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- **Thanks for having me today! This is my first law and society event, and I'm relatively new to this field in an academic sense, so thanks for having me!**
- **Before I start I want to thank CIHR & Concordia for supporting my work, and to my supervisors, Dr. Viviane Namaste, Dr. Martin French and Dr. Amy Swiffen, especially Amy for encouraging us to participate in this today!**
- **I'm going to start by presenting two case narratives that are comprised through media reports, police press releases, court documents, and bulletin boards from sex offender watch and nightclub information websites.**

First Case

In 2004, a Hamilton nurse visited a 26-year old white HIV-positive woman (who I will call R.C.) from her local public health unit. The nurse was delivering a legal order to a under provincial public health law requiring R.C. to disclose her HIV-positive status to all future sex partners - R.C., a single mother, had tested HIV-positive a year earlier. Upon being served the legal order, the nurse counselled R.C. on the conditions with which she was to adhere. Three years later in 2007, Toronto Police Services arrested R.C. for not being compliant with the order. The police had received information from a concerned individual who claimed to have had sex with R.C. and that she had not told him that she had HIV.

Upon her arrest in 2007, Toronto Police Services stated that they used R.C.'s non-compliance with the past public health legal order as a rationale to release her photograph

as a 'public safety warning' to the media and community during a press conference – releasing her photo, which the police noted was an "unusual" step, but that R.C. presented a "huge threat" to public safety. After her arrest, R.C. was released, but given a curfew of 11:00p.m. to 7:00a.m. She was known to frequent nightclubs and bars around the city, so this curfew was intended to prevent this.

As a result, numerous Internet bulletin boards and discussion forums lit up with posts of the photo and information about the case under headings such as: "*Beware of HIV+ female rapist*", "*Girl with HIV having unprotected sex with clubbers*", "*Lock this whore up*", and "*Broad has the HIV*". Before the trial it was noted by one media outlet that during a trip to public pool with her toddler, other pool goers recognized R.C. from a newspaper cover. As a result, she was publically ridiculed and kicked out of the pool.

The trial of R.C. ended in 2009, where she pled guilty to one charge of sexual assault under Canada's Criminal Code. R.C. was sentenced to two-years house arrest, three-years probation, and labelled as a sex offender for life. Her crime: having sex with a condom (the condom broke) and not abiding by the requirements of the 2004 public health order.

R.C.'s sexual assault charge was related to two sex acts she had with the same man. She had met this man at a party in 2007 and they two had intercourse with a condom. At a later date, they had sex again, this time the condom broke, and at that time she told the man her HIV-positive status. The man went to the police based on the encounter, at which time she was arrested. While R.C.'s privacy was widely breached in the interests

of 'public safety', the man and others in the case where protected under a publication ban protecting his identity. The man in question was not infected with HIV, although the judge mobilized the trial testimony of his fear and anxiety of being potentially infected during R.C.'s sentencing hearing.

During a media interview at the time of the press conference on her case R.C. said: "nobody understands what my life is like" and that she did not tell the man right away about her HIV-positive status because she "got scared". It was also noted that R.C.'s lawyer indicated during her trial that she was only semi-literate and was a "simple" woman of little means.

Second Case

In 2011, there was a new development in one of the most well known cases of HIV non-disclosure in the country. The 'offender', a then 57-year old Ugandan-born man (J.A.) was convicted in 2009 of two counts of first degree murder, ten counts of aggravated sexual assault, and one count of attempted aggravated sexual assault. There were eleven women who the Crown presented as sex partners of J.A.'s, to whom it was claimed that he had not disclosed his HIV-positive status. Seven of these women acquired HIV (although there was no scientific evidence proving they acquired HIV from J.A.). Two of the women died of AIDS-related cancers. Their deaths were attributed to the fault of J.A., not as a failure of the healthcare system to identify, treat and support women with HIV. J.A. was sentenced to life imprisonment with no possibility of parole for 25 years. With J.A., negative media portrayals of him focused on his sex drive, his blackness, and the

fact that most of the women were white – with his picture above headlines such as "*HIV Killer –Has High Libido - Threat to Reoffend*".

In 2011, the Crown decided to peruse the exceptional case of having J.A. labelled as a 'dangerous offender'. While public health orders had figured prominently throughout his case, they were mobilized as evidence against him in this new hearing. J.A. was already going to be incarcerated for a long-time due to his convictions, the Crown was concerned that he may still be able to access parole at a future date. In the hearing to have him held indefinitely, the Crown had to argue that J.A.'s past behaviour posed a future threat to public safety. What they used to do this was J.A.'s engagement with public health, and the public health order under he was issued in 2002. At the time, J.A. had not been compliant with the order, which required that he disclose his status to all sex partners, use a condom for penetrative sex, and provide public health nurses with of names and contacts of all of his sex partners. This was brought forward by the Crown prosecution as evidence by the expert psychiatric witness, specifically, Dr. Klassen, the forensic psychiatrist who examined J.A. before the hearing used J.A.'s past non-compliance with the public health order to state that he "presents a substantial risk to the community" but Kalssen was unable to state what the 'likelihood' of this risk occurring because of the uniqueness of the case (Ontario Superior Court of Justice, pg. 30). Dr. Klassen noted that he did not have any relevant actuarial risk analysis tools to assist in his diagnosis, as J.A. was a different kind of sex offender on which there was not enough data.

J.A.'s lawyers argued that the mandated counselling he received as a result of the Section 22 order was inadequate, not culturally appropriate. J.A. had also experienced a great deal of HIV-related stigma and did not know how to talk about sex or HIV with women due to his very religious background. In Uganda, where he was raised, there was no education on sex, sexual health or sexuality. J.A. stated that he was a man of "conscious" and that he believed that the verdict from his previous trial had been racist and driven by AIDS-phobia, and as a consequence of how much negative media attention his trail had garnered that he would never have to disclose to another person again due to his personal life being now so public.

The judge ruled in favour of the Crown citing primarily Klassen's expert testimony. As of 2011, J.A. was the first dangerous offender in relation to HIV non-disclosure.

Brief analysis

In the R.C. and J.A. cases (two of many unique, but increasing cases I could elaborate on), we can see the overlapping and intertwining of the two different legal instruments: the ***Ontario Health Promotion and Protection Act (HPPA)*** and the ***Criminal Code*** – and the various practices that comprise both. These two instruments operate with different logics, at different jurisdictional levels, and through this interlegality make possible the **justification for exceptional measures** against people living with HIV, exceptional measures that may not have come to be realized through one of the legal systems being enacted alone.

The heath risk knowledge that is mobilized becomes obscured, reified and transformed through ideological fears about infectious disease. Today – when treated most people with HIV become no longer infectious to others, and can live long healthy lives. In these cases, the institutional marking of both recalcitrant public health risk, *and* criminal actor come to constitute an unique threat to conceptual notions of public safety, and here results in intensified punitive material consequences for the individual, including heightened forms of surveillance, suspension of rights, discipline and forms of detention. What also takes place, which is outside of these different jurisdictional authorities, is the enactment of forms of out-sourced and informal community policing - or the dispersion of monitoring and surveillance to the public – facilitated through media reports and online networks.

With this micro examination, the concept of **interlegality** is useful for analysis. The concept as developed by Boaventura de Sousa Santo can help elaborate the ongoing productive interaction and cross-over of heterogeneous legal systems, ones operating at different jurisdictional levels, with different governing logics and rationalities (sometimes complementary, or contradictory), which can have, in their integrated effects, outcomes that would not be possible through one of the legal systems working alone.

In terms of interlegality for these 2 legal tools, there is no generalized rule that could be asserted about how public health orders come to be enacted, or why charges under criminal code jurisdiction are also enacted in some cases and not in others. In general terms, public health law, (under provincial jurisdiction) can be regarded as what should

be the entry point legal instrument for epidemic control. With the increase of coercive elements being ramped up as scales of "risk" increase – and the criminal law (at federal level, but administered municipally and provincially) being mobilized as a last resort. In practice one can't say for certain what actually happens, one of the laws is not deterministic of the other – for example, some people have received public health orders when already incarcerated.

In talking about interlegality in this case, my focus is ***not*** a doctrinal examination of the actual text written in legal documents that are aimed at different jurisdictional scales and how they may overlap, or compete or contradict one another: rather – I am looking at what social processes, forms of knowledge are activated, who is involved and what practices take place when the doctrine of legal instruments is activated, or what practices predicate the enactment of legal processes and **how** people become constituted as criminal and public health risks through forms of institutional and expert knowledge.

I'm in student at the Interdisciplinary Centre for the Study of Society and Culture, and as such my inquiry traverses traditional institutional boundaries, and is situated within what Timmermans and Gabe (2003) have coined as the '*medico-legal borderland'* – a analytical space conceptualized to assist in an intersectional sociological analysis of criminality and health and illness - where we can examine how the 'sick', 'infectious' and the 'criminal' are classified and re-classified in relational contexts across a range of institutions, and can thus be deemed in need of care, control, retribution, containment, inclusion or exclusion.

History & Context

Under Section 22 of the *Ontario Health Promotion and Protection Act (HPPA)* it states that the Medical Officer of Health who oversees a specific a Health Unit (there are 36 Health Units across the province) can issue a written order requiring a person living within the bounds of that health unit who is labelled as **'unwilling' or 'unable'** to take or to refrain from taking any action that is indicated in the order in respect of a communicable disease who presents a potential risk of transmission to the public. The orders are often delivered in person by a public health nurse who also provides a form of counselling around the contents of the order. A person who receives such an order has 15 days to request a hearing at the *Health Protection Appeal Board (HPAB)* for contestation. Orders can mandate attendance to counselling about disclosure and HIV prevention, to have sex with condoms, to restrict penetrative sex, and to reveal the names of sex partners with public health authorities. All Section 22 orders are enforced with a $5,000 a day fine for failure to comply.

Dawn Moore's notion of Therapeutic Surveillance is helpful in this context – Moore's analysis elaborates how ***care*** and ***control*** are often positioned as dichotomous in surveillance studies, but within certain cases and institutional practices these two can join to become one – in this the case, forms of personal health counselling along with coercive behaviour regulations act to normalize the abnormal, and render neutral the infectious (Moore, 2011).

Under this same Act, there are also allowances for the Medical Officer of Health to make an application to a judge of the Ontario Court of Justice for the quarantine of people with classified 'virulent' communicable diseases who are not following orders to prevent transmission. In 1990 Ontario's Chief Medical Officer of Health Dr. Richard Schabas made a public call for the quarantine of people living with HIV in the media and also recommended to the Minister of Health that HIV be reclassified as virulent. There was a large activist reaction countering Schabas' call, which resulted in the largest rally to-date organized by the direct-action activist group AIDS ACTION NOW! The rally had over 500 demonstrators who marched on the provincial legislature at Queen's Park demanding Schabas' resignation (Silversides, pg. 219). HIV was not reclassified. Schabas later moved to a rural health unit, where he still works as the Medical Officer of Health.

But Schabas' call was not out of line with the historical trajectory of the Ontario's public health project, which is known for an alignment more towards public safety aims, than the protection of individual rights, using mandatory nominal reporting of communicable diseases and contact-tracing – contentious practices for some public health practitioners due to their suspension of rights to privacy.

In relation to the criminal code and HIV non-disclosure:

With upwards of 155 criminal cases related to people with HIV not telling sex partners their status cases in this area have been swiftly on the rise and Canada is now known as a world leader in criminalizing such cases. The 2012 Mabior and D.C. Supreme Court decisions outline that people are required to tell a partner they have HIV before they

engage in sex that poses a 'realistic possibility' of transmission. This legal test requires disclosure for vaginal intercourse unless sex a condom is used and the person with HIV has a low viral load. A majority of those are charged with aggravated sexual assault, one of the most severe charges in the criminal code. HIV does not have to be transmitted for a prosecution to occur. High conviction rates and high rates of incarceration upon conviction serve to distinguish HIV non-disclosure from other (aggravated) sexual-assault offences. A large majority of those prosecuted face long sentences, are registered as sex offenders provincially and federally. Eric Mykhalovskiy and Glenn Betteridge have noted that the increase in charges and prosecutions of this type are aligned with the 'tough on crime' policy turn at a Federal level.

My research

The focus of my doctoral research is on examining the disjuncture that exists between the lives of people living with HIV and how they come to be known, defined, classified, and understood through a range of diverse forms of authoritative and expert forms of knowledge and the intertwining practices and processes of various institutions and actors.

With my initial discussion of R.C. and J.A. I am aware that I am talking about specific people who live with HIV in the world and I do not speak for these people – I am aware of the narratives constructed are based on the ways in which legal documents and media reports construct histories, histories in the service of a logic at odds with the lives of people living with HIV. But through piecing together media reports, and juridical documents we can come to understand how aspects of the cases of R.C. and J.A. are

taken up socially and institutionally constructed discursively as **cases** and thus come to known in the world as risks in need of care and control. With this, I am hoping to step beyond the dichotomous narratives provided through legal discourse – where I am not interested in presenting "innocent" subjects in contrast to the "guilty" mark of institutions. Rather, I want to understand the materiality of being marked as a criminal and a risk to public safety.

One consequence the label of **criminal that gets applied to individuals**, is that what in the past were contentious public health practices, such as that of quarantine, are now justified, public health quarantine becomes house arrest, or indefinite detention. While the material consequences are similar, confined space for a specific duration of time as a risk management strategy - the practice happens within a different jurisdiction, but through mobilizing knowledge from the other.

Another reason, why it is important to understand why laws come to be intertwined is that this analysis helps intervene in commonly held ways of understanding "the law". In ***the fast growing body of literature on HIV criminalization***, public health legislation itself is rarely accounted. When it is talked about, public health law can be presented as a distinct option to abate the overuse of the criminal law. In some cases certain activists, policy-makers and academics call for HIV exposure, non-disclosure and transmission to be legally responded with solely under the jurisdiction of public health legislation. Through examining the interplay of heterogeneous legal formations– **we can reveal the complexity of forms of governance at play and can challenge the**

assumption that public health institutions, policing and criminal law institutions act distinctly from one another, and that they operate using different forms of distinct knowledge.

Some critics of criminal law application towards cases such as R.C. and J.A. say that it is an overly simplistic system, based on the binary of innocent and guilty, which obscures power relations and is ill equipped to deal with complex social issues such as HIV prevention, care and support. But appealing to public health law as an alternative, which can enacted the same force, may not be the answer. It can also obscure how the practices of public health professionals can support criminal law cases. Thus, instead of appealing to one formation of law over another, an attention to the practices of detention, exclusion, coercion, and incapacitation are what is needed.

Thank you!