an officer feared he may have been at risk of HIV, including his fear to kiss loved ones (Foster, 2014).

Spitting and biting are already criminalised, with judges scrutinising cases to ensure procedural fairness

Handing decision-making power to police makes mandatory testing laws vulnerable to misuse, including the possibility of their operation as extrajudicial punishment, which undermines public confidence in the system

If there a real risk of HIV transmission, PEP must be started before test results can be returned if it is to be effective, making mandatory testing unnecessary

HIV is not easily transmissible and it is now a chronic, manageable health condition. Treating it as anything other in media discourse or in legislation is stigmatising and irresponsible. It is an absolute priority for our organisations that people who fear they may have been exposed to HIV do not undergo undue stress regarding the likelihood of HIV transmission or are not allowed to labour under erroneous, outdated and stigmatised misconceptions of what it means to live with HIV today.

2. Rationale and Methodology

Despite community sector resistance to the use of mandatory testing laws (Australian Federation of AIDS Organisations, 2015; Australasian Society for HIV Medicine, 2016a; Australasian Society for HIV Medicine, 2019), little work has been undertaken to understand how mandatory testing laws have been used and whether they have delivered any benefit. This is particularly concerning given very limited transparency regarding governments' or other systems monitoring of the effectiveness of the legislation (an issue raised in community sector submissions to governments during development of the legislation), and the absence of accessible analysis of any monitoring.

This national audit of mandatory disease testing laws has been developed with reference to the assertion contained in the *National HIV Testing Policy* that:

situations deemed necessary to impose mandatory or compulsory screening should be closely scrutinised from an evidence-based perspective on a regular basis to ensure that decision-making guidelines are adequate, and that the breach of the principle that testing be voluntary is still warranted (Australasian Society for HIV Medicine, 2017).

Additionally, review of the mandatory test laws is timely given:

- the NSW Government has been undertaking a process to consider the introduction of mandatory disease testing legislation since 2017: a process that has included a NSW Parliamentary Committee Inquiry (Parliament of NSW, 2019), NSW Government Response Options Paper (NSW Government, 2018), and calls for stakeholder submissions (Department of Justice, 2018).
- the relevant Western Australian legislation, the *Mandatory Testing (Infectious Diseases) Act 2014* includes a section (34) requiring review of the operation and effectiveness of the Act as soon as practicable after 1 January 2020 (five years after commencement), with a report of the review to be tabled in Parliament.
- Current review of Victoria's *Public Health and Wellbeing Regulations 2009*, with public submission closing 30 September 2019.

In late 2018, the National Association of People with HIV Australia (NAPWHA) began working with the HIV Justice Network (HJN) to devise a process to better understand the use of Australian mandatory HIV testing laws, particularly as they apply to HIV³. A list of priority questions was developed, including:

- How many times have the mandatory disease testing laws been used to test for HIV or other communicable diseases in each state?
- What means of exposure to HIV is alleged to have occurred, for example, spitting, blood splash, needle stick?
- Who ordered that the tests be undertaken?
- How many times has mandatory testing revealed a positive result to identify a person tested was living with HIV, hepatitis B, hepatitis C or another BBV?

³ This project was made possible by funding from the Robert Carr Fund for civil society networks using core funding to HJN and a small grant to NAPWHA channelled through the HIV Justice Global Consortium.

- Has there been a case of transmission of HIV, hepatitis B, hepatitis C or another BBV as a result of an incident related to mandatory testing?
- How many and what proportion of incidents and testing have occurred in country or metropolitan areas?
- How many of those tested are Aboriginal or Torres Strait Islander persons?

Further, the process hoped to learn more about the experience of health care workers required to undertake mandatory testing.

The national audit of mandatory disease testing laws process has included:

- review of current Australian laws, guidelines and operating procedures⁴
- review of Australian and international literature regarding use of mandatory testing laws
- Freedom of Information (FOI) requests to state governments where mandatory testing laws are in operation, requesting data (July 2014 – June 2018)⁵
- ad hoc contact with police and health department staff in numerous states, seeking clarification of information obtained through FOI
- targeted interviews and discussions with clinicians involved in the implementation of the laws

The results of these investigation are detailed below.

Unfortunately, the audit process met with only partial success. This is likely the result of a number of intersecting factors, including refusal of access to applicable data, but also an apparent lack of data collection related to this area by police, health and other government departments. It is also fair to say that NAPWHA and HJN have limited contacts in police and justice departments, and negotiating these unfamiliar paths proved challenging.

Consequently, we offer the data contained herein as an incomplete record. All efforts have been made to ensure the

accuracy of its contents, however, we invite all interested parties to contact us directly should they have additional information to add or requests for corrections.

We hope this will be the beginning of an engaging process including our community, community-based colleagues, healthcare practitioners and counterparts in state health and policing departments, and a useful point from which to start formulating a better understanding of these laws and their effects on our communities and workforces.

4 See summary table of key elements of laws (checked by the HIV/AIDS Legal Centre) at Annexure B.

5 See sample of FOI request (Western Australia) at Annexure C

3. Report on State Legislative Systems

Northern Territory

Overview of Legislation⁶

Division 7AA of the Police Administration Amendment Act 2016 outlines two differentiated systems to enable forced HIV testing, depending on whether the person is or is not a protected person, i.e. a child or a person unable to give consent.

For most people, the Act allows a senior police officer (who is not involved in the investigation) to authorise a blood test when there are grounds for suspecting a transfer of blood, saliva or faeces into broken skin or a mucous membrane of a police officer, police-related officer or police service employee as a result of an assault, their lawful apprehension or detention, or any other prescribed circumstances. Where the person is a protected person, police are required to apply to a magistrate for an order.

For a non-protected person, authorisation of a blood test includes provision for a healthcare practitioner taking blood to ask for assistance that is necessary and reasonable, and for the healthcare practitioner or person assisting to use force necessary to obtain a sample. For protected person, the law states that force may be used to enforce the order.

In both instances, police may apprehend and detain the transferor for as long as is reasonably necessary to enable the blood test to be undertaken.

If the person is not a protected person, approval may be granted in writing or may be granted orally, in person or by radio, telephone or any other available means of communication. If granted orally, a written record must be made. A copy of the disease test approval must be served on the accused before it can take effect.

If the person is a protected person, the matter must be heard before a court so that an order can be made, with all parties given the opportunity to be represented by a lawyer. The accused must be told that force may be used to enforce the order and of their right to appeal to the Supreme Court. In theory, the court must take all reasonable steps to ensure that the explanation provided to the transferor is expressed in a language and manner that the transferor is likely to understand, although a failure to comply with this requirement does not invalidate the disease test order.

In both instances, failure to comply is an offence, although a defence is available if the accused has 'a reasonable excuse'.

The healthcare practitioner must take a blood sample unless there is a serious risk that serious harm would be caused to the transferor, or another person, by the taking of the sample, and/or the health of the transferor would be adversely affected (authorisation).

⁶ This overview is a synopsis of the Northern Territory legislation and does not include all provisions. For detailed description, please refer to the *Police Administration Amendment Act 2016*.

It is also notable that the police officer who is suspected of coming into contact with the accused's bodily substances cannot be compelled to give evidence at a court hearing, but can appeal a decision if a court does not make the disease test order.

Review of Implementation

NAPWHA's Freedom of Information request to secure documents relating to implementation of the *Police Administration Act* and the *NT Police Policy and Standard Operating Procedures* failed to provide any information regarding use of the Act. The application was denied on the basis that it is NT Police standard operating procedure for the requested information to be recorded on a software system known as PROMIS, where it is recorded within the individual PROMIS job to which it refers. Each PROMIS job relates to an incident, for example, an assault or break and enter, etc., with the system only able to search by incident. NT Police "has no process in place to capture" the information requested. In short, the request was refused under Section 27 of the *Information Act (NT)* on the grounds that the policy agency "reasonably believes that the requested information does not exist". Further inquiries through senior police failed to identify if or where the data may be held.

Approaches were also made to community health and sexual health agencies, state government health and pathology services. Although all contacts were interested and helpful, none were able to identify how the desired information might be obtained. Contacts from the Sexual Health and Blood Borne Virus unit noted they were not aware of any instance of the mandatory laws being used, noting the Act does not mandate involvement of the unit. Contacts at likely testing sites were not aware of mandatory tests having been undertaken.

NAPWHA notes with concern that mandatory testing in laws in the Northern Territory appear to have been adopted without clear mechanisms to monitor and assess their application.

Northern Territory	
Prescribed diseases	HIV, Hep B, Hep C and 'other prescribed'
Person making order	Police (or magistrate if protected person)
Due process: Making the order	No defence provisions (unless protected person)
Threshold for testing	<u>Suspects</u> a transfer of certain bodily fluids
Context	Assault, lawful apprehension or detention, or any other prescribed circumstances
Limits	Suspect transfer of blood, saliva or faeces into broken skin or mucous membrane
Use of force	Necessary force
Detention	As long as reasonably necessary to take sample
Due process: Failure to comply	Defence of 'reasonable excuse' (approval or order)
Penalty for non-compliance	100 penalty units: \$15,500 (2018-19)
Appeal	Supreme Court (order)
Compels healthcare practitioner	Must take blood sample unless risk of harm to patient

Queensland

Overview of Legislation⁷

Queensland does not have specific laws relating to risk of HIV transmission against police or other emergency services workers in the course of their duties. Instead, Queensland's Chapter 18 of the Police Powers and Responsibilities Act 2000 is framed around the testing of an arrested person who a police officer reasonably suspects has committed a particular sexual offence or other serious assault.

Compulsory testing is framed in terms of its association with serious offences, with its stated purpose being "to help ensure victims of particular sexual offences and serious assault offences, and certain other persons receive appropriate medical, physical and psychological treatment". Other persons are those who may have been exposed to semen, blood, saliva or another bodily fluid during or soon after the commission of the offence, so could include emergency services workers.

Police must apply for an order to a magistrate or, if the person is a child, to the Children's Court. The application must be in writing, and the accused must be given a copy of the application and informed they have the right to be represented by a lawyer. An order may be made if the court is satisfied there are reasonable grounds a Chapter 18 offence has been committed and a blood sample should be taken. A disease test order may be appealed to the District Court.

A disease test order allows a police officer to ask a doctor or prescribed nurse to take a blood sample, although there is no specific requirement for the healthcare practitioner to do so. The doctor or nurse may ask other persons to give reasonably necessary help if needed. It is lawful for the doctor or nurse and a person helping the doctor or nurse to use reasonably necessary force for taking the sample.

The legislation does not include penalties for non-compliance, although a person may be held in custody "for the time reasonably necessary to enable a sample ... to be taken".

Queensland	
Prescribed diseases	HIV, Hep B, Hep C and 'other prescribed'
Person making order	Magistrate
Due process: order	Yes, including right to a lawyer
Threshold for testing	Transfer of certain bodily fluids <u>may have</u> occurred
Context	Sexual offense or other serious assault*
Limits	Semen, blood, saliva or another bodily fluid may have been transmitted into the anus, vagina, a mucous membrane, or broken skin
Use of force	Reasonably necessary force
Detention	Time reasonably necessary to take sample
Due process: Failure to comply	Not specified
Penalty for non-compliance	-
Appeal	District Court
Compels healthcare practitioner	No but makes it lawful to take blood sample

⁷ This overview is a synopsis of the Queensland legislation and does not include all provisions. For detailed description, please refer to the *Police Powers and Responsibilities Act 2000*.

Review of Implementation

NAPWHA made submissions to Qld Police's Freedom of Information unit, aiming to establish whether and how many times Chapter 18 of the *Police Powers and Responsibilities Act 2000* has been used, particularly in cases where a person suspected of having HIV, hepatitis B or hepatitis C has been subject to mandatory testing orders under *section 540: Application for order for blood and urine testing of a person*. In particular, we sought details about whether section 540 had been used:

- In cases of spitting or biting during (or unrelated to) a serious assault
- In cases involving emergency services personnel

No formal response was provided. Further approaches were made to the Queensland Government Statistician's Office and Statistical Services Queensland Police Service, however, they were not able to provide results.

South Australia

Overview of legislation⁸

South Australia's laws were amended to allow forced testing for communicable diseases through the introduction of additional sections to the *Criminal Law (Forensic Procedures) Act 2007*, commencing December 2016.

South Australia now has a two-tiered system. In general terms, section 20B allows a senior police officer to issue directions that a blood test be undertaken if satisfied that an accused committed a 'prescribed' offence (including assault, causing harm or serious harm, endangering life, riot, affray (*Criminal Law Consolidation Act, 1935*)⁹, assaulting or hindering police, violent disorder (*Summary Offences Act, 1953*)¹⁰, or any other serious offences), and it is likely that a police or emergency services worker or healthcare provider has been exposed to the accused's biological material. Biological material includes blood, bodily fluids, or any biological material capable of communicating or transmitting disease. If the accused fails to comply with

directions, police may apply to a Magistrate's Court for a warrant for the person's arrest so they may be brought to a police station for the blood test. Reasonable force may be used to take the blood sample. A person who intentionally obstructs or resist the carrying out of a forensic procedure is liable to a maximum penalty of 2 years' imprisonment.

The *Criminal Law (Forensic Procedures) (Blood Testing for Diseases) Variation Regulations 2016 (4A)* provide further detail, requiring a person to be provided with a written notice that blood will be drawn and tested for communicable diseases, although failure to comply does not invalidate the authority to undertake the procedure, the procedure or material obtained.

An important feature of the *Criminal law (Forensic Procedures) Act 2007* is the inclusion of a section (57(1)), which requires an annual audit to monitor compliance of South Australian Police's (SAPOL) with the Act, with a report of the audit deliverable to the Attorney-General on or before 30 September each year. Responsibility for conducting that audit was delegated to the Police Ombudsman until 2017, when responsibility was transferred to the state Ombudsman.

Review of Implementation

NAPWHA's Freedom of Information request to secure documents relating to implementation of the *Criminal Law*

⁸ This overview is a synopsis of the South Australian legislation and does not include all provisions. For detailed description, please refer to the *Criminal Law (Forensic Procedures) Act 2007* and *Criminal Law (Forensic Procedures) (Blood Testing for Diseases) Variation Regulations 2016*.

⁹ The preceding list is drawn from the *Criminal Law Consolidation Act 1935*.

¹⁰ The preceding list is drawn from the *Summary Offences Act 1953*.

(Forensic Procedures) Act 2007 was denied on the basis that section 50 prohibits disclosure of information obtained under the Act unless it is requested for specific reasons (listed at Annexure D), none of which allowed for release of data for the purposes of this audit. A follow up request resulted in the release of the risk assessment matrix used by SAPOL to consider whether conditions are met for a blood test under section 20B (at Annexure F). The risk assessment matrix outlines a series of factors to be considered to decide whether conditions for testing are met and whether testing is recommended. Although the document is useful in its clarity addressing a number of conditions that must be met, it is unclear whether factors relating to transmission risk are comparable with those that would be applied in other occupational settings or more generally. In particular, the risk assessment appears more closely associated with that which may be used when a person is known to have HIV, rather than a member of the general public (fewer than 0.1% of whom have HIV).

Fortunately, compliance requirements detailed in section 57(1) of the *Criminal law (Forensic Procedures) Act 2007*, has facilitated the public availability of additional data identified through the above mentioned, required annual audit. Although not annual, the audit process has resulted in the delivery of two useful reports. While limited in scope, considering only SAPOL's compliance with the Act, both reports provide useful information:

- a) the Police Ombudsman's *Criminal Law (Forensic Procedures) Act 2007, Report on Annual Compliance Audit 12 December 2015 to 3 February 2017*

The Police Ombudsman's report outlines the result of an audit of forensic procedures conducted between 12 December 2015 and 7 February 2017, involving randomised inspection of 110 files: 1.08% of the total 10,807 forensic procedure conducted during that period. No evidence of forensics procedures conducted to test for communicable diseases were identified, with the Police Ombudsman informed that no such testing had been undertaken. That suggests that the *Criminal law (Forensic Procedures) Act 2007* was not used for the purposes of testing for communicable diseases during the approximately eight weeks from its commencement, 12 December 2016, to 3 February 2017.

Of some relevance, although the audit found that SAPOL's procedures and record-keeping regarding forensic procedures were of a high standard, minor (unsystematic)

South Australia	
Prescribed diseases	Not named. Only 'communicable diseases'
Person making order	Police (Magistrate if person fails to comply with direction)
Due process: order	
Threshold for testing	Likely that exposed to certain biological materials
Context	Prescribed offence including assault, causing harm or serious harm, endangering life, riot, affray, assaulting or hindering police, violent disorder
Limits	Likely came in contact, or was otherwise exposed to blood, bodily fluids or other biological material capable of communicating or transmitting disease as a result of a suspected offence
Use of force	Reasonable force
Detention	-
Due process: Failure to comply	None
Penalty for non-compliance	Up to 2 years imprisonment
Appeal	None
Compels healthcare practitioner	Does not compel but healthcare practitioner may be included under 'failure to comply provisions'

non-compliance issues relating to intrusive forensic suspect procedures remained. These involved cases where audio-visual recording did not occur because officers failed to identify a procedure as 'intrusive', where a respondent was not informed of their right to have a medical practitioner of their choice to witness the procedure because the senior police officer order authorising the forensic procedure had not identified the procedure as 'intrusive', and where the respondent had not been served a copy of the order authorising the procedure before the procedure was undertaken. Those findings point to the need to ensure scrutiny to ensure systematic compliance of all intrusive forensic procedures, including testing for communicable diseases.

b) the Ombudsman SA, *Audit of compliance with the Criminal law (Forensic Procedures) Act 2007*

The Ombudsman SA report outlines the result of an audit of forensic procedures conducted between 8 February 2017 and 10 May 2018, involving randomised inspection of 487 records: 3.56% of the total 13,686 forensics procedure conducted during the period.

The audit found widespread compliance with the Act. The main area of concern related to suspects procedures authorised by senior police officers. 43 records were examined, and 30 instances of apparent non-compliance were detected, including many where suspects were not afforded fairness. Despite that, the Ombudsman notes that each of the eleven audio-visual records of intrusive forensic suspect procedures viewed demonstrated that the procedure were carried out in a respectful, humane and sometimes very kind manner.

The Ombudsman identified that the laws had been used on seven occasions to undertake a blood test for communicable diseases after an incident where police deemed an officer had likely come in contact, or been otherwise exposed to blood, bodily fluids or other biological material capable of communicating or transmitting disease as a result of a suspected offence. The specific types of exposure and the results of those tests are not available. All procedures related to police officers (i.e. no other emergency workers).

The Ombudsman did not consider the grounds for testing, i.e. whether testing was warranted, but whether the law and regulations had been followed, relying on a checklist of relevant legislative requirements (Annexure E), as well as

follow up inquiries to SAPOL.

That review found that the agency had complied with the following requirements:

- suspects were advised they could nominate a medical practitioner to receive their results (regulation 4A(1)(b))
- suspects were provided with a copy of the written record of grounds for undertaking a forensic procedure (section 20B(2))
- the Commissioner took reasonable steps to notify each affected person/nominated medical practitioner of the test results (regulations 4B and 4C)
- blood samples were destroyed as soon as practicable (section 39A)

Contrary to regulatory requirements, the Ombudsman found that suspects were not given a copy of the written application for the test (form PD430) prior to the procedure being conducted, instead being provided a copy at the conclusion of the procedure. Consequently, all seven procedures were not undertaken in compliance with the regulations. The Ombudsman recommended that that practice be amended.

As noted by the Ombudsman, 'communicable diseases' is 'a term of very wide definition, encompassing everything from the common cold to hepatitis'. The Ombudsman was unable to advise what diseases had been searched for when suspects' blood samples were tested.

Victoria

Overview of Legislation¹¹

The *Public Health and Wellbeing Act 2008* and associated *Public Health and Wellbeing Regulations 2009* came into effect on 1 January 2010. Under the Act, the Chief Health Officer has a number of functions and powers including developing and implementing strategies to promote and protect public health and wellbeing. These include the power to make orders that restrict individuals' freedom in order to protect the community, including orders to compel a person to be examined or tested or to refrain from certain activities that may pose a serious risk to public health.

The Victorian laws differ from others considered in this audit because they are public health legislation and consequently are both contextualised by public health principles and related provisions, and their use is instigated by the Victorian Chief Health Officer, not police.

As in all jurisdictions, very senior health officials have the power to initiate processes to make a public health order relating to an individual who may be putting others at risk: powers which are infrequently used. Victorian mandatory testing law does not rely on the commission of an offence, and requires the approval of the Chief Health Officer, who is a medical professional.

Victoria has a two-tiered system relating to the use of force to undertake blood testing. The Chief Health Officer has the power to make an examination and testing order or a public health order, but of particular relevance to this audit, under section 134, the Chief Health Officer also has powers to make an order if they believe that an incident has occurred where a 'specified infectious disease' could have been transmitted to a caregiver or custodian during the course of their duties. Victoria is the only state to have

Victoria	
Prescribed diseases	HIV, hepatitis transmitted by blood or body fluid
Person making order	Chief Health Officer (Magistrate if force required)
Due process: order	No, unless force required (Magistrate level)
Threshold for testing	Believes an incident has occurred in which the disease could have been transmitted
Context	Incident
Limits	1. CHO: Believes an incident has occurred in which HIV or hepatitis transmitted by blood could have been transmitted 2. Magistrate: exceptional circumstances
Use of force	Reasonable force
Detention	-
Due process: Failure to comply	If reaches Magistrates Court
Penalty for non-compliance	-
Appeal	VCAT (pre-Magistrates Court)
Compels healthcare practitioner	-

¹¹ This overview is a synopsis of the Victorian legislation and does not include all provisions. For detailed description, please refer to the *Public Health and Wellbeing Act 2008* and associated *Public Health and Wellbeing Regulations 2009*.

introduced such public health provisions specifically related to 'caregivers or custodians, which, in Victoria include a doctor, dentist, nurse, paramedic, pathologist, other health service employee or police. A specified infectious disease is currently defined as HIV, or any form of hepatitis which may be transmitted by blood or body fluid.

Under Victorian law, an order must be in writing, must name the disease to be tested, and must be served before it takes effect. A person who is subject to a public health order may apply to VCAT for a review of the decision (s122). If the Chief Health Officer believes it is necessary to enforce an order, they may apply to the Magistrates' Court for an order to authorise a police officer to use reasonable force to take the person for testing, including to restrain the person to enable a medical practitioner to take a blood sample. Importantly, the section states the Magistrates' Court may make an order if satisfied that the circumstances are so exceptional that the making of an order is justified.

The Victorian system includes a range of safeguards including:

- the person to whom the disease could have been transmitted has been counselled about the risk of infection and has consented to be tested, and
- the person who could have transmitted the disease has been offered counselling before refusing to be tested (or lacks capacity to give consent), and
- the making of the order is necessary in the interest of rapid diagnosis and clinical management and, where appropriate, treatment for anyone involved in the incident, and
- if alternative measures are available which are equally effective in ensuring rapid diagnosis and clinical management, the measure which is the least restrictive should be chosen.

Further, the *Guidelines for post-incident testing orders and authorisations, Part 8, Division 5 of the Public Health and Wellbeing Act 2008* state:

'the vast majority of orders or authorisations will involve incidents where the potential source lacks capacity to consent for testing. ... Very infrequently the potential source will have capacity but will not consent to testing.

In such circumstance every effort should be made to resolve any concerns the potential source has in relation to testing. Reaching an agreement to test is by far the preferred position as it impacts least on the rights of all involved, potentially inflicts the least harm on the potential source, maintains the best possible relationship between the hospital and the potential source, may prove more timely and efficient, and poses least danger to staff who are required to take the blood sample.

The *Public Health and Wellbeing Act 2008* also provides other options to test the blood of a person who they believe may have transmitted a 'specified infectious disease' to a caregiver or custodian during the course of their duties. Under section 135, the Chief Health Officer may test a sample of blood or urine that has been stored for another purpose, or under section 136, may examine existing health records held by the health department.

Although a medical officer cannot use force to obtain the blood sample, they may request the assistance of a police officer who may use reasonable force to detain the person. No specific penalties for failure to comply with an order are listed in the Act.

Review of Implementation of Victorian Laws

The *Public Health and Wellbeing Act 2008* requires the Chief Health Officer to "publish on a biennial basis and make available in an accessible manner to members of the public a comprehensive report on public health and wellbeing in Victoria". Victorian Department of Health and Human Services annual reports have routinely included details about the making of public health orders, showing that public health orders are only occasionally made or extended. Between July 2014 and June 2018, annual reports confirm that there had been no order for tests under section 134 after an incident has occurred.

	Section 134, Order for tests if an incident has occurred	Section 113, Other examination and testing orders	Section 117, public health order	Section 118, Extension of public health order
2017-2018 (Victorian Government, 2018)	0	0	2	0
2016-2017 (Victorian Government, 2017)	0	0	1	2
2015-2016 (Victorian Government, 2016)	0	0	1	2
2014-2015 (Victorian Government, 2015)	0	0	1	2

Western Australia

Overview of legislation¹²

Western Australia's *Mandatory Testing (Infectious Diseases) Act 2014* outlines two differentiated systems to enable forced HIV testing, depending on whether the person is or is not a protected person, i.e. a child or a person unable to give consent. Blood may be tested for HIV, hepatitis B and hepatitis C and any other prescribed disease capable of being transmitted by the transfer of bodily fluid.

The Act states a police officer or other public officer may apply to a senior police officer not involved in the investigation for a disease test approval against a person who is not a protected person. If impractical, the application need not be in writing although a written record must later be made. The person may be detained for as long as necessary to determine the application. The approval may be made if there are reasonable grounds for suspecting a transfer of semen, blood and saliva from a suspected

transferor to a public officer as a result of an assault against the officer, their apprehension or any other prescribed circumstances. Again, approval need not be in writing but a written record should be made as soon as practicable. Following approval, police may enter any place they reasonably suspect the accused is located, may transfer the accused to a facility to take a blood sample, and may detain the accused for as long as necessary to take the blood sample. The law provides that "a doctor, nurse or qualified person may then take a blood sample".

If the person is a protected person an application must be made to the Children's Court or Magistrates Court. The court may make a disease test order if they find reasonable grounds for disease testing, allowing a police officer to apprehend the accused and detain them for as long as is reasonably necessary to take the blood sample. This process includes identification of a 'responsible person' (usually a parent or guardian), who must be informed of their right to obtain legal advice and the right of appeal to the District Court. If the court does not make a disease test order, the public officer who applied for the order may appeal to the District Court.

¹² This overview is a synopsis of the Western Australian legislation and does not include all provisions. For detailed description, please refer to the *Mandatory Testing (Infectious Diseases) Act 2014*.

Western Australia	
Prescribed diseases	HIV, hepatitis B and hepatitis C and any other prescribed disease capable of being transmitted by the transfer of bodily fluid
Person making order	Police (or magistrate if protected person)
Due process: Making the order	No defence provisions (unless protected person)
Threshold for testing	Reasonable grounds for suspecting a transfer of certain bodily fluids into anus, vagina, mucous membrane or broken skin
Context	Assault, lawful apprehension or detention, or any other prescribed circumstances
Limits	Reasonable grounds for suspecting a transfer of semen, blood and saliva
Use of force	Force – to enforce order Necessary force – to take sample
Detention	As long as reasonably necessary to take sample
Due process: Failure to comply	If reaches court (protected person)
Penalty for non-compliance	\$12 000 and 12 months' imprisonment

In theory, the court must take all reasonable steps to ensure that the explanation provided to the transferor is expressed in a language and manner that the transferor is likely to understand, although a failure to comply with this requirement does not invalidate the disease test order. The same requirement is not applied to the approved test approval process.

Both a disease test approval and disease test order must be served before they can take effect. A person who fails to comply with a disease test approval or disease test order attracts a fine of \$12 000 and 12 months' imprisonment. In the case of a disease test order, the 'responsible person' is liable.

The Operational Directive associated with the Act, *Mandatory Testing of a Suspected Transferor for an Infectious Disease*, states that as a quality assurance measure, a risk assessment regarding 'likely exposure to an infectious disease' should be carried out before disease test authorisation. As 'a quality assurance measure', the attending doctor should also conduct a risk assessment in line with WA Health's *Management of Occupational Exposure to Blood and Bodily Fluids in a Health Care Setting*, assessing:

- the nature and extent of the injury/exposure
- the nature of the object causing the exposure
- the volume of blood or bodily fluid that the police officer was exposed to
- the vaccination and immune status of the police officer
- if known, the blood-borne virus status of the accused
- the likelihood of the accused being HBV, HCV or HIV positive

The guidelines also recommend that the attending doctor consult with a nominated sexual health or infectious disease physician, and then discuss with police whether, based on the likelihood of 'exposure', testing is 'necessary'. Management of a 'likely transmission' should be in line with WA's *Management of Occupational Exposure to Blood and Bodily Fluids in the Health Care Setting, and the Protocol for Non-Occupational Post-Exposure Prophylaxis (NPEP) to Prevent HIV in Western Australia*. The attending doctor should then discuss their risk assessment with the accused and the requesting police officer separately.

However, the guidelines state that where the course of action recommended by the attending doctor differs from that sought by WA Police, the police may override the attending doctor's recommendation. This provision is visually represented on the *Processing a disease test authorisation/order for WA Country Health Services* flowchart where, if a doctor recommends not proceeding based on a risk assessment, but the police officer who considers themselves at risk asks for testing to proceed, testing will occur regardless (Annexure G).

Both a disease test approval and disease test order state that a doctor, nurse or qualified person may take a blood sample from the suspected transferor. Section 26 relating to disease test authorisation states that a doctor, nurse or qualified person may ask another person to give any reasonably necessary help to take the blood sample. The doctor, nurse or qualified person, and a person helping the doctor, nurse or qualified person, may use any reasonably necessary force for taking the blood sample. Section 19 states that the order may be subject to conditions that the court considers appropriate. Section 20 states that the 'suspected transferor and third party' must be informed that force may be used to enforce the order.

The Regulations state a suspect must be transferred to an appropriate facility for the blood sample to be taken. Within Perth metropolitan, those facilities are Royal Perth Hospital Sexual Health Clinic during business hours or Perth Watch House when the clinic is closed (although we understand blood is usually drawn at the Watch House). Within regional areas, testing should be done at one of 20 hospitals¹³. While the Operational Directive includes a Patient support and information' document at Appendix 4, which provides a list of support organisations, it includes no reference to that list, including how it may be used. That is, it does not suggest any point at which a referral might be made to the listed services.

Importantly, section (34) of the Act requires review of the operation and effectiveness of the Act as soon as practicable after 5 years from its commencement: a period which begins as of January 2020. That section requires that the Minister must, as soon as practicable prepare a report about the outcome of the review which must be tabled in Parliament.

Review of Implementation

NAPWHA lodged an FOI request to WA Police in December 2018. WA Police requested an extension on three occasions 'due to the current volume of FOI applications'. A response was received on 30 July 2019 which included the findings from a search of a number of WA Police Force facilities and databases including Executive and Ministerial Services, Health Welfare and Safety Division, Injury Coordination Unit, Perth Watch house, Regional WA, and the Safety Branch. The results included WA Police Standing Operating Procedures on Mandatory Testing (Infectious Diseases) comprising:

- Non-Protected Person – flow chart
- Protected Person Juvenile – flow chart
- Protected Person Incapable – flow chart
- Perth Watch House Procedures
- Information for Mandatory Testing in Regional WA

Review of the Standing Operating Procedures revealed that, despite WA law allowing both detention for as long as reasonably necessary to take a sample, and force to be used to take a sample, both the Non-Protected Person – flow chart and the Perth Watch House Procedures state that if a person is not willing to comply with a Disease Test Approval, they are to be informed that they have committed a criminal offence, issued a summons to court, and released immediately. The contents of the Act and Standard Operating Procedures are difficult to reconcile.

In the case of a Protected Person Juvenile or Protected Person Incapable, "the suspected transferor is not to be detained for the purpose of obtaining a Disease Test Order and is to be released unconditionally when no other issues are outstanding", while the process to apply for a Disease Test Order is undertaken. That process comprises assessing if the matter is appropriate for referral to State Control Centre (SCC), completing a Section 16 Grounds for Disease

13 Nominated regional sites for testing Kimberley: Broome Hospital, Derby Hospital, Kununurra Hospital; Pilbara: Port Hedland Hospital, Nickol Bay Hospital, Newman Hospital; Midwest: Geraldton Hospital, Carnarvon Hospital, Meekatharra Hospital; Wheatbelt: Merredin Hospital, Narrogin Hospital, Northam Hospital, Moora Hospital; Goldfields: Kalgoorlie Hospital, Esperance Hospital; Great Southern: Albany Hospital, Katanning Hospital; Southwest: Bunbury Hospital, Busselton Hospital, Margaret River Hospital.

Test Order, forwarding the form to SCC for assessment, assessment at SCC and if approved, application to the Magistrates Court or Children's Court, completion of an affidavit by the affected officer, completion of Application Under Conferring Act Form 53, getting the affidavit sworn by a judicial officer or JP, and delivering the affidavit to the local prosecuting office ... before a date for hearing can be made and the application heard. Clearly that is a time intensive process so cannot inform treatment of an affected officer who, if genuinely concerned about a risk of HIV transmission, should be referred for PEP, probably before the long paperwork process is even commenced.

The Perth Watch House Procedures document also contain instructions against unrestricted detention and use of force, stating that when blood testing is done at Perth Watch House, the person is to be accompanied by arresting officers and escorted by PWH staff into the nursing station. It then says that:

Only persons who are compliant and consenting will have their sample obtained at the PWH. *If the person is not willing to comply, the arresting officer should inform them that they have committed a criminal offence for failing to comply with the requirement to submit to the taking of a blood sample under section 13 of the MDIT Act and will be issued with a summons to court. If there are no outstanding issues the suspect should be released.*
(Italics from original document)

Review of the Information for Mandatory Testing in Regional WA also outlines some important factors. Firstly, it states that "when a disease test authorisation has been granted by SCC and the suspected transferor has not refused to comply [added emphasis], they may be transported for the obtaining of a blood sample". Again, testing depends on the person's compliance. Exactly how the laws might be implemented is confusing given that the legislation overrides subordinate regulations and guidelines

The regional testing instructions also give instructions relating to the time and distances that may be involved in getting a person tested. These include that:

- The testing site will be the nearest regional/district Emergency Department of local medical facility ... in most instances, despite the fact that the *Mandatory Testing of a Suspected Transferor for an Infectious Disease* state "testing should be done at one of 20 hospitals".
- Consideration needs to be made to the time and place of testing to avoid lengthy delays in waiting times (so they are 'reasonable'), and it is incumbent on WA Police to also return the person to where their journey commenced.

'In RWA [rural Western Australia] this may be a very long distance and full consideration will need to be made as to what type of vehicle you use and where the suspected transferor might sit during the journey.'

This highlights the logistical issues and additional costs (including allocation of resources) associated with testing in rural areas, as well as the additional burden on the person being tested. It also raises the issue of lengthy transportation in difficult conditions being used or considered as punishment.

- Medical personnel are not compelled to take a sample, so every OIC should endeavour to be aware of who is available and agreeable to conduct such procedures in their sub-district. If no one is available, alternative arrangements at nearby sub-district's facilities need to be in place.

This recognises that many healthcare practitioners find mandatory testing obligations problematic (see section 4 below), and also raises the possibility of even greater expenditure of time and resources, with an additional burden on the person being tested.

An additional request made to the Commissioner of Police, channelled through the WA Department of Health, resulted in the release of data on a number of points, including the number of tests conducted. The data shows that of the 387 applications for mandatory disease testing from 1 January 2015 to mid-December 2018, approval had been granted 377 times (and rejected 10 times), suggesting the legislation has been used approximately 100 times a year to trigger mandatory testing for HIV.

	Applications	Approved	Not approved
2018 to mid Dec	75	73	2
2017	108	108	0
2016	122	121	1
2015	82	75	7
Total	387	377	10

Given the information gleaned from the Standing Operating Procedures on Mandatory Testing, the data suggests that 387 people were told that they must submit to a blood test but that force should not have been used to enable to blood draw. Unfortunately, NAPWHA has been unable to gain further information about the circumstances surrounding each test, including whether or not force was used.

Of those 387 requests, 262 were made in metropolitan areas and 125 were made in regional areas, a practice which has additional cost implications given in some instances, accused must be escorted long distances under guard to an appropriate testing facility.

	Applications	Metropolitan	Regional
Jan to mid Dec 2018	75	46	29
2017	108	67	41
2016	122	88	34
2015	82	61	21
Total	387	262	125

The Commissioner also noted that “the WA Police Force has not collected statistics in relation to Aboriginal and Torres Strait Islander people. However, the agency endeavours to commence collecting this information from the start of 2019”.

The FOI response clarified that the number of BBVs diagnoses, is not interpreted or retained by WA Police Force, with results of the transferor’s mandatory disease testing blood tests received from the Pathology Laboratory and forwarded on to the police officer’s GP for interpretation and explanation to the affected police officer. The Commissioner adds:

the WA Police Force is unable to provide comment in relation to diagnoses of occurred transmissions, as this information is forwarded to doctors and comment is not provided to anyone (including officers, unless further testing is required), to ensure the results are not misinterpreted.

4. Operation of Mandatory Testing Laws in a Healthcare Context

It is unclear what healthcare workers make of the mandatory testing system. Certainly, many of those involved in the HIV response were vocal in their opposition to the laws early on, with clinicians joining calls for:

a HIV response grounded in evidence and protective of the human rights of people living with and affected by HIV ... [, expressing] profound disappointment in the governments of South Australia, Western Australia and the Northern Territory for enacting anti scientific and counterproductive laws mandating HIV testing for people accused of spitting on law enforcement personnel, in the face of

overwhelming evidence that such laws are neither effective nor necessary.

Generally healthcare practitioners' practice is based on an understanding that, under common law, all competent adults can consent to or refuse medical treatment. However, under laws in Northern Territory, Queensland, South Australia, Victoria and Western Australia, in certain circumstances, healthcare practitioners will be required to ignore a patient's refusal to consent to blood being drawn and tested. Moreover, provisions in the Northern Territory, Queensland and Western Australia allow a healthcare practitioner to use reasonable force necessary, and to ask another to give any reasonable help necessary.

Use of force in healthcare setting

Northern Territory	<ul style="list-style-type: none"> The medical practitioner, nurse or qualified person may ask another person to give assistance that is necessary and reasonable if assistance is required for taking a blood sample - Police Administration Act 1978 (NT) s 147FR(5). The medical practitioner, nurse or qualified person may use the force that is reasonably necessary for taking the blood sample - s 147FR(6).
Queensland	<ul style="list-style-type: none"> The doctor or nurse may ask other persons to give reasonably necessary help if help is required to take the sample - <i>Police Powers and Responsibilities Act 2000 (Qld)</i> s 545(4). It is lawful for the doctor or nurse to use reasonably necessary force for taking the samples - 545(5).

<p>South Australia</p>	<ul style="list-style-type: none"> Authorising officer to carry out a forensic procedure or a person assisting such a person may use reasonable force (a) to carry out the authorised forensic procedure; and (b) to protect material obtained by carrying out the forensic procedure - <i>Criminal Law (Forensic Procedures) Act 2007 (SA)</i> s 31(1).
<p>Victoria</p>	<ul style="list-style-type: none"> An authorised officer may request the assistance of a member of the police force. A member of the police force may use reasonable force to detain the person subject to an examination and testing order - <i>Public Health and Wellbeing Act 2008 (Vic)</i> s 123. Police may restrain the person - <i>Guidelines for post-incident testing orders and authorisations, Part 8, Division 5 of the Public health and Wellbeing Act 2008.</i>
<p>Western Australia</p>	<ul style="list-style-type: none"> The doctor, nurse or qualified person may ask another person to give any reasonably necessary help if help is needed for taking a blood sample - <i>Mandatory Testing (Infectious Diseases) Act 2014 (WA)</i> s 26(4). The doctor, nurse or qualified person may use any reasonably necessary force for taking the blood sample - s 26(5).

In Western Australia, the legislation goes further, allowing the affected officer (who may have been exposed to bodily fluids) to insist on testing of the third party even when it is against the advice or recommendation of the healthcare professional, who will be required to undertake testing unless arrangements are made to go elsewhere.

The audit process included ad hoc contact with police and health department staff in numerous states seeking clarification of information obtained through FOI, as well as targeted interviews and discussions with clinicians involved in the implementation of the laws. In general terms, healthcare practitioners interviewed expressed discomfort regarding mandatory testing and the use of force to undertake blood tests. Issues included those relating to:

- Taking blood:** Statements that they would not perform a blood test without a patient's consent, particularly if it were necessary to physically restrain a patient, based on medical ethics, the logistical difficulty of forcibly obtaining a blood sample, and the harm that may cause the patient.
- Running pathology:** Statements that they operated on a presumption that consent had been obtained: a factor which was not clear from the pathology order, before running tests for a range of diseases. Further, there were examples of testing being done for all diseases named

in the relevant Act as a default position, regardless of the risk event, with no transparency for pathologists or those delivering results about the risk event.

- Giving results:** Statements that despite wanting to give results to the person who had been subject to the mandatory testing order, it was often not possible because the person could not be located, sometimes because they were homeless or from an otherwise vulnerable population.

Certainly, WA Police's 'Information for Mandatory Testing in Regional WA' confirms reticence on the part of some healthcare practitioners to engage in mandatory testing:

All personnel need to be mindful medical personnel are not compelled to take a sample of the suspected transferor's blood. Every OIC should endeavour to be aware of who is available and agreeable to conduct such procedures in their sub-district, if none available, alternative arrangements need to be in place (sub-district's facility).

The WA Police Standard Operating Procedures suggest WA Police are well aware of this discomfort and are having to engage in doctor shopping to get testing done. That practice has also been observed in other states.

The reality is that mandatory testing laws require healthcare practitioners to operate in a way far removed from principles of healthcare best-practice, including those contained in the AMA Code of Ethics (Australian Medical Association, 2016). That different approach is embodied in the language of the legislation, including terminology referring to the person to be tested as the transferor (NT)/ relevant person (Qld)/ a person (SA)/ the person (Vic), and the suspected transferor (WA). That raises serious considerations for healthcare practitioners including, at what point does the person undergoing mandatory testing stop or start being 'the patient', and is testing in the patient's best interest given the context in which it is occurring?

Although the audit included only a limited number of conversations with healthcare workers engaging with mandatory testing laws, their responses suggest a clear disconnect between the mandatory testing laws and delivery of healthcare. More research is needed in this area.

5. Commentary

Legislative Framework

Threshold/trigger for testing too low Mandatory HIV testing is an invasive procedure that is contrary to national testing policy and, unless specifically allowed under legislation, constitutes civil trespass or assault, yet states have routinely set a low threshold for testing orders, including:

- Suspect transfer of blood, saliva or faeces into broken skin or mucous membrane (Northern Territory)
- Semen, blood, saliva or another bodily fluid may have been transmitted into the anus, vagina, a mucous membrane, or broken skin (Queensland)
- Likely came in contact, or was otherwise exposed to blood, bodily fluids or other biological material capable

of communicating or transmitting disease as a result of a suspected offence (South Australia)

- Believes an incident has occurred in which HIV could have been transmitted (Victoria)
- Has reasonable grounds for suspecting a transfer of semen, blood and saliva into anus, vagina, mucous membrane or broken skin (Western Australia)

Decision making by non-experts The issue of low thresholds is exacerbated by the delegation of decisions about risk of transmission prompting testing to people without medical expertise. This appears to have the consequence of blood being tested for all possible disease allowed under the respective acts, regardless of risk event.

	For all people (unless otherwise stated)	A protected person (child or lacking capacity to consent)	If use of force required
Northern Territory	Police	Magistrate	
Queensland	Magistrate		
South Australia	Police		Magistrate
Victoria	Chief Health Officer	Magistrate	Magistrate
Western Australia	Police	Magistrate	

In general terms, in Northern Territory, South Australia and Western Australia, the decision to forcibly test a person for HIV is made by a senior police officer unless the person is a child or person lacking capacity to consent. Decisions at Magistrates level require a higher burden of proof, however, whether or not expert medical evidence is provided is case dependent. In Western Australia, decisions about whether testing proceeds eventually turn on the opinion of the individual police officer who believes they have been put at risk, with the law specifically allowing them to overrule an expert assessment by a clinician on whether testing is necessary or advised. This undermines fundamental principles of criminal law, allowing the victim to punish the perpetrator.

Understanding of HIV transmission risk and best practice approaches to treatment are not static, having continued to evolve since the beginning of the epidemic. Keeping up-to-date requires ongoing review of clinical evidence: a task routinely undertaken by specialist HIV and sexual health clinicians. Victoria is the only state where the initial decision to make a mandatory testing order is delegated to a specialist medical officer with a comprehensive knowledge of HIV transmission risk. Notably, Victoria is also the only state known to have not used mandatory HIV testing legislation during the audit period: July 2014 – June 2018.

The reality that “laws and prosecutions have not always been guided by the best available scientific and medical evidence (UNAIDS, 2013), have not evolved to reflect advancements in knowledge of HIV and its treatment, and can be influenced by persistent societal stigma and fear associated with HIV (Global Commission on HIV and the Law, 2012), is a persistent issue. Recently, both domestic and international expert consensus statements on HIV transmission risk and harm have been authored by renowned HIV scientists and specialist clinicians, with a specific goal of addressing the misuse or rejection of current science in criminal law (Boyd et al., 2016) (Barré-Sinoussi et al, 2018), with the same observations relevant to the issue of mandatory testing.

Decision making does not routinely allow procedural fairness. In Queensland, forced testing can only occur if ordered by a magistrate. In Northern Territory and Western Australia, a magistrate’s order is required if a person is a child or person lacking capacity to consent. In South Australia and Victoria, a magistrate’s order is required if the accused fails to follow the initial order (made by police or the Chief Health Officer, respectively) and use of force is required.

Otherwise, in the Northern Territory, South Australia and Western Australia, most people will be subject to mandatory HIV testing orders approved by senior police, without the means to present a defence or for that defence to be considered by an independent party to decide whether such intervention by the state is warranted.

Detention is not time restricted Laws in Northern Territory, South Australia and Western Australia state that a person may be detained for as long as ‘reasonably necessary’ to make the order and to be detained for as long as ‘reasonably necessary’ to take the test. Open-ended detention is highly concerning in itself but is also highly problematic given the possibility that a threat of ongoing detention may be leveraged to coerce compliance with the mandatory testing provision. Time limited detention is a fundamental limit of the power of the state over the individual, and should be applied only in the most extreme and pressing circumstances.

Use of force is allowed All states allow force or reasonable force to be used to enforce an order. In Queensland, South Australia and Victoria, use of force requires a court order. In Northern Territory or Western Australia, the law does not require a court order unless the person is a child or otherwise not able to give consent, although WA Police Standing Operating Procedures state that if a person is not willing to comply, they are to be informed they have committed a criminal offence and will be issued with a summons to court, and are then to be released immediately. It is difficult to reconcile the provision in the Act and Standard Operating Procedures. Three states allow the healthcare practitioner to ask for assistance and also to use force.

Hefty criminal penalties apply In the Northern Territory, South Australia, Victoria and Western Australia, failure to consent to a disease test order is a criminal offence with hefty penalties attached:

- Northern Territory \$15,500 fine
(2018-19: 100 penalty units)
- South Australia Up to 2 years’ imprisonment
- Western Australia \$12,000 and 12 months’
imprisonment

Whether or not the penalties are applied, they represent a forceful instrument to coerce compliance with an order rather than obtain agreement or consent to be tested.

Notably, they are far removed from the principles driving Australia's HIV response. The issue of whether consent has been given under the threat of penalties remains fraught.

Legislation is at odds with national HIV strategy

As outlined above, the National HIV Testing Policy outlines the key principles guiding HIV screening and diagnostic testing. These include the requirement that HIV testing is voluntary and performed with informed consent. Moreover, the principles require that HIV testing

is conducted ethically and is beneficial to the person being tested (Australasian Society for HIV Medicine, 2017).

Notably, it is only in Victoria that the law requires that a person who could have transmitted the disease has been offered counselling before refusing to be tested (or lacks capacity to give consent), and that every effort be made to resolve any concerns the person may have regarding being tested.

Summary of Audit Results

How many times have mandatory testing laws been used to test for communicable diseases?

Unfortunately, data was not available for Northern Territory or Queensland but the audit revealed markedly different results for the other three states:

- Victoria - public health based legislation allowing mandatory testing for incidents involving emergency services and healthcare workers has not been used since at least July 2014 (if ever)
- South Australia – mandatory testing laws appear to have been applied with some discretion, totalling seven tests during a 15-month period
- Western Australia - mandatory testing laws have been used almost 100 times/year since 2015

Number of mandatory HIV tests			
Jurisdiction	Number of times laws used	Time period	Source of data
Northern Territory	Not known	2016 - 2018	Police computer system unable to extract data
Queensland	Not known	2016 - 2018	Police computer system unable to extract data
South Australia	7	Feb 2017 – May 2018	Ombudsmans' audit
Victoria	0	July 2014 – June 2018	Department of Health and Welfare Annual Report
Western Australia	387 requests (377 approvals)	Jan 2015 – mid Dec 2018	WA Police Commissioner / WA Police Force Health, Welfare and Safety Unit

The results from Western Australia are particularly alarming, particularly given the Explanatory Memorandum associated with the Mandatory Testing (Infectious Diseases) Bill 2014, which states:

In 2013, there were 147 incidents recorded where officers were exposed to bodily fluids during the course of policing. However, only a small number of these cases will result in a requirement to take a blood sample under a disease authorisation. This is because the legislation will require a senior police officer to be satisfied that there has been a transfer of bodily fluid through penetration of a mucous membrane or through the broken skin of another person.

Instead, it seems that mandatory blood tests are being undertaken in many, if not a majority of incidents. Unfortunately, the audit was not able to identify associated risk events but it seems highly unlikely that the majority of incidents would have included risk of HIV transmission given the conditions required for HIV transmission to be possible (and findings from surveillance data, see below).

Who ordered that the tests be undertaken?

No states provided information about who had ordered that tests be undertaken, i.e. a senior police officer or magistrate, although it is known that in Victoria, neither the Chief Health Officer nor magistrates ordered tests as no orders were made. In South Australia, mandatory testing is initially ordered by a senior police officer. In Western Australia, mandatory testing is ordered by a senior police officer or, by a magistrate if the person is a child or person lacking capacity to consent but it is unclear whether courts have been involved. Importantly, the law allows the overruling of a specialist physician regarding the need for a test if an individual police officer who believes they have been put at risk wants a test to be done. If testing is extra-judicial, then transparency and accountability must be prioritised.

What means of exposure is alleged to have occurred?

No information was provided about the about the means of alleged HIV exposure related to each test, or about how

the risk of transmission related to HIV exposure has been assessed prior to testing. This is highly concerning as the opaque system means it is not possible to ascertain whether testing for HIV related to risk events.

How many times has mandatory testing of an accused revealed a positive HIV result?

No states provided information about the number of times an accused has tested positive for HIV. It appears that in the interests of ensuring the confidentiality of the emergency services worker, police have delegated responsibility for identifying and notifying cases of HIV to individual doctors, and consequently, there is no collection or recording of the results of tests.

Although the rationale is to be commended, it is unclear whether emergency services organisations have any systems in place to assess how often, if ever, mandatory testing has returned a positive result, making it difficult to assess whether mandatory testing is effective legislation/policy. It appears, the system is structurally unable to determine its effectiveness.

Has there been a case of HIV transmission resulting from an incident?

No states provided information describing whether HIV transmission to emergency services personnel had resulted from an incident. The WA Police Commissioner noted that:

WA Police Force is unable to provide comment in relation to diagnoses of occurred transmissions, as this information is forwarded to doctors and comment is not provided to anyone (including officers, unless further tests are required) to ensure the results are not misinterpreted. These end results do not pass through the Health, Welfare and Safety Unit.

It is likely the situation is similar in South Australia as the Commissioner of Police must take reasonable

steps to notify a person of the results of testing, but is taken to have complied with this requirement on provision of the results to a medical practitioner nominated by the person (sections 4B & 4C, Regs).

It seems then, that in the interests of ensuring confidentiality of health information, police have delegated responsibility for identifying and notifying cases of HIV to individual doctors, and consequently, there is no collection or recording of the results of tests. It is not known whether emergency services organisations and associated unions have mechanism in place to consider whether the legislation is contributing to the beneficial treatment of their personnel.

Given the lack of information available through these channels, NAPWHA initiated further discussions with staff at the Kirby Institute. In fact, national HIV surveillance data reveals that there have been no national HIV notifications for the years 2003-2017 following HIV diagnosis in Australia with a reported occupational exposure risk¹⁴. That is, we know from HIV surveillance data that there have been no cases of HIV transmission to emergency services personnel as a result of occupational exposure since any of the legislation has been introduced.

How many/what proportion of testing has occurred in metro/regional areas?

Only Western Australia provided information about the number and proportion of tests that had occurred in metro/regional areas. That data showed that 68% of applications for testing (262 of 387 cases) occurred in metropolitan areas, while 32% (125 of 387 cases) of applications for testing were made in regional areas of Western Australia. Ten of the 387 applications were rejected (i.e. no order was made) although it is unclear whether those were in metropolitan or regional settings.

This data from Western Australia raises a number of issues including the costs associated with testing, which include transporting accused long distances to specific hospitals for testing.

How many/what proportion of those tested are Aboriginal or Torres Strait Islander?

No states provided information describing how many/what proportion of those tested were Aboriginal or Torres Strait Islander, although the Western Australian Police Commissioner noted plans to start collecting that data from 2019.

14 Correspondence with Kirby Institute based on national surveillance data, 16 May 2019.

Conclusion

The results of the audit are concerning. Aside from the mandatory testing laws being at odds with national HIV testing policy and operating outside the clearly structured and highly successful HIV responses managed by departments of health, the audit found that in many instances, the laws, their implementation, and monitoring were flawed. Given the complexity of the use of mandatory testing laws nationally, based on separate and distinct state systems, generalisations are difficult, however, a number of major issues were identified, usually occurring in multiple states:

Many structural failures were identified, usually operating across multiple states. These included issues relating to design of legislation: the threshold/trigger for mandatory testing being set too low; decision making being delegated to non-experts; decision making not routinely allowing procedural fairness; use of force being allowed; and hefty criminal penalties applying. Threats of force and threats of criminal penalties to coerce consent or agreement to undergo testing remain a major concern.

There are also major structural failures relating to the implementation and monitoring of mandatory testing laws, including: contradictions between laws, guidelines and practices - including whether laws are implementable in a clinical context; lack of monitoring processes; lack of transparent and accessible mechanisms to gain information about testing practices; lack of a successful interface between health and police; and laws being overused.

The opaque nature of mandatory testing systems means that in two states, it was not possible to access information on the number of times mandatory HIV testing had been carried out. No states provided information on the reasons mandatory testing had been conducted (type of exposure) and it is unclear whether this type of information is collected.

It was not possible to ascertain whether any person

subjected to mandatory testing had tested positive for HIV in any state. It appears that in the (commendable) interests of ensuring the confidentiality of health records, police have delegated responsibility for identifying and notifying cases of HIV to individual doctors, and consequently, there is no collection or recording of the results of tests. It is unclear whether any state governments have systems in place to record data in this area.

Similarly, police departments do not keep records of HIV diagnosis resulting from an occupational incident (i.e. whether HIV has been transmitted) so were not able to provide data on this point, however, our queries to the Kirby institute found national HIV surveillance data showing there have been no national HIV notifications for the years 2003-2017 following HIV diagnosis in Australia with a reported occupational exposure risk¹⁵. That is, we know from HIV surveillance data that there have been no cases of HIV transmission to emergency services personnel as a result of occupational exposure since any of the legislation has been introduced.

HIV prevalence is extremely low in Australia so emergency services workers will seldom come into contact with a person with HIV during their regular work. The odds of being exposed to bodily fluids are far, far lower still. And the possibility of acquiring HIV as a result of an exposure - much reduced again. The availability of PEP, which can stop HIV in its tracks, makes the possibility of HIV transmission through occupational exposure quite remote. That explains why emergency services workers are not getting HIV through occupational exposures.

15 Correspondence with Kirby Institute based on national surveillance data, 16 May 2019.

Laws are heavy handed and are not necessarily implementable. Procedural fairness is not uniformly accessible. Implementation is not clearly understood by all concerned and monitoring is weak or absent ... and it is not transparent. Expert clinicians and health departments are locked out of decision making and monitoring. No one is testing positive for HIV.

The National Association of People with HIV Australia and the HIV Justice Network recommend consideration of the following:

1. Repeal of all mandatory testing laws used to test people for HIV following a possible exposure of a person to another's bodily fluids, given only a remote possibility of transmission and the availability of post-exposure prophylaxis to prevent HIV acquisition. These laws criminalise behaviour that is already criminalised. They cannot prevent HIV transmissions where no risk exists.
2. Immediate review of current systems regarding use of mandatory testing laws given clear overuse in some locations, use to test for 'all' possible diseases regardless of risk events, lack of a successful interface with clinicians and health departments, disregard for the welfare of persons being tested, and a lack of mechanisms scrutinising the use and effectiveness of these laws
3. Amendment of mandatory testing laws so that all mandatory/forced testing requires the order of a judge and the affirmative recommendation of a qualified medical specialist, with police officers prevented from ordering mandatory tests, to ensure the tests cannot be misused as extra-judicial means of punishment.
4. Amendment of mandatory testing laws to communicate consent (or the absence of consent) and the means by which consent was gained be recorded and communicated to staff undertaking pathology and delivering results.
5. Amendment of mandatory testing laws to include robust monitoring requirements (factors to be monitored), with a condition that results of monitoring be published annually.
6. Amendment of mandatory testing laws to restrict mandatory testing for any transmissible infection to situations where there has been a real risk of transmission (as confirmed by a medical specialist) of that specific infection.
7. Review of clinical and other support procedures, including application of occupational PEP guidelines, to ensure effective treatment of emergency services workers who fear they have been put at risk of HIV transmission.
8. Scaling up of education targeting emergency services workers' organisations and media regarding current science on HIV risk and treatments to alleviate fears of occupational HIV exposure and transmission and to enable a better understanding of the realities of living with HIV.

Annexure A: Persons/Occupations to Whom Third Party Mandatory Testing Laws Relate

	Northern Territory	Queensland	South Australia	Victoria	Western Australia
Police	Yes	No	Yes	Yes	Yes
Police-related officers	Yes	No	No	No	No
Police service employees	Yes	No	No	No	No
Paramedics	No	No	Yes	Yes	No
Doctors	No	No	Yes	Yes	No
Nurses	No	No	Yes	Yes	No
Emergency service workers	No	No	Yes	Yes	No
Pathology-related	No	No	Yes	Yes	No
Caregivers	No	No	No	Yes	No
(Victims of sexual offences and serious assaults and) persons who may have been exposed to bodily fluid during or soon after commission of the offence	No	Yes	No	No	No

Annexure B: Summary of Key Elements of Mandatory Testing Laws

	Northern Territory	Queensland	South Australia	Victoria	Western Australia
	Criminal Police Administration Act 1978 (NT)	Criminal Police Powers and Responsibilities Act 2000 (Qld)	Criminal Criminal Law (Forensic Procedures) Act 2007 (SA)	Public Health Public Health and Wellbeing Act 2008 (Vic)	Criminal Mandatory Testing (Infectious Diseases) Act 2014 (WA)
Involvement of Court	<p>If a protected person (otherwise senior police officer)</p> <p>The Court must hear and decide the application with as little delay as possible in the absence of the public. (s147FJ)</p>	<p>Police officer may apply to a magistrate or, if the relevant person is a child, the Children's Court for an order authorising the taking of a sample of blood and urine. s540(2) The magistrate may refuse to consider the application unless the police officer gives all the information the magistrate requires. (s540(5))</p>	<p>A police officer may apply to the Magistrates Court for the issue of a warrant to have the person arrested and brought to the police station for the purpose of carrying out the forensic procedure if the person fails to comply with directions. (s29(3))</p>	<p>The Chief Health Officer may apply to the Magistrates' Court if enforcement necessary (otherwise Chief Health Officer). Magistrate to make order only if satisfied that exceptional circumstances justify order. (s134(3))</p>	<p>If child or person lacking capacity (otherwise senior police officer)</p>
Service	<p>The applicant must serve a copy of the application personally on a third party for the transferor. (s147FI)</p>	<p>Before the application is made, the police officer must provide a copy of the application and inform the person has the right to be represented by a lawyer. (s540(4))</p>	<p>The authorising officer must make a written record of grounds and copy of the record must be given to the person. (s20B(2))</p>	-	<p>A copy of the disease test approval must be served personally on the suspected transferor. 540(4)</p>

	Northern Territory	Queensland	South Australia	Victoria	Western Australia
	Criminal Police Administration Act 1978 (NT)	Criminal Police Powers and Responsibilities Act 2000 (Qld)	Criminal Criminal Law (Forensic Procedures) Act 2007 (SA)	Public Health Public Health and Wellbeing Act 2008 (Vic)	Criminal Mandatory Testing (Infectious Diseases) Act 2014 (WA)
Person served before test	Copy of the disease test approval must be served personally on the transferor. s147FE(1) Application/ Order must be served before it takes effect. (s147FE(3))	-	Order must be served before it takes effect. s4A(1).	An order has effect from the time that it is served on the person named in the order. (s134(2)(g))	Order must be served before it takes effect. (s11(3))
Purpose articulated	-	To help ensure victims of particular sexual offences and serious assault offences (and others) receive appropriate treatment by authorising the taking of blood and urine samples from a person a police officer reasonably suspects has committed the relevant offence. (s537)	-	Public health framing - minimum restrictions on rights of person (s111), least restrictive measures (s112)	Disease Test Approval - To help ensure that a police officer or other public officer is exposed to the risk of transmission of certain infectious diseases, in the course of duty, by authorising the taking of a blood sample and the analysis of the blood sample. s3 Disease Test orders – to provide for the mandatory testing of a suspected transferor who is a protected person. (s14)

	Northern Territory	Queensland	South Australia	Victoria	Western Australia
	Criminal Police Administration Act 1978 (NT)	Criminal Police Powers and Responsibilities Act 2000 (Qld)	Criminal Criminal Law (Forensic Procedures) Act 2007 (SA)	Public Health Public Health and Wellbeing Act 2008 (Vic)	Criminal Mandatory Testing (Infectious Diseases) Act 2014 (WA)
Restrictions mitigating use	-	-	-	Order must explain why the CHO believes the person is infected with the disease (s117), all reasonable efforts should be made to obtain consent before resorting to CHO powers (Regs), risk assessment by medical staff (Regs)	-
Testing humanely	-	-	Must be carried out humanely and with care, by a medically qualified person (a) to avoid offending genuinely held cultural values or religious beliefs; and (b) to avoid inflicting unnecessary physical harm, humiliation or embarrassment. (s21(1))	-	-

	Northern Territory	Queensland	South Australia	Victoria	Western Australia
	Criminal Police Administration Act 1978 (NT)	Criminal Police Powers and Responsibilities Act 2000 (Qld)	Criminal Criminal Law (Forensic Procedures) Act 2007 (SA)	Public Health Public Health and Wellbeing Act 2008 (Vic)	Criminal Mandatory Testing (Infectious Diseases) Act 2014 (WA)
Appeal possible	The third parties for a transferor may, on behalf of the transferor, appeal to the Supreme Court against the order. (s147FP(1))The appeal must be filed without delay and does not stay the operation of the disease test order.(s147FP(2)) The Supreme Court must hear and decide the appeal (a) within 48 hours after the order is made; (b) in the absence of the public; and (c) without adjourning the appeal. (s147FP(4))	A relevant person may appeal against a disease order to the District Court. (s544) The court must hear and decide the appeal (a) within 48 hours (b) in the absence of the public; and (c) without adjourning the appeal. (s544(4))	-	A person subject to a public health order may at any time while the order is in force apply to VCAT for a review of the decision to make the order. (s122)	A third party may, on behalf of the suspected transferor, appeal against a disease test order to the District Court. (s24(1)) The District Court must hear and decide the appeal (a) within 48 hours after the order is made; (b) in the absence of the public; and (c) without adjourning the appeal. (s24(4))
Language	Must take all reasonable steps to express in a language & manner likely to understand. (s147FL(2))	Must arrange for the presence of an interpreter if officer suspects a person is unable to speak with reasonable fluency in English. (s512)	If a person on whom a forensic procedure is not reasonably fluent in English, the person is entitled to be assisted by interpreter, including having an interpreter present during the forensic procedure if requested. (s22)	The Chief Health Officer must facilitate any reasonable request for communication made by a person detained under an examination and testing order. (s125)	Must be communicated in a language & manner likely to understand, although failure doesn't invalidate order. (s20(2))

	Northern Territory	Queensland	South Australia	Victoria	Western Australia
	Criminal Police Administration Act 1978 (NT)	Criminal Police Powers and Responsibilities Act 2000 (Qld)	Criminal Criminal Law (Forensic Procedures) Act 2007 (SA)	Public Health Public Health and Wellbeing Act 2008 (Vic)	Criminal Mandatory Testing (Infectious Diseases) Act 2014 (WA)
Test results inadmissible	-	The making of an application of a disease test order or the test results are inadmissible in evidence. (s548)	Test results of forensic procedure will be inadmissible in evidence except for civil proceedings (s48A). If the person obstructs or resists a person related to the carrying out of the forensic procedure, evidence of that fact may be admissible in proceedings against the person. (s30(b))	The information is not admissible in any action or proceedings before any court or tribunal or any board, agency or other person. (s139(5))	Test results are inadmissible in evidence (a) the making of an application for a disease test authorisation; (b) the giving of a disease test authorisation; (c) the results of an analysis of a blood sample under this Act. (s31)
Counselling	A psychiatrist, psychologist or social worker providing counselling for an affected member or the transferor. (s147FU(1)(f))	-	-	A person who made an order or authorised the testing of a sample of a blood or urine must ensure that the relevant person is offered counselling including exploration of factors that may inform reluctance to test. (May also review medical history) (ss134(1) & 138)	-

	Northern Territory	Queensland	South Australia	Victoria	Western Australia
	Criminal Police Administration Act 1978 (NT)	Criminal Police Powers and Responsibilities Act 2000 (Qld)	Criminal Criminal Law (Forensic Procedures) Act 2007 (SA)	Public Health Public Health and Wellbeing Act 2008 (Vic)	Criminal Mandatory Testing (Infectious Diseases) Act 2014 (WA)
Limited to types of offences	-	Limited to particular sex offences and sexual assault s537 & (s538)	Limited to prescribed serious offence (including assault) (20B)	-	-
Authorising officer not involved	Authorising officer not involved in the investigation (s147FB)		The person must be allowed a reasonable opportunity to arrange for the attendance of a medical practitioner of the person's choice to witness the forensic procedure. (s25(1))		Authorising officer not involved in the investigation (s8)
Time limit	Must be made as soon as practicable (s147FB(4)) or Court must decide with as little delay as possible and in the absence of the public (s147FJ(1))	Must hear and decide the application with as little delay as possible, in the absence of the public & satisfied the person has been informed of their right to representation (s542)	Application may be sent by fax or email, otherwise may be read to the officer over the telephone and the copy must be provided as soon as practicable after the application is made s38(3)	The Chief Health Officer must as is reasonably practicable provide a copy of an examination and testing order (s114(2))	Must be made as soon as practicable (s180) or Court must decide with as little delay as possible and in the absence of the public (s18)
Application in writing	Test application/ approval needn't be in writing if has knowledge of the circumstances & not feasible with a reasonable time (must later make record in writing) (s147FD)	The application must be written and state the grounds on which it is made. (s540(3))	The authorising officer must make a written record of the grounds to determine whether the forensic procedure should be carried out on a person. (s20B(2))	An order must be in writing; give details of the incident; name the person to whom it applies; name the disease to be tested. (s134(2))	The application must, if practicable, be in writing and state the full name, official details of the applicant, affected public officer and suspected transferor and also state the grounds for suspecting (s8(3))

	Northern Territory	Queensland	South Australia	Victoria	Western Australia
	Criminal Police Administration Act 1978 (NT)	Criminal Police Powers and Responsibilities Act 2000 (Qld)	Criminal Criminal Law (Forensic Procedures) Act 2007 (SA)	Public Health Public Health and Wellbeing Act 2008 (Vic)	Criminal Mandatory Testing (Infectious Diseases) Act 2014 (WA)
Penalty	Failure to comply – Maximum: 100 penalty units (s147FG)	-	Wilful obstruction – Maximum penalty: 2 years imprisonment (s32)	-	Failure to comply – fine \$12 000 and 12 months (s13)
Period of detention	May detain a person for as long as is reasonably necessary to enable determination & take blood (s147FC)	A police officer may detain the person for 1 hour or a longer reasonably necessary time. (s515)	-	A Person who is arrested or detained must be informed at the time of the arrest or detention of the reason why the person is being arrested or detained. (s123(8)) The period of the detention commences when the person is in the physical custody of the person who is taking that person to the specified place of detention (s114(3))	A police officer may apprehend and detain a person for as long as is reasonably necessary to enable determination & take blood. (s9)
Entry	Authorises entry into any place the person may be and can transfer person to an appropriate facility to take blood. (147FF & 147FN)	May take them to a place with appropriate testing facilities (s543(c))	-	-	Authorises entry into any place the person may be and to transfer them to an appropriate facility to take blood (s10)

Annexure C: Reasons for Denial of FOI Request, South Australia

The application was denied on the basis that section 50 of the *Criminal Law (Forensic Procedures) Act 2007*, prohibits disclosure of information obtained under the Act unless it is requested for specific reasons (listed at Annexure A).

- criminal investigation purposes or a missing persons inquiry
- proceedings for a serious offence or proceedings under the *Criminal Assets Confiscation Act 2005*
- determining whether it is necessary to carry out a forensic procedure under this Act or a corresponding law
- coronial inquest or inquiry
- making the information available to the person to whom the information relates; or
- administering the DNA database system
- arrangement entered into by the Minister under section 41(2)
- the disclosure is necessary for the purpose of, and in accordance with, the *Mutual Assistance in Criminal Matters Act 1987* or the *Extradition Act 1988* of the Commonwealth
- investigation by the Ombudsman
- the disclosure is necessary for the purpose of an investigation under the *Police Complaints and Discipline Act 2016*
- the disclosure is necessary for the purpose of an audit under section 57; or
- the disclosure is made to a legal practitioner and is made for the purpose of obtaining legal advice
- the information is publicly known
- the disclosure is necessary for the purpose of civil proceedings (including disciplinary proceedings) that relate to the way in which the procedure was carried out
- the disclosure is necessary for the medical treatment of the person to whom the information relates or any other person
- the person to whom the information relates consents to the disclosure
- the information is disclosed for a purpose of a kind prescribed by regulation.

Annexure D: Sample of Freedom of Information request to state governments

Western Australia FOI Request

I am seeking digital copy, of if not possible, hard copy, of the following:

- Specific information as outlined in number 1-9 below of on the application of Mandatory Testing (Infectious Diseases) Act 2014 (the Act).
- The WA Police Policy and Standing Operating Procedures.

I would like the information below for the following financial years:

2014-2015; 2015-2016; 2016-2017; 2017-2018.

I would also like, if possible, to have the information broken down by:

- in country areas vs metro
- subject of law was Aboriginal or Torres Strait Islander
- the number of minors
- male/female/other?

1) The number of applications for disease tests approvals applied for under *s8* of the Act

2) The number of disease tests approvals issued under *s10* of the Act.

3) The reasonable grounds stated for applications for disease tests approvals authorised under *s10* of the Act.

4) The number of blood test samples taken by a doctor nurse or qualified person under *s26* of the Act.

5) The number applications taken to the court for a disease test order under *s16* of the Act.

6) The number of applications for disease test authorisations under *s16* of the Act.

7) The number disease test orders approved by the court under *s19* of the Act.

8) The number disease test orders approved by the court as per *s7.6* of WA Department of Health Operational Directive 0632/15 - *Mandatory Testing of a Suspected Transferor for an Infectious Disease*¹⁶.

9) The number of BBVs diagnosed – broken down by hep B, hep C and HIV if known.

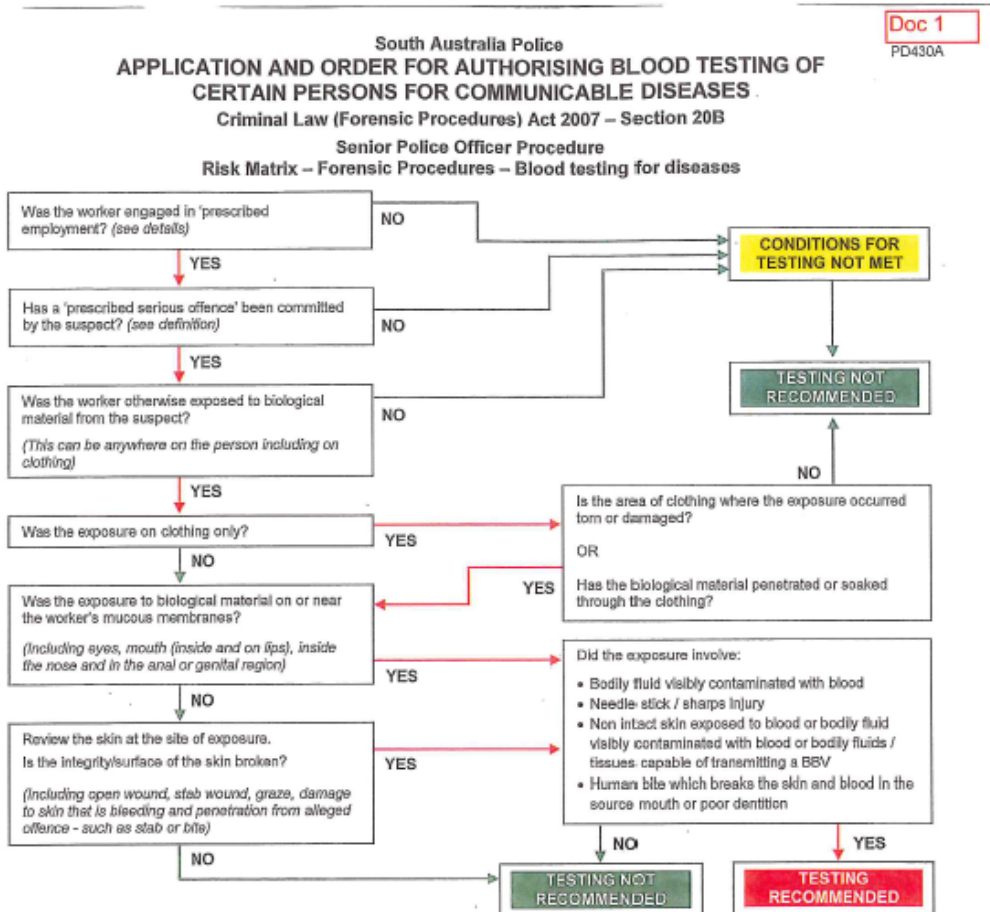
¹⁶ 7.6 In the case where WA Police do not accept the recommendation for action resulting from the risk assessment conducted by the attending doctor, WA Police may request to override the attending doctor's recommendation. The Act authorises WA Police to present with a disease test authorisation, and the courts to provide WA Police with a disease test order. Available at: https://ww2.health.wa.gov.au/~/_media/Files/Corporate/Policy%20Frameworks/Public%20Health/Policy/Mandatory%20Testing%20of%20a%20Suspected%20Transferor/OD632-Mandatory-Testing-of-a-Suspected-Transferor-for-an-Infectious.pdf

Annexure E: Check list of relevant legislative requirements – Checklist for Ombudsman SA Audit

Blood testing for communicable diseases checklist

1. Did the forensic procedure that was carried out consist only of the taking of a sample of blood from the subject?
 - Yes, go to Q2.
 - No, non-compliant. Go to Q2.
2. Did a senior police officer authorise the forensic procedure?
 - Yes, go to Q3.
 - No, non-compliant. Go to Q3.
3. Was the authorising officer satisfied that the subject was suspected of a prescribed serious offence?
 - Yes, go to Q4.
 - No, non-compliant. Go to Q4.
4. Was the authorising officer satisfied that a person engaged in prescribed employment came into contact with/ was exposed to the subject's biological material?
 - Yes, go to Q5.
 - No, non-compliant. Go to Q5.
5. Did the authorising officer make a written record of the grounds on which they determined that the forensic procedure should be carried out on the subject?
 - Yes, go to Q6.
 - No, non-compliant. Go to Q7.
6. Was a copy of the record given to the subject?
 - Yes. Go to Q7.
 - No, non-compliant. Go to Q7.
7. Before the procedure was carried out, did the authorising officer give the subject written notice:
 - a) that a blood sample was to be taken from the subject pursuant to S20B of the Act? (Regulation 4A)
 - b) that the blood would be tested for communicable diseases?
 - c) inviting the subject to nominate a medical practitioner to receive a copy of the results?
 - Yes, go to Q8.
 - No, non-compliant. Go to Q8.
8. Was the procedure carried out by a medical practitioner or a person who is qualified as required by the regulations?
 - Yes, go to Q9.
 - No, non-compliant. Go to Q9.
9. Was the person given an opportunity to have a witness present (see s25 of the CLFPA Act)?
 - Yes, go to Q10.
 - No, non-compliant. Go to Q10.
10. Did the Commissioner take reasonable steps to notify each affected person/nominated medical practitioner of the test results?
 - Yes. Go to Q11.
 - No, non-compliant. Go to Q11.
11. Did the Commissioner ensure that the blood sample was destroyed as soon as practicable after it was tested?
 - Yes. Complete.
 - No, non-compliant. Complete.

Annexure F: SAPOL Risk Matrix – Forensic Procedures – Blood testing for diseases



NOTE: If any doubt exists surrounding the risk, medical advice can be obtained during office hours from SAPOL Employee Assistance Section Ph: 7322 3257 or after hours (on call arrangements) by contacting SAPOL Communications Centre.

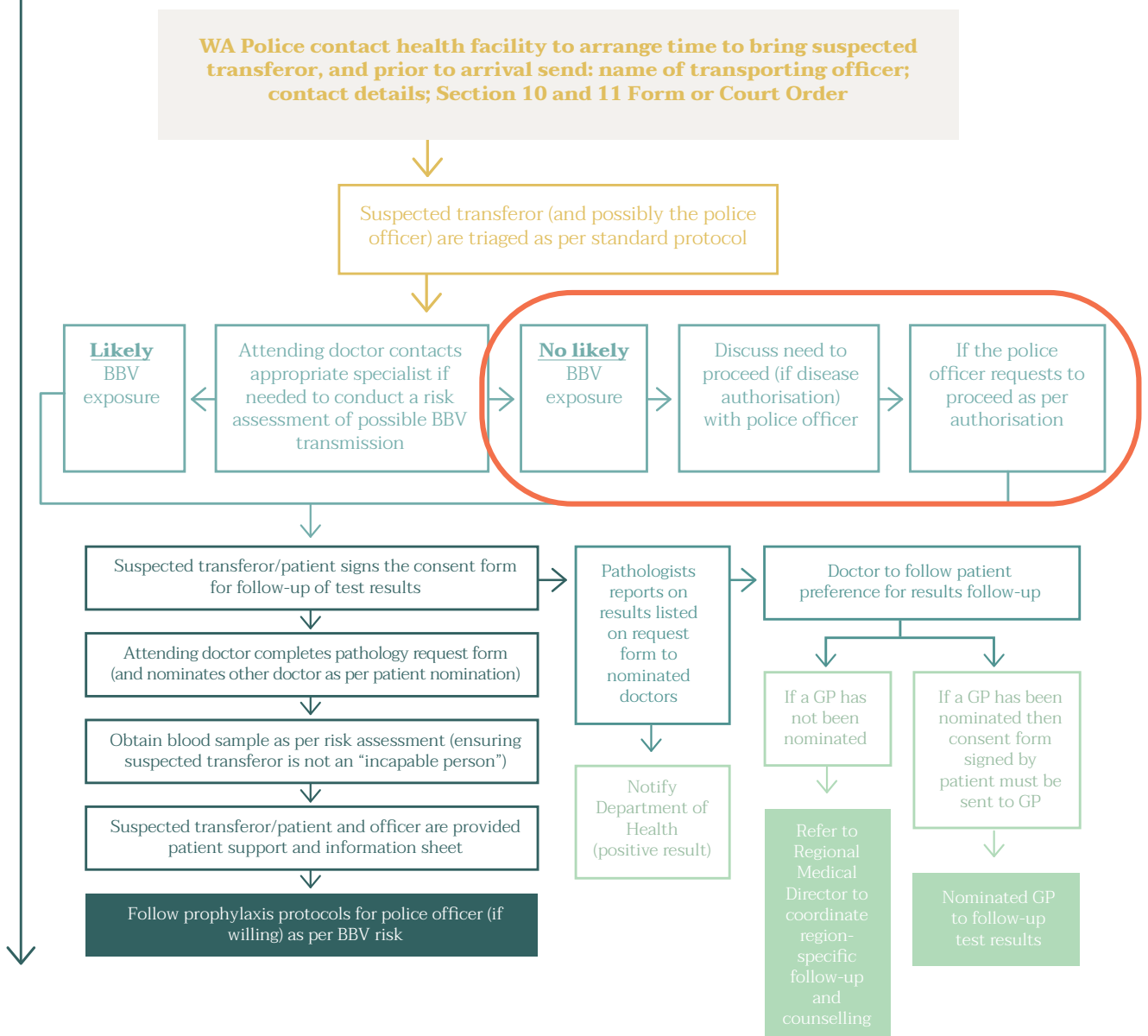
<p>High Risk Exposure Type:</p> <ul style="list-style-type: none"> > Deep needle stick from needle used for venipuncture, blood gasses or other blood withdrawal > Deep injury from instrument contaminated with concentrated virus > Extensive and/or prolonged contact with blood / visibility contaminated body fluids or fluids / tissue capable of transmitting blood borne virus* > Injection or transfusion of potentially infectious fluid 	<p>Low Risk Exposure Type:</p> <ul style="list-style-type: none"> > Needle stick / sharps injury which <ul style="list-style-type: none"> • Did not bleed spontaneously • Was a solid sharp, suture needle or probe • Was an intradermal injection • Was a spontaneous injection • Was a small dental needle used for local anesthetic > Non intact skin exposed to small amount of blood or body fluid visibly contaminated with blood or body fluids / tissues capable of transmitting BBV* > Human bite which broke the skin and blood in source mouth or poor dentition
<p>Moderate Risk Exposure Type:</p> <ul style="list-style-type: none"> > Needle stick / sharps injury where <ul style="list-style-type: none"> • The injury bled spontaneously • From a needle visibly contaminated with blood through gloves or less deep needle stick from a needle used for venipuncture, blood gasses or other blood withdrawal • Intramuscular injection • Cut from scalpel with significant blood exposure > Contact with blood / visibility bloody body fluids or fluids / tissues capable of transmitting BBV* to mucous membranes or to a significant area of non-intact skin 	<p>No Risk Exposure Type:</p> <ul style="list-style-type: none"> > Clean needle stick or sharps > Intact skin exposed to blood or bodily fluid > Mucous membranes (eye, mouth) exposed to bodily fluid (urine, spit, vomit or sputum) not visibly contaminated with blood or fluids capable of transmitting BBV* > Human bite or scratch which did not break the skin

*Body fluids / tissues capable of transmitting blood borne virus (BBV) include cerebro-spinal fluid, synovial fluid, pleural fluid, amniotic fluid, peritoneal fluid, pericardial fluid, semen and vaginal secretions and tissues and laboratory specimens that contain concentrated virus

DISTRIBUTION:
ORIGINAL – Applicant or Investigating Officer
COPY – Suspect
COPY – Senior Police Officer
COPY – Employee Assistance Section (E8)

Annexure G: Extract from Mandatory Testing of a Suspected Transferor for an Infectious Disease

Processing a disease test authorisation/order for WA Country Health Services



References

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Northern Territory

Police Administration Amendment Act 2016

Police Administration Amendment (Forensic Procedures) Act 2004

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Queensland

Police Powers and Responsibilities Act 2000

South Australia

Criminal Law (Forensic Procedures) Act 2007

Criminal Law (Forensic Procedures) (Blood Testing for Diseases) Variation Regulations 2016.

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Victoria

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Western Australia

Health Practitioner Regulation National Law (WA)

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Mandatory Testing (Infectious Diseases) Act 2014

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napwha national association of
people with HIV australia



The System is Broken
Audit of Australia's Mandatory Disease
Testing Laws