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ONTARIO COURT OF JUSTICE

HER MAJESTY THE QUEEN

v.

W[redacted] V[redacted]

R E A S O N S F O R J U D G M E N T

BEFORE THE HONOURABLE JUSTICE N. D. BOXALL
on November 22, 2019 at OTTAWA, Ontario

INFORMATION CONTAINED HEREIN CANNOT BE PUBLISHED, BROADCAST OR TRANSMITTED PURSUANT TO SECTION 486.4 OF THE *CRIMINAL CODE OF CANADA* BY ORDER OF JUSTICE H. E. PERKINS-McVEY, ONTARIO COURT OF JUSTICE, DATED DECEMBER 6, 2017.

APPEARANCES:

J. Ramsay — Counsel for the Crown

W. Murray — Counsel for W[redacted] V[redacted]

Publication Ban

Table of Contents

ONTARIO COURT OF JUSTICE

T A B L E O F C O N T E N T S

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W I T N E S S E S

E X H I B I T S

Legend

[*sic*] - Indicates preceding word has been reproduced verbatim and is not a transcription error.

(ph) - Indicates preceding word has been spelled phonetically.

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FRIDAY, NOVEMBER 22, 2019

R E A S O N S F O R J U D G M E N T

BOXALL, J. (Orally):

These are Reasons for Judgment in the matter of W[redacted] V[redacted]. I will begin with a brief summary of the evidence, starting with the Crown's case.

On October 4th, 2017, Mr. V[redacted] was informed that he had tested positive for HIV by public health nurse, L[redacted] O[redacted]. Mr. V[redacted] has been diagnosed with epilepsy and has a history of seizures; he has also had diagnoses for ADHD, PTSD, general anxiety, and depression. On October 4th, staff provided him with counselling about his HIV diagnosis in a manner which was tailored to accommodate his "cognitive delay" and concerns about his level of comprehension. He was clearly advised and understood that he was HIV positive; further, that he should not engage in sexual intercourse until his was on anti-viral medications and then only with a condom.

On October 11th, 2017, Mr. V[redacted] attended the Ottawa General Hospital HIV Clinic where blood was collected. It was determined that his plasma HIV RNA viral load was 1,300 copies per millilitre. That determination was done at a later date.

I am going to refer to the complainant as K.F. for the purposes of protecting her privacy and it is not intended in any way to be disrespectful that I am not using her full name.

K.F. and Mr. V[redacted] had unprotected --meaning no condom was used-- oral, vaginal, and anal sex on October 10th, 2017, and October 13th, 2017. Before these occurrences, Mr. V[redacted] did not disclose that he was HIV-positive. In fact, he falsely gave assurances that he was "clean". K.F. was not aware that W[redacted] V[redacted] was HIV-positive and it is accepted she would not have engaged in any form of sexual activity had she known. There was some delay before Mr. V[redacted] began his anti-viral drug therapy because of other medication he was on for his epilepsy. It began after the relevant period in this case.

The entire Crown's case was admitted and filed in writing, and I will quote extensively from the documentation filed.

M.C.: M.C. is a person that Mr. V[redacted] was involved in and knew K.F. M.C.'s evidence is that she met Mr. V[redacted] in 2015 at Stars Palace on Montreal Road. They started dating in February 2017 and were engaged the following month. They lived together from February 2017 onwards. They had a short break up; 20th of July, 2017, they were back together. She described September 2017 as a difficult month. A

rash all over her body led her to the doctors who recommended screening for syphilis. She was diagnosed with syphilis at the end of September/early October 2017 and sent for treatment. She disclosed this to Mr. V[redacted] as they had been sexually active together. The accused was also tested at the Sexual Health Centre on Clarence Street. They returned on October 4th and met with a registered nurse, L[redacted] O[redacted]. L[redacted] O[redacted] spoke with the accused alone in a separate room. She then invited M.C. in approximately 25 minutes later. The accused's head was hanging low and he appeared doe eyed. He asked for a few minutes alone with M.C. He informed her that the tests came back and he was HIV-positive.

...WHEREUPON AN UNRELATED MATTER IS ADDRESSED.

Approximately five minutes later, registered nurse L[redacted] O[redacted] returned and told Mr. V[redacted] a number of things in M.C.'s presence: that Mr. V[redacted] needed to get a more extensive test done to discover his count, referring to the viral load count; that Mr. V[redacted] needed to go see a team at the General Hospital, which included support workers; that they should use protection during sex given M.C. was HIV-negative and Mr. V[redacted] was HIV-positive; that they should not even kiss as the syphilis could be retransmitted but that after two weeks there should not be an issue; this resulted in them sleeping in separate

rooms following that date and they had not had sex for approximately two weeks leading up to October 4th; that any oral, anal, or vaginal sex must be avoided until Mr. V[redacted] was on the HIV medication and that even once on that medication they would have to use a condom.

In the aftermath of that meeting, on Sunday, October 8th, M.C. and Mr. V[redacted] were making out and Mr. V[redacted] suggested they go to the bedroom to engage in sexual intercourse. M.C. said, "No. You know we're not allowed. We can do other things but not that." They did not have any condoms in the house so she told him to take care of it himself, which upset Mr. V[redacted].

The evidence of M.C. as it relates to K.F.: during the week of October 10 to 17, Mr. V[redacted] texted M.C. expressing an interest in K.F., a mutual acquaintance of theirs from the Stars Karaoke Bar. M.C. told Mr. V[redacted] to ensure to disclose his HIV-positive status to her, to which he replied that he had already told her.

On Saturday, October 14th, Mr. V[redacted] and K.F. attended Stars Karaoke Bar, where M.C. was working, and they sang, kissed, and danced together. Later that night, M.C. texted the accused and told him to tell K.F. that if he did not disclose as HIV-positive to her that M.C. would.

On October 15th, 2017, K.F. texted M.C. and asked if she was aware that Mr. V[redacted] was HIV-positive. M.C. replied that she had known for 1.5 weeks, to which K.F. said that Mr. V[redacted] had told her that he had just gotten the results today, that being the 15th of October. K.F. told her that she was already in a relationship with the accused when he and M.C. broke up five days before and that they had had sex that night. M.C. encouraged K.F. to make a complaint to the police.

Approximately one month before December 4th, Mr. V[redacted] told M.C. that his viral load was considered low at 1350 and that doctors believed he had contracted HIV within the previous year. He also informed her that he had prepared a list of 23 people with whom he had had sexual contact since the time of his last test three years prior.

On December 4th, 2017, as M.C. gave her statement, Mr. V[redacted] was sleeping in her apartment. They had been intimate with protection in the preceding month. Mr. V[redacted] was adamant about the use of condoms with M.C. once he received a court order requiring him to do so, amongst other things. M.C. spoke with Mr. V[redacted] before going to see the police. He was upset that K.F. had gone to the police and expressed this to M.C. who told him that he knew he was HIV-positive and went and had unprotected

sex with a girl. Mr. V[redacted] replied that he had, "Fucked up."

The admitted evidence of K.F. is that she would not have engaged in sexual activities with Mr. V[redacted] if she had been aware of his HIV-positive diagnosis. She gets tested for STD or STI every three months. She had known Mr. V[redacted] for approximately two years or so through family friends before exchanging suggestive messages with him, but they both deleted them as they were seeing other people at the time.

Tuesday, October 10th, 2017, she had began to date the accused three to four days after breaking up with her previous partner on October 10th by going to a movie. Mr. V[redacted] had told her he had broken up with M.C. the day before but she later learned from M.C. that it actually took place the night of the 10th. While kissing K.F.'s neck and body, Mr. V[redacted] repeatedly told her he was clean after she suggested they wait to have sex until they got tested. He said he had been tested recently and that if he did have anything it was something small like gonorrhea or chlamydia that would be easy to take care of. They had unprotected sexual intercourse, vaginal, oral, and anal, in the basement at Mr. V[redacted]'s ex-girlfriend's house. Mr. V[redacted] ejaculated in her vagina and rectum on this occasion. K.F. noticed she had some anal bleeding after this incident. She then went home and remained at his

ex-girlfriend's house.

Wednesday, October 11th, 2017, K.F.'s evidence is they met the following day at Place d'Orléans where Mr. V[redacted] said he had 16 vials of blood taken, which struck her as excessive for an STD test. He changed the subject when she asked him about it and she did not pursue the matter.

Friday, October 13th, Mr. V[redacted] went to K.F.'s house and they had unprotected oral, anal, and vaginal sex and then hung out with her roommates. Mr. V[redacted] ejaculated in her vagina on this occasion. K.F. noticed that she had some anal bleeding following this occasion as well.

Sunday, October 15th, 2017, Mr. V[redacted] contacts K.F. via text message and said he just got his results back and discloses his HIV-positive status. M.C. tells K.F. via Facebook message that Mr. V[redacted] had known about his HIV-positive status since October 4th after they had been both tested at the Sexual Health Centre on Clarence Street on the 26th of September. She also tells K.F. that the appointment Mr. V[redacted] had to go to on the 11th of October was to meet an HIV counsellor or doctor, in order to discover when he contracted the virus. K.F. immediately terminated her relationship with Mr. V[redacted] and went to the emergency room at the General Hospital. According to K.F., the aftermath was that she took the HIV cocktail of medication for

one month as well as other medication for chlamydia as a preventative measure. She did not contract HIV.

The admitted evidence of the registered nurse L[redacted] O[redacted] is that she advised Mr. V[redacted] of his HIV and syphilis diagnoses on the 4th of October, 2017. They engaged in a lengthy discussion about his disclosure obligations and other safety precautions. She told him to abstain oral, vaginal, or anal sexual intercourse until the HIV was treated, and once he was receiving treatment, they should use a condom. She advised him to abstain from kissing for two weeks on account of the possibility of syphilis retransmitting. She made referrals for him to attend the General Hospital for medical follow up as well as social work follow up. She advised Mr. V[redacted] that he would have to go to the General Hospital to get more extensive tests to discover his count, referring to the viral load count. Ms. O[redacted] also explained that he should use protection, given M.C. was HIV-negative and he was HIV-positive. Ms. O[redacted] further explained that any oral, anal, or vaginal sex must be avoided until Mr. V[redacted] was on the HIV medication and, even once on that medication, they would have to use a condom. She did inform them that kissing was allowed after two weeks abstention period.

The defence expert evidence: Dr. Shafran was

qualified to give expert opinion in his area of expertise with respect to HIV/AIDS, including the manner of transmission and the risk of transmission.

Dr. Shafran testified that the knowledge of HIV/AIDS has advanced considerably and there is a much better understanding of the risk of transmission with specific sexual acts in 2019 than there was in 2008 or even 2014. He testified the viral load is a measurement of the concentration of HIV in the blood. The viral load in untreated HIV-positive persons can vary widely but is relatively stable within individual persons. By relatively stable, it means the viral load can increase or decrease by half a log or a factor of approximately three up or down. The measurement of the viral load is described in copies per millilitre. An average viral load in an untreated person is 50,000 to 75,000 copies per millilitre. Dr. Shafran estimates only five percent of untreated HIV-positive persons would have a viral load of less than 1,500 copies per millilitre.

There have been a number of adjectives used to describe viral loads of an individual person. One of the problems of using various adjectives to describe viral loads or risk is that, if they are not defined with precision, they can become subjective and mean different things to different persons. Dr. Shafran believes that categories or

thresholds of viral loads as they relate to risk of transmission should now be as follows: (1) undetectable - less than 40 or 50 copies per millilitre, depending on the lab; (2) suppressed - less than 200 copies per millilitre; (3) threshold for transmissible - more than 1,500 copies per millilitre.

In Dr. Shafran's opinion, although it may be impossible to say with absolute certainty, the fact that remains that there has never been a documented case of transmission at a level less than 200 copies per millilitre and he puts the risk of transmission as zero for a viral load less than 200 copies per millilitre. Dr. Shafran believes 1,500 copies per millilitre is the relevant public health threshold for when the disease is transmissible. This categorization leaves a gap of those cases between 200 and 1,500 copies per millilitre, which is of course the critical level in this case. Dr. Shafran used a number of adjectives to describe potential transmission when the infected partner has a non-suppressed level of HIV between 200 and 1,500 copies per millilitre. He described the risk as "negligible to none." Negligible, to Dr. Shafran, is a risk that is so low it is not clinically meaningful. He testified transmission with a level between 200 and 1,500 copies per millilitre would be "extremely rare event."

Dr. Shafran did not feel comfortable assigning a

specific percentage to the risk in the case at bar. He said it is extremely difficult to give robust probabilities of events that are so incredibly rare. He opined that the risk would be less than 1 in 10,000, and it may be way less than that, but he could not confidently express it in percentage terms. He did testify the risk of transmission with anal sex is significantly higher than vaginal penile sex.

Dr. Shafran's expert opinion on the risk of transmission with viral loads of less than 1,500 copies relies on his review of the literature. Dr. Shafran could find four documented cases in the literature with transmission believed to be at levels less than 1,500 copies and one of these was at 1,479 copies.

Thomas Quinn of Johns Hopkins University conducted a study in Uganda and showed there was a correlation between viral load and transmission, and in that study did not identify a single case of HIV transmission occurring with a viral load of less than 1,500 copies in the infected partner.

Another study referenced by Dr. Shafran found that 1 of 39 persons who may have contracted HIV from an infected person with a viral load between 1,000 and 9,999 copies per millilitre.

A further study in Thailand of 493 heterosexual

couples in which there were 218 transmissions found one transmission of a viral load believed to be below 1,500, and that viral load was 1,094.

A further study in Brazil in 2008 found that 1 out of 52 people had been infected as a result of sex with an infected person who had a viral load less than 1,500, and that level was believed to be 1,479.

There are no large-scale studies on the risk of transmission, nor are there likely to be any done in the future.

I interrupt this review of the evidence to note that, in my opinion, there are many weaknesses in the studies available. They are all small samples and the results could be distorted. Viral loads fluctuate within an individual by a factor of three and it is impossible to know the actual viral load at the time of transmission. Furthermore, we do not know the actual sexual acts carried out, or their frequency, with clear accuracy, and it is, of course, possible the couples may not have been faithful during the study period.

Dr. Shafran testified there have been a number of recent papers, more or less commencing in 2015, with a paper written by Gary Marks of the Centre for Disease Control that proposed 1,500 copies per millilitre is the threshold for transmission.

In cross-examination, Dr. Shafran testified that risk of transmission generally, when not controlled for viral load, is 1.38 percent per act of anal sex when the insertive partner is infected with HIV. For vaginal sex, the risk would be 0.8 percent when the insertive partner is infected. Furthermore, the risk is independent for each sexual activity and thus increases when there are increased sexual acts. These percentages are not adjusted by viral load but for the population at large. The average risk would be higher at higher viral loads and lower as the viral load decreases.

In cross-examination, Dr. Shafran put in context the fact that there are only four documented cases where transmission is believed to have occurred with viral loads of less than 1,500 copies by acknowledging the number of transmissions with a known viral load is also low, although he did not testify to the total number. Furthermore, although there were only four documented cases of transmission with viral load believed to be less than 1,500 copies per millilitre, the doctor is sure there have been more but it is hard to know how many.

Mr. V[redacted]'s viral load was measured to be 1,300 copies as of October 11th, 2017 when blood was taken. It was measured to be 2,324 copies per millilitre on November 8, 2017 when blood was taken. According to Dr. Shafran, on October 10

and 13, the days of the sexual acts in question, Mr. V[redacted]'s load could have been as low as 425 copies per millilitre or as high as 3,900 copies per millilitre. He testified the difference between 1,300 copies per millilitre and 1,500 copies per millilitre is a trivial difference and not biologically meaningful.

The use of language to describe the various thresholds of transmission has not been consistent or done with precision in the literature. In fact, in one of Dr. Shafran's own publications, as recently as 2017, the categories were described as follows: (1) viral load less than 40 copies - risk negligible to none; (2) viral load less than 40 copies but concomitant sexually transmitted infection - present risk but not zero; (3) viral load more than 40 copies per millilitre - risk substantial.

Dr. Shafran testified that this was an error in the publication and the last category should have been more than 200 copies, not more than 40; however, even allowing for the fact that the levels should have been expressed as 200 copies and not 40, the description of the risk above 200 as substantial appears at odds with his testimony that 1,500, not 200, is the threshold for transmission. From a clinical perspective, if Dr. Shafran was a treating physician for Mr. V[redacted] and knew his viral load was 1,300 copies per millilitre, he would have advised Mr. V[redacted]

that he is fortunate his viral load is low and that his risk of transmission is extremely low but he should still either not have sex or only have sex with condoms until such time as his viral load was suppressed.

My factual findings: Mr. V[redacted] engaged in both unprotected anal and vaginal penetrative sex and the anal sex is the highest risk for transmission. Risk of transmission increases when the viral load increases. HIV is not transmissible when the viral load is below 200 copies per millilitre. HIV is definitely considered transmissible at viral loads of 1,500 copies per millilitre or higher. Some risk is considered to exist at a viral load between 200 and 1,500 copies per millilitre. The extent of that risk is not known with any scientific precision. In percentage terms, it may be 1 in 10,000, it may be much less than 1 in 10,000, or, in fact, it may be somewhat more than 1 in 10,000. On the evidence before me, I cannot make a reliable finding of the statistical risk of transmission when unprotected sex occurs with an infected partner who has a viral load of less than 1,500 copies per millilitre. If Mr. V[redacted]'s viral load was in excess of 1,500 copies per millilitre, then the HIV virus is considered transmittable by unprotected vaginal or anal sex.

Mr. V[redacted]'s viral load was determined to be

1,300 copies per millilitre on October 11th, 2017. It is impossible to know his exact viral load on October 10 or October 13 when the sexual activity took place. On October 10 and 13, the days of the sexual acts in question, Mr. V[redacted]'s viral load could have been as low as 425 copies per millilitre or as high as 3,900 copies per millilitre on the evidence before me.

The legal test: in a sexual assault trial, the Crown is required to prove the accused intentionally applied force to the complainant, the complainant did not consent to the force applied, and the force was applied in circumstances of a sexual nature. There is no issue in this case that force was intentionally applied and it was in circumstances of a sexual nature. The issue is if the Crown has proven non-consent by K.F. It is agreed that K.F. agreed to participate in the sexual activity and, in that sense, consented. However, what would otherwise amount to consent can be vitiated in certain circumstance. The relevant circumstance in this case is that consent can be vitiated by fraud; however, not every deceitful or dishonest act will vitiate consent in circumstances of sexual activity.

In a case where the complainant otherwise consented and the deceit relates to the accused's HIV status, to vitiate consent, the Supreme Court of Canada in *R. v. Mabior* placed the burden upon

the Crown to prove beyond a reasonable doubt the following: (1) the accused was HIV-positive; (2) the accused did not disclose his or her status as HIV-positive; that the complainant's consent to the sexual activity was vitiated by fraud; failing to disclose HIV-positive status amounts to fraud when the complainant would not have consented had they known the accused was HIV-positive; and the sexual contact between the complainant and the accused created a realistic possibility of transmission of HIV.

In *R. v. Felix*, 2013 ONCA 415, our Court of Appeal at paragraph 57 set out what would amount to a *prima facie* case and when an evidential or tactical burden would shift to the accused:

> It follows, in my opinion, that once it was established in this case that: (1) the appellant was HIV-positive; (2) the appellant did not disclose his HIV-positive status prior to intercourse with the [complainants]; (3) the complainants would not have engaged in sexual activity with the appellant had they known of his HIV-positive status, and (4) the appellant failed to use a condom on the relevant occasions of intercourse, the Crown had established a *prima facie* case of a realistic possibility of HIV transmission.

In these circumstances, the evidential or tactical burden then shifts to the accused to

negate the *prima facie* case.

Analysis: the Crown has proven beyond a reasonable doubt that: (1) the accused was HIV-positive on October 10 and October 13, 2017; (2) the accused knew he was HIV-positive; (3) he knew and understood from medical advice that any oral, anal, or vaginal sex must be avoided until he was on the HIV medication, and even once on that medication, he would have to use a condom as there was a risk of transmission; (4) that the accused did not disclose his status as HIV-positive, in fact, he explicitly denied it, knowing he was positive; (5) Mr. V[redacted] and K.F. engaged in oral, vaginal, and anal sex without a condom and without having commenced treatment for HIV on October 10 and October 13; (6) the complainant would not have consented had she known the accused was HIV-positive.

Remaining issue: thus, the only issue left to determine is for the Crown to prove the complainant's consent is vitiated is if the Crown has proven beyond a reasonable doubt that the sexual contact between the complainant and Mr. V[redacted] created a realistic possibility of transmission of HIV.

The Crown's evidence established a *prima facie* case. In this case, the evidential or tactical burden shifted to the accused to negate the *prima facie* case. The question then is: does the

expert evidence of Dr. Shafran, when considered in the context of all of the evidence, negate the *prima facie* case and leave me with a reasonable doubt?

The Crown is not required to prove specific pieces of evidence beyond a reasonable doubt, but rather is only required to prove the essential elements of the offence beyond a reasonable doubt; however, specific pieces of evidence can sometimes become of increased importance in determining if the essential elements are proven. On the evidence, I am left with more than a reasonable doubt that Mr. V[redacted]'s viral load at the time of the sexual acts was less than 1,500 copies per millilitre. The requirement of the Crown is not to prove a specific viral load but rather if there was a realistic possibility of transmission of HIV as that term is used in a criminal prosecution when the Crown is seeking to vitiate the complainant's consent.

The Supreme Court of Canada has made clear that it is not any risk, no matter how small, and there is no onus on the accused to show zero risk; rather, the onus is on the Crown to prove beyond a reasonable doubt a realistic possibility of transmission. On the evidence in this case, some risk of transmission is considered to exist at a viral load between 200 and 1,500 copies per millilitre. The extent of that risk is not known with any scientific precision. In percentage

terms, it made be 1 in 10,000, it may be much less than 1 in 10,000, or, in fact, it may be somewhat more than 1 in 10,000. On the evidence before me, I cannot make any reliable findings of statistical risk of transmission when unprotected sex occurs with an infected partner who has a viral load of less than 1,500 copies per millilitre.

I am directed by the Supreme Court of Canada to consider if the Crown has proven beyond a reasonable doubt that there was a realistic possibility of transmission. What is a realistic possibility in the context of this type of criminal proceeding and is there a proven risk in this case that amounts to such a realistic possibility?

In *Mabior*, the Supreme Court of Canada considered the issue of what would be a significant risk when discussing the earlier case of *R. v. Cuerrier*. The Supreme Court expressed concern about defining a legal concept of significant risk in a known statistical percentage and said as follows: courts across the country are faced with the same problem the *Cuerrier* test posed. In *Cuerrier*, the debate surrounding what significant risk means was premised on statistical premises. That's from *Mabior* at paragraph 16.

> Is a 1% risk "significant"? Or should it be

> 10% or 51% or, indeed, .01%? How is a prosecutor to know or a judge decide? And if prosecutors, defence counsel and judges debate the point, how — one may ask — is the ordinary Canadian citizen to know? This uncertainty is compounded by the fact that a host of variables may affect the actual risk of infection.

Quotes also from *Mabior* at paragraph 16.

Later in *Mabior*, the Court said:

> What emerges is a complex calculus that makes it impossible, in many cases, to predict in advance whether a particular act is criminal under s. [273.1 of the *Criminal Code*].

Although the language in *Cuerrier* shifted from "significant risk" to a realistic possibility of transmission in *Mabior*, the same criticism applies to some extent. Is a 0.01 percent risk of transmission realistic? Is a 0.001 chance of transmission a realistic possibility? How is the prosecutor to know or a judge to decide?

Although the viral load is the most important factor to determine the risk of transmission, there are a number of factors apart from the viral load that affect the risk. These include, but are not limited to, the nature of the sexual activity, if a condom is used, if there was

ejaculation, and if there was bleeding.

Mr. V[redacted] engaged in the highest risk activity. He engaged in anal sex without a condom, he ejaculated, and some bleeding occurred, all at a time when he had been told by a medical professional not to engage in sexual activity; however, I still need to determine if this risk amounted to a realistic possibility as that term was used by the Supreme Court of Canada.

The evidence before me is that the viral load of the infected person is the most important factor in determining if there is a realistic possibility of transmission. While the comments in other cases may be instructive in interpreting the legal meaning of a realistic possibility, with respect to the facts, this case must be determined on the evidence before me. The evidence before me was the higher the viral load, the higher the risk of infecting the complainant. This is intuitively sensible and similar evidence existed in *R. v. Boone*, paragraph 119.

The *Mabior* court held that 1,500 copies per millilitre of plasma was considered a low viral load; however, science, indeed, advances rapidly and the Supreme Court of Canada allowed for this, suggesting that advancing expert evidence may assist the trier of fact in future cases in determining what is a realistic possibility of transmission. In *Mabior*, the Supreme Court of

Canada provided guidance on what was not a realistic possibility. The Court held that no realistic possibility of transmission is established when an accused has a low viral load and also wears a condom. See *Mabior* at paragraph 108. However, the Court then added this general proposition, "does not preclude the common law from adapting to future advances in treatment and to circumstances where risk factors other than [low viral load and condom use are relevant]."

The acknowledgment that science has progressed since *Mabior* was decided is perhaps best exhibited by the Minister of Justice's directive to federal prosecutors that was issued in 2018. The purported objective of the directive is to harmonize prosecution practices with scientific evidence and risk of sexual transmission of HIV, and since science evolves over time, the directive reflects recent scientific advances related to the risk of sexual transmission of HIV. The directive states that the Attorney General of Canada:

- shall not prosecute where the person living with HIV has maintained a suppressed viral load (i.e. under 200 copies of the virus per millilitre of blood) because there is no realistic possibility of transmission;

- shall generally not prosecute where the

person has not maintained a suppressed viral load but used condoms [...] because there is [...] no realistic possibility of transmission [....];

- shall generally not prosecute whether the person [...] engaged only in oral sex [...] because there is [...] no realistic possibility of transmission [....];

- shall generally not prosecute [when the person with HIV status] [...] was taking treatment as prescribed unless other risk factors are present, because there is [...] no realistic possibility of transmission [....];

- shall prosecute using non-sexual criminal offences instead of sexual offences where this would better align with the individual's situation [....]; and

- [shall] take into account whether a person living with HIV has sought or received services from public health authorities [....]

Science has advanced. Today with the evidence existed on the three counts that the Supreme Court of Canada entered convictions on with respect to Mr. Mabior, those matters would not be

prosecuted or acquittals would result; however, it must be acknowledged that the fact situation before the Court does not fall within the fact situations in which prosecutions are either not to or generally not to take place pursuant to the Minister of Justice's federal directive. In the case at bar, it is still necessary for the Court to determine if the Crown has proven a realistic possibility of transmission.

The Supreme Court did not express a realistic possibility of transmission in terms of a percentage risk; however, inferentially, the evidence in the *Mabior* case was that the risk of unprotected vaginal intercourse was in the range of 1 in 1,250 and it would decrease by approximately 90 percent if the infected person had a low viral load and a further 90 percent if a condom was used. At the time of the case, the Supreme Court of Canada required both condom use and a low viral load to conclude there was no realistic possibility of transmission. One might infer, therefore, that a risk of 1 in 10,000 was in the opinion of the Supreme Court a realistic possibility; however, the Court never provided an objective arithmetic percentage, and in my opinion, the case was clearly decided as a compromised decision on policy grounds. See Stuart, initial D, "Vagueness, Inconsistency and Less Respect" (2013), 63 S.C.L.R. (2d) 441 at page 443.

For example, I note, if the sex act was repeated ten times, the risk of transmission with both a condom and low viral load would exceed the risk if it was a single act with only either a condom or a low viral load. Nevertheless, the test as set out by the Supreme Court of Canada would mandate an acquittal in the former case and a conviction in the latter, despite the fact the risk in the latter would be lower.

There is very little authority that assists in defining realistic possibility with objective mathematical criteria so that it is not merely subjective. Risks in the range of 1 in 1,000 remain realistic risks for the purpose of determining when non-disclosure of HIV status vitiates consent to sexual activity. See *R. v. Boone* at paragraph 130.

Clearly, accused persons are under duty to disclose HIV-positive status to the complainant before engaging in sexual activity that poses a realistic possibility of transmission of HIV. That is from *Mabior* at paragraph 104.

The burden rests on the Crown to show that the complainant's consent to sexual activity was vitiated by the accused's fraud as to his HIV status. Risks in the range of 1 in 1,000 remain realistic risks for the purpose of determining when non-disclosure of HIV status vitiates consent to sexual activity.

Non-disclosure of HIV-positive status criminalizes not the consequence of the act but the risk. Consequence may become relevant, however, when assessing a realistic possibility of transmission. See *R. v. Boone*, paragraph 129.

The greater the potential harm, the less of the likelihood needed to satisfy the realistic possibility of the transmission requirement. Again, from *Boone*, paragraph 139.

All of that to say, what was the risk on the evidence in this case?

On the evidence before me, I am left with a reasonable doubt that the risk was exceedingly small. I cannot say how small. I do not accept Dr. Shafran's evidence allows me to conclude that the risk was 1 in 10,000, or even much lower than that; however, equally, the Crown has not proven beyond a reasonable doubt that the risk was higher than that. I am left in reasonable doubt as to what the risk was. It was, however, clearly a very low risk. While the risk is almost certainly too high for the complainant or a prospective partner, and is certainly a risk that is not recommended to take by medical professionals, the Supreme Court of Canada did not set the level of risk for a criminal prosecution at anything above zero or at a risk acceptable to the complainant. Some persons would argue that consent should be said to be

vitiated unless the risk is zero when it was obtained by deceit or that it should be the uninfected partner who determines if they wish to consent with knowledge of the circumstances; however, I am required to apply the law as set out by the Supreme Court of Canada which requires the Crown to prove beyond a reasonable doubt a realistic possibility of transmission, not merely a risk of transmission.

In this case, although I do not accept all of Dr. Shafran's opinions, I do accept that the risk was very low. I have to decide this case on the evidence before me and the Crown has called no expert evidence. I cannot accept Dr. Shafran's evidence of the statistical risk; however, I am unable to reject it and make an affirmative conclusion otherwise.

I am not an expert. The Crown has not called expert evidence. It is not my function in the absence of evidence to, in effect, become an expert myself and make a positive finding of risk contrary to Dr. Shafran's opinion, which I am unable to completely reject.

I am left in a reasonable doubt that the risk was exceedingly low and that it could be described as negligible.

In any criminal case, the potential decisions with respect to realistic possibility of

transmission are: (1) the Court could find that a realistic possibility of transmission was proven beyond a reasonable doubt; (2) that there was no realistic possibility of transmission; or (3) given the state of evidence, the Court is left in reasonable doubt if a realistic possibility was proven to exist.

In considering all of the evidence, and the lack of any expert evidence called by the Crown, this case falls in the third category; that is, I am left in reasonable doubt if a realistic possibility of transmission was proven to exist.

In coming to this conclusion, I wish to make clear that I am not saying it is acceptable from a criminal law perspective that Mr. V[redacted], or indeed anyone else with an untreated viral load lower than 1,500 copies, can have unprotected sex with a non-infected partner and be deceitful about their condition and not be potentially liable to a criminal prosecution and conviction. In another case, the evidence might be different and the Court might be able to conclude beyond a reasonable doubt there is a realistic possibility of transmission. Furthermore, the fact that this prosecution for sexual assault was unable to establish beyond a reasonable doubt a realistic risk of transmission does not in any way reduce Mr. V[redacted]'s moral blameworthiness. He should not have done what he did and his actions were morally reprehensible, particularly now that

effective treatment is available, and with the new guidelines for the prosecution of these types of offences, any prejudice or limitation on infected persons right to engage in consensual sexual acts has been substantially alleviated and no reasonable person should engage in unprotected sex when they are HIV-positive until they have commenced treatment and obtained a suppressed viral load; however, I am required to apply the law as set out by the Supreme Court of Canada.

On all of the evidence, I am left with a reasonable doubt if there was a realistic possibility of transmission. This is an essential element the Crown must prove beyond a reasonable doubt to vitiate what would otherwise be consent in this case. Accordingly, I am left with a reasonable doubt if the Crown has proven the essential element and I am required to find Mr. V[redacted] not guilty.

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Certification

FORM 2

CERTIFICATE OF TRANSCRIPT (SUBSECTION 5(2))

Evidence Act

I, Cassandra Colbert, certify that this document is a true and accurate transcription of the recording of *R. v.* W[redacted] V[redacted] in the Ontario Court of Justice held November 22, 2019, at 161 Elgin Street, Ottawa, Ontario taken from Recording(s) No. 0411_CR07_20191122_084729__6_BOXALLN.dcr, courtroom 7, which has been certified in Form 1 by A. Sebesta.

December 4/19
(Date)

Cassandra D. Colbert

*This certification does not apply to the Reasons for Judgment, which was judicially edited.