TORT LAW'S ROLE IN PREVENTING PRISONERS' EXPOSURE TO HIV INFECTION WHILE IN HER MAJESTY'S CUSTODY*

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[This paper discusses the role that the tort of negligence can play in preventing the spread of HIV/AIDS in prisons. Needle exchange programmes, syringe cleaning materials and condoms are accepted in the community as necessary measures to prevent the spread of HIV/AIDS but are not available while in Her Majesty's custody. Injection drug users, gay men and lesbians, and prisoners, are among the most marginalised and disadvantaged members in the community. Due to the conduct and choices of most states' governments and prison administrators these people are also the most at risk of contracting HIV/AIDS. After providing a background to the problem of HIV infection while in prison, this paper considers traditional legal approaches to the problem before a discussion of an hypothetical negligence action. The recognition of a legally cognisable duty of care in such an action does not merely provide the basis of an action for breach of that duty; it provides a framework within which the traditional hysteria and political unpopularity associated with openly confronting these issues may be reconstituted as a legitimate legal and political position. It is this educative function of tort as 'ombudsman', establishing community standards, that may ultimately translate one prisoner's injury into institutional reform.]

I THE PROBLEM (AND THE NEED FOR A REMEDY)

Australian prisons detain gay and bisexual men, some of whom have unprotected intercourse with one another. Some men who identify as straight (or heterosexual) may also engage in unprotected sexual activities with males. Australian prisons also detain women and men who, while incarcerated, inject illegal drugs using unclean needles. Lesbian sexual activities, involving the exchange of body fluids, also takes place. All of these individuals run the risk of contracting the HIV virus and suffering complications from AIDS.[1]

* I would like to thank the following for their assistance: Peter Morrissey, Garrie Moloney, Di Crawford, the Australian Research Council, Stuart Ross of the Policy and Planning Unit of the Office of Corrections, the Aboriginal Legal Service of New South Wales and Dr Ralf Jürgens, Project Coordinator of the Canadian HIV/AIDS Legal Network/Canadian AIDS Society joint legal project. I would like to thank Simon Chesterman in particular, for his invaluable work as research assistant and contributions in writing some segments of this paper. Finally, I would like to express my appreciation to many of the participants at Canada's first national HIV/AIDS and Prisons conference (held in Kingston in August 1995); I am indebted to them for sharing their insight, experiences and unique perspectives in our discussion of difficult — and, for many people, painful — issues concerning HIV/AIDS and prisons.

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1 John Godwin, Julie Hamblin, David Patterson and David Buchanan, *Australian HIV/AIDS Legal Guide* (2nd ed, 1993) 263. Watson states:

> By far the largest number of AIDS cases in Australia have been in homosexual men (87% — three percent of whom were also injecting drug users), the next largest group (4%) being those who received infected blood or blood products before mid-1985. Injecting drug users who were not homosexual males (2%), those exposed to heterosexual risk (3%) and 'other' (3%) make up the remainder of the cases. Among those with a positive HIV antibody test, the great

A *Seroprevalence in Gaol*

Because the prevalence of HIV infection in prisons is difficult to assess with precision, attempts to do so are somewhat speculative in nature. One reported figure suggests that between zero and 2.9% of prisoners detained in Australian prisons are HIV positive.[2] Dolan states:

> A low prevalence of HIV infection has been reported in Australian prisons. During the calendar year 1991, there were over 34,000 (34,710) prison receptions in Australia and over 28,000 (28,756) HIV tests conducted on reception into prison. Of those tested, only 71 cases of HIV infection were found of which only 11 were previously unaware of their HIV status. This gave a national HIV prevalence of 0.25% in Australian prisons in 1991. In 1992 the figure was 0.4%.[3]

Dolan also considers several jurisdictions outside Australia. For example, one of the highest levels of HIV infection among prisoners is in Spain; in New York State, 17% of male prisoners were infected; in Brazil 18% of female prisoners were infected; and in some American states the prevalence of HIV among female prisoners was nearly double that found among male prisoners.[4] Hammett specifies rates of infection by state:

> Inmate seroprevalence rates of higher than 1% include the following states: New York, 17% male; Florida, 7% male and female combined; Maryland, 15% female and 7% male; Illinois, 4% male; Virginia, 3% male; California, 2.5% male and 3% female; Texas, 2% male; Georgia, 3% male, 2% female; Michigan, 2% male, 2% female .... Transmission of HIV infection among correctional

majority are once again found to be homosexual men (85% — including three percent who were injecting drug users). However, the proportion of injecting drug users who were not homosexual males (5%) and those exposed to hetrosexuals [*sic*] risk (6%) is much higher than for cases of AIDS.

C Watson, 'The Nature of HIV/AIDS' in *HIV/AIDS Law, Policy & Directions* (1993) 3, 5.

2 Intergovernmental Committee on AIDS, Legal Working Party, *Therapeutic Goods and HIV/AIDS*, Discussion Paper (1992) 33, citing Matt Gaughwin, Robert Douglas and Christopher Liew, 'HIV Prevalence and Risk Behaviours for HIV Transmission in South Australian Prisons' (1991) 7(5) *AIDS* 845. Sources and studies from which information can be gathered as to the rate of HIV infection in prison, and the kind of risk-taking behaviour practised while incarcerated, include: Gaughwin *et al*, noted above; J Wolk, A Wodak, A Morlet, J Guinan and J Gold, 'HIV-related Risk Taking Behaviour, Knowledge and Serostatus of Intravenous Drug Users in Sydney' (1990) 152 *Medical Journal of Australia* 453; Kate Dolan, 'Evaluation of a Program of Syringe Decontamination for NSW Prisoners' (paper presented at the Australian and New Zealand Society of Criminology 10th Annual Conference, University of New South Wales, 28 September 1994).

3 Dolan, 'Evaluation', above n 2, 3. According to Chappell and Norberry, at the end of 1990, there was a cumulative total of 7,000 reported AIDS cases in US gaols, and a seroprevalence rate of between 0.7% and 1% in UK gaols; they note that the infectivity rate among drug users was very high: Duncan Chappell and Jennifer Norberry, 'HIV/AIDS: Policy Trends in Prisons' in Judi Fortuin (ed), *Issues in HIV/AIDS in the Australian Prison System* (1992) 23, 24-5. The New South Wales Corrections Health Service's chief executive officer, Dr P Brown, estimates that at any one time between 30 and 50 inmates of the prison population of 6,500 are known to be HIV positive; the national prevalence is said to be less than 0.4%: Christopher Zinn, 'Australia: Climbing the political agenda' (1995) 310 (No 6975) *British Medical Journal* 279.

4 Dolan, 'Evaluation', above n 2, 3. Canada's Expert Committee on AIDS and Prisons (ECAP) also cites prevalence figures from several European countries, the United States and Australia: Expert Committee on AIDS and Prisons, *HIV/AIDS in Prisons* (1994) 18-9 ('ECAP Report'). This Committee was created by the Solicitor General of Canada in 1992. Its Report, consisting of three documents (Final Report, Summary Report and Recommendations, Background Materials) was released in 1994.

inmates remains a subject of widespread concern. Fragmentary data from Maryland and Nevada suggest low rates.[5]

In Canada, 'the number of prisoners with HIV infection or AIDS in federal penitentiaries is unknown, since there has been no widespread testing of prisoners for HIV infection', although several studies have been undertaken at provincial institutions.[6] However, 'the studies undertaken in provincial institutions suggest that the problem of HIV/AIDS in Canadian prisons, including federal penitentiaries and regardless of gender, may be more widespread than has previously been thought.'[7] There is a suggested overall infection rate in Canadian federal institutions of one in 128 inmates (0.78%).[8]

B *High Risk Behaviour in Gaol*

Conditions in Australian prisons are conducive to the spread of HIV.[9] Between 37% and 66% of Australian prison entrants have a history of injecting drug use; 33% overall and 50% of male injecting drug users in Australia have a history of imprisonment.[10] Needle sharing and failure to clean injecting apparatus adequately are not unheard-of practices in Australian prisons, and injecting various kinds of drugs is common.[11] According to Chappell and Norberry:

5 Theodore Hammett, Dana Hunt, Michael Gross, William Rhodes and Saira Moini, 'Stemming the Spread of HIV among IV Drug Users, their Sexual Partners, and Children: Issues and Opportunities for Criminal Justice Agencies' (1991) 37(1) *Crime and Delinquency* 101, 115. Merritt notes: 'Given the nature of the population that finds its way into state and local correctional institutions, this population is likely to be infected with the human immunodeficiency virus (HIV) at a somewhat higher rate than that of the general population': Frank Merritt, 'The Theoretical Basis of Liability for the Transmission of HIV in Prisons and Jails' in Brenda Strama (ed), *AIDS and Governmental Liability* (1993) 105.

6 ECAP Report, above n 4, 15. Generally speaking, in Canada, the federal government has jurisdiction over penitentiaries, and the provinces have control over prisons; a prisoner sentenced to a term of over two years is detained in a federal gaol (although the jurisdictional split and its consequences are far more complex than this statement suggests). ECAP's report and recommendations were made with respect to federal institutions. The authors state at 10: 'ECAP believes that most of the efforts that need to be undertaken to reduce or prevent HIV infection in federal correctional institutions also need to be undertaken at the provincial level and that many, if not all, of its recommendations could be implemented also in provincial prisons'.

7 Ibid 18.

8 Ibid. In fact, the actual prevalence may be higher than this figure suggests. The Report states that 'it has been claimed that it is more likely that the number of individuals with HIV infection in federal penitentiaries is closer to one in 20 than to one in 128'.

9 'It is generally recognised that the prison environment is a potential reservoir for the spread of HIV/AIDS': Chappell and Norberry, 'Policy Trends', above n 3, 25.

10 Nick Crofts, Tony Stewart, Peter Hearne, Xin Yi Ping, Alan Breshkin and Stephen Locarnini, 'Spread of bloodborne viruses among Australian prison entrants' (1995) 310 (No 6975) *British Medical Journal* 285. In support of their statement concerning drug use, the authors cite several journal articles and studies at 288. One considers HIV prevalence and risk behaviours for HIV transmission in South Australian prisons; another two consider alcohol and drug use patterns among prisoners in Perth. In the authors' Victorian study, 46% (1562 of 3429 prison entrants) gave a history of use of injected drugs. Generally speaking, the range of findings disclosed by studies of this nature demonstrates the difficulty of measuring matters as sensitive as individuals' illegal drug use histories.

11 Grimsley notes that because of its illegal nature, it is difficult to determine the extent of needle sharing in prison, and assess how many used injecting drugs prior to their detainment: 'we do know that IDUs [injection drug users] are disproportionately represented in prisons, that injecting drug use does occur within prisons, and that many inmates who did not use on the outside may now use in prison': Alan Grimsley, 'HIV/AIDS: Education and Training' in Fortuin, above n 3, 1, 3. See also

> Sharing of unclean needles and syringes is the major risk factor in the spread of HIV among injecting drug users in correctional institutions. Not surprisingly, large numbers of prisoners share a small number of needles and syringes. According to the Working Panel on Intravenous Drug Use and HIV/AIDS, in one New South Wales prison up to 40 women had shared a 'fit' and in a Victorian prison 70 men had shared one 'fit'. In a study by Conolly and Potter (1990), 94 per cent of inmates who said they used in gaol said that they had shared needles in gaol; only 30 per cent had cleaned them adequately.[12]

Dolan reports that in her study of NSW prisoners: over one-third were aware of syringes on their wing in the four weeks prior to her survey ('Respondents were aware of a mean of 10 injectors but only aware of a mean of four syringes — strongly indicating that inmates were sharing syringes'); nearly two-thirds of the sample reported a history of ever injecting drugs and almost half had injected in prison at some time; one-quarter said they had injected in the prison where they were surveyed; and 76% of these said they had shared syringes.[13]

Canada's Prisoners with AIDS/HIV Support Action Group (based in Toronto) paints a rather vivid picture of the situation:

> Despite high levels of injection drug use, the presence of syringes used to inject illegal drugs is severely limited. Only a handful of needles will circulate in a population of 400-600 people. Accordingly, once incarcerated, with no access to clean needles or bleach, yet ongoing access to injectable drugs, inmates using injection drugs must share needles even though they may not have shared on the outside. Needle sharing usually occurs in bathrooms, cells, and hidden areas. Home-made and unsafe sharps (needle substitutes) are fashioned out of

Matt Gaughwin, 'HIV/AIDS: Risk Behaviours Research Findings and their Implications for Prevention' in Fortuin, above n 3, 101, 108.

12 Chappell and Norberry, 'Policy Trends', above n 3, 28. Two Canadian commentators note that prisoners generally engage in a greater number of high risk behaviours and do so more often than members of the general community. Furthermore, because they engage in many of these behaviours while they are confined within prisons, in which they interact with a limited population that is itself at high risk for HIV infection and AIDS, their risk becomes compounded: Louis Pagliaro and Ann Pagliaro, 'Sentenced to Death? HIV Infection and AIDS in Prisons — Current and Future Concerns' (1992) 34 *Canadian Journal of Criminology* 201, 204. According to Tomasevski, cited in ECAP Report, above n 4, 65-6, two characteristics of inmates determine the magnitude of the dual problem of HIV/AIDS and drug use: the high proportion of injection drug users in the prison population is a consequence of penalising drug offences by imprisonment, while a large proportion of the prison population is dependent on drugs, whether or not prisoners have been detained for a drug-related crime. See also Crofts *et al*, above n 10, 285: 'One Australian study estimated that 36% of prisoners had injected themselves intravenously, and 12% had participated in anal intercourse at least once while in prison.'

13 Of the sharers, 94% said they had used disinfectant to clean the syringe: Dolan, 'Evaluation', above n 2, 9. Hanson, in her study of Quebec prisoners, noted that 6% of 693 injecting drug users in prison in Quebec said they continued to inject while in gaol: *Age* (Melbourne), 6 November 1994. By way of contrast, Roughley, of the Queensland Corrective Services Commission, having studied Queensland prisons, HIV transmission and risk, tentatively raises an alternative argument: prisons have a curtailing effect on risk behaviours, and the fears of transmission in gaols is not as great as was predicted. She draws on empirical material which suggests that although IV drug use is more likely in prison than in the general community, it is not more likely than in the drug using population: Dianne Roughley, 'Queensland Prisons and the Transmission of HIV Infection' (1993) 4(3) *Criminology Australia* 25, 27. The (dubious) corollary of this is that as the general population is not likely to commence IV using practices, the fear of increased HIV spread in prisons from risk behaviour is 'questionable'.

> hardened plastic and ball-point pens, often causing damage to veins, scarring, infections, and blood poisoning.[14]

In Canada, the Correctional Service is said to have done everything in its power to try to prevent drug use in gaol. Notwithstanding these efforts, however, injecting drug use persists. According to the Expert Committee on AIDS and Prisons, the Committee 'heard repeatedly that inmates would share their injection equipment, and would often do so without cleaning it between uses'.[15] In England and Wales in any one year, approximately 15,000 prisoners have a history of drug use. Furthermore, 'between a quarter and two thirds of prisoners who have ever injected drugs have done so within prison, where use of injecting equipment previously used by others is the norm'.[16]

Sexual activity among prisoners is less common than intravenous drug use, but when it occurs it is nearly always unprotected.[17] One study suggests that 9-12% of male prisoners engage in sexual activities while in Australian prisons.[18] It is sometimes accompanied by violence and lack of consent, although it is most often consensual.[19] The unavailability of condoms had led to some prisoners using bread bags and surgical gloves as condoms and margarine as lubricant,

[14] Submission quoted in ECAP Report, above n 4, 64-5. Kelly notes: 'A typical inmate explained why he was more likely to share needles within prison: "You shoot up in the yard where you can easily exchange needles. On the outside there were very few times that I ever shared a needle, because for two bucks you can get new works (hypodermic needles)"': Joseph Kelly, 'AIDS, Prisoners and the Law' (1992) 142 *New Law Journal* 156, 158. Vaid comments on the American situation: 'intravenous drug abusers probably continue to share needles as they did when they were free, particularly because needles are even scarcer in jail than outside': Urvashi Vaid, 'Prisons' in Harlon Dalton, Scott Burris and the Yale AIDS Law Project, *AIDS and the Law — A Guide for the Public* (1987) 235, 239.

[15] ECAP Report, above n 4, 5. The Committee states at 63: 'there are no reliable data on the prevalence of injection or other drug use in Canadian prisons'. However, it further states at 64 that '[w]hile it is generally agreed that it is difficult to determine exactly how much injection drug use and needle sharing occurs in prisons, it is also agreed that, in Canada and elsewhere, injection drug use is prevalent in prisons and that the scarcity of needles often leads to needle sharing'.

[16] The figure is said to be between one in 13 and one in seven prisoners: O Noel Gill, Ahilya Noone and Julia Heptonstall, 'Imprisonment, injecting drug use, and bloodborne viruses' (1995) 310 (No 6975) *British Medical Journal* 275.

[17] In her study of NSW prisoners, primarily concerned with evaluating a syringe decontamination program, Dolan reports that when asked about their sexual activity, one-sixth of the respondents knew of inmates on their wing who were sexually active while in prison, 8% had masturbated and had oral sex with another inmate, and 4% had anal sex while in prison: Dolan, 'Evaluation', above n 2, 10. ECAP states, '[t]here are no reliable data on the prevalence of consensual sexual activity in Canadian prisons. Nevertheless, there is no reason to presume that it does not occur or that it may not be widespread': above n 4, 55. Pagliaro and Pagliaro, above n 12, 204, note that even though anal intercourse had previously been the major mode of HIV transmission, currently the greatest percentage of new cases in North America are due to sharing needles.

> [T]hus, even though homosexual activity among male prison inmates, including situational homosexuality, is a significant, widely-recognised behaviour pattern in prisons, it is not the major risk factor for the spread of AIDS in prisons. In fact, higher rates of the incidence of seropositive status are found among female, as compared to male, inmates.

ECAP also reports that HIV infection is prevalent among women inmates, especially among those with a history of injection drug use: 'HIV seroprevalence among women prisoners generally exceeds that of male prisoners. Among prison entrants in the United States, HIV seroprevalence rates are also generally higher for women than for men': above n 4, 109.

[18] Cited by Kate Dolan, 'Sex in the Slammer' (1994) 8(6) *National AIDS Bulletin* 12.

[19] 'There are no reliable data on the prevalence of non-consensual sexual activity in Canadian prisons. Nevertheless, there is reason to presume that it does occur': ECAP Report, above n 4, 60.

although the majority of the sexual activity was unprotected.[20] Overcrowding of prisons is a growing problem which favours these high risk activities, with double bunking becoming the norm and single cell accommodation the exception. While problems of overcrowding should be addressed regardless of the risk of contracting HIV, its presence among the prison population makes action and an adequate response to the problem particularly urgent.[21]

As noted earlier, '[p]risons have been identified as potential "incubators" for HIV infection because of the risk of HIV transmission via injecting drug use and homosexual sex .... The fast turnover of prisoners in the correctional system exacerbates this problem.'[22] The problem is not limited to transmission by one prisoner to another within institutions; the virus also may spread to the general community by former detainees, or perhaps as a consequence of conjugal visits.[23]

C *The Immediacy of the Problem: Recent Developments*

Injection drug users, gay men, lesbians, prisoners: these individuals — among the most marginalised and disadvantaged in the community — are also those most at risk of contracting the disease as a result of the conduct and choices of most states' governments and prison administrators. This paper examines the legal consequences of that conduct and those choices, and considers, in particular, an important legal avenue available to prisoners to challenge them.

Crucial to a meaningful examination of the problems presented by HIV in prison is a willingness — and preparedness — to confront the issues head on. Simply put, it will be argued that it is inappropriate and unreasonable for a prison authority to assert, for example, that because it does not want to be seen to encourage same sex activity in prison it can pretend that it does not occur (and deny the reality that it does). It is also inappropriate and unreasonable for a prison authority to deny that a prison has a role to play in minimising the risks associated with using intravenous drugs on the basis that they are illegal. Unless governments and prison administrators are able to guarantee an environment free from the danger of infection, including high-risk conduct (and manifestly they cannot), then there is at the very least a plain moral duty to face up to that danger and address it.[24] Arguably, this duty goes beyond being characterised as

20 Cited in Dolan, 'Sex in the Slammer', above n 18, 13.

21 Robert Douglas, 'AIDS in Australian Prisons: What are the Challenges?' in Jennifer Norberry, Matt Gaughwin and Sally-Anne Gerull (eds), *No 4 HIV/AIDS and Prisons Conference Proceedings* (1991) 23, 25.

22 Intergovernmental Committee on AIDS, *Therapeutic Goods*, above n 2, 33.

23 Gaughwin's broad perspective is an important one. See Gaughwin, 'Risk Behaviours', above n 11, 102:

> [W]hile there should be concern about transmission in prisons, the wider issues of the occurrence of risk behaviours among prisoners, former prisoners and those at risk of incarceration, risk to their partners, children and prison staff should be considered also. Prisons have a definite role to play in limiting the spread of HIV both inside and outside prisons.

24 Michael Kirby, 'A Legitimate Concern' (1991) 2(3) *Criminology Australia* 9, 15. Cf Hammett *et al*, above n 5, 119, concluding that although the message sent by supplying syringe cleaning equipment is contradictory, ignoring that contradiction is not an option.

'merely' a moral one; it is legal in nature.

Three recent developments demonstrate the currency and importance of the argument presented here: that prison authorities are negligent in their failure to grapple seriously with the possibility of transmission of the HIV virus in gaol, and that they must be made accountable for their conduct — not taking reasonable enough measures to contain its transmission — through the use of a common law negligence action.

The first development is the fact that Australia recently documented its first case of a prisoner's seroconversion while detained in Her Majesty's Custody. The second development is evidence of the rapid spread of Hepatitis B and C in Victorian gaols and, by extension, potentially rapid transmission of HIV. The third is an action brought on behalf of 50 prisoners against the State of New South Wales.

1 *Seroconversion While in Her Majesty's Custody: The Possibility of Transmission has Become a Reality*

The first development — which ought to have been and, moreover, could have been, prevented — involves Australia's (and perhaps the world's) first confirmed case of seroconversion while in prison. Studies by the National Drug and Alcohol Research Centre — and a team of AIDS researchers including Kate Dolan — report that at least one person has contracted the virus while in gaol:[25]

> This is the first reported case of a prisoner incarcerated continuously from before HIV became prevalent in the local community, and before HIV infection was known to be present in Australia, who reported risk behaviours in prison and had documented HIV seroconversion and reported symptoms indicative of seroconversion illness. We conclude that our subject became infected with HIV in an Australian prison. High-risk behaviours and limited opportunities for limiting risk in prisons increase the potential for HIV transmission, but rapid turnover of prison populations may mean that the chance of detecting such transmission is reduced.[26]

Although this is the first documented and confirmed case of HIV transmission in an Australian prison, Sydney AIDS expert, Dr Julian Gold, warns that 'a disturbingly high number of HIV transmissions might have occurred';[27] 'given the prevalence of infection and the prevalence of risk behaviour it would appear

[25] Kate Dolan, Wayne Hall, Alex Wodak and Matt Gaughwin, 'Evidence of HIV transmission in an Australian prison' (1994) 160 *Medical Journal of Australia* 734. The 32 year old man had been incarcerated from 1980-90 and had previously tested negative for HIV antibodies in 1987 but positive in November 1989. He reported that his first experience of homosexual contact and drug injection occurred in prison: *Age* (Melbourne), 6 June 1994. He had shared a syringe with a fellow inmate in 1987, who has since died of an AIDS-related illness.

[26] Dolan *et al*, 'Evidence', above n 25, 734. Commenting on the problems of accuracy in some studies, Dolan states elsewhere: 'There have only been 57 documented cases of HIV being transmitted in prison worldwide. Most of these are poorly documented.' With respect to confirmed evidence of transmission, she continues that '[i]n Australia, one study respondent who had tested negative in prison eight years after being continuously incarcerated later tested positive. Another five respondents reported evidence indicative of infection being acquired in prison': Dolan, 'Evaluation', above n 2, 4-5.

[27] *Age* (Melbourne), 7 June 1994.

that the potential is enormous'.[28]

In any event, even one case is one case too many.

This case has re-energised calls from a range of sources, including the NSW Prisoners Action Group and medical practitioners and researchers, for the provision of preventative measures in Australian gaols. Researchers warn that greater emphasis on preventing the spread of the virus in prisons is required by introducing measures which include syringe disinfection, possibly needle exchange programs, drug treatment schemes (including methadone programs) and provision of condoms.[29]

Scottish researchers recently reported finding conclusive evidence of custodial seroconversions; at least eight documented cases of HIV infections resulting from the sharing of contaminated equipment by injecting drug users occurred within a Scottish prison during the first half of 1993.[30]

> This is the first report which provides definitive evidence for an outbreak of HIV occurring within a prison [cf Dolan, n 25]. Sharing needles and syringes was undoubtedly the behaviour responsible. Eight transmissions definitely occurred in prison during the first half of 1993, and a further six possibly took place .... Although some behavioural studies support the belief that prisons throughout the world might be fertile environments for the spread of HIV, hitherto such spread has been shown only rarely .... This paucity of evidence for infection in prison is probably accounted for by the difficulties in determining the time of HIV seroconversion in relation to the period of incarceration rather than by the rarity of the event.[31]

28 Dolan, 'Evaluation', above n 2, 5, even though, on the basis of research findings, it seems at first glance that transmission of the HIV virus in gaol is a relatively infrequent occurrence. See Thomas Schuck and Lawrence Hoyt, 'AIDS and the Criminal Justice System' in David Webber (ed), *AIDS and the Law* (2nd ed, 1992) 267, 280; Vaid, above n 14, 238.

29 Dolan *et al*, 'Evidence', above n 25, 734; they note that these measures were endorsed by consensus at the 1990 National Conference on HIV/AIDS and Prisons in Australia. Because of the high rate of seropositive status among inmates (compared to the general population) and because of the factors that tend to foster the transmission of HIV in prisons, it is expected that AIDS will soon be the biggest cause of inmate death across North America: Pagliaro and Pagliaro, above n 12, 203. They further state at 202: 'Prisons have been noted as being fairly effective barriers to the unscheduled egress of inmates, but they are entirely ineffective in terms of preventing the entrance, exit, and spread of HIV infection and AIDS'.

30 Gill *et al*, above n 16, 275. Christie reports '[t]hirteen prisoners who shared injecting drug equipment with an HIV positive inmate at Glenochil jail in 1993 have been found to be infected': Bryan Christie, 'Scotland: Learning from experience' (1995) 310 (No 6975) *British Medical Journal* 279. In 1989, Lambrou stated that while some surveys showed AIDS spreading more slowly in prisons than in the general population, this was probably due to the fact that a major proportion of arrests and convictions involve people already exposed to the virus, reducing the percentage of inmates who first become infected while in prison; however, incidence rates are predictably higher in gaols because of the concentration there of persons with characteristics closely associated with the virus and because risky sexual contact between prisoners and needle sharing occur regularly in prisons, and these activities are the highest risk behaviour for the transmission of AIDS: Irene Lambrou, 'AIDS Behind Bars: Prison Responses and Judicial Deference' (1989) 62 *Temple Law Review* 327, 330.

31 Avril Taylor, David Goldberg, John Emslie, John Wrench, Laurence Gruer, Sheila Cameron, James Black, Barbara Davis, James McGregor, Edward Follett, Janina Harvey, John Basson, and James McGavigan, 'Outbreak of HIV infection in a Scottish prison' (1995) 310 (No 6975) *British Medical Journal* 289, 291-2. The authors state:

> As some injectors discontinue their injecting while in prison, incarceration may have a protective effect on their health. The restricted access to drugs and injecting equipment, which was probably responsible for the cessation of injecting by some inmates in Glenochil, however, did

These confirmed cases of custodial seroconversion may in fact have a long-term impact benefiting the general prison community, by providing the catalyst necessary for legal action, and consequent reasonable responses (if not initiatives) by the prison authorities. It is possible that something positive for prisoners generally may be salvaged from this tragedy.

2 *Hepatitis B and C*

Researchers in Victoria recently reported finding an extremely high incidence of Hepatitis among male prisoners who were aged under 30, and injection drug use: 41% of these men were becoming infected with Hepatitis C each year and 21% with Hepatitis B.[32] Of 3,627 prisoners tested, one-third had been exposed to Hepatitis B and 39% to Hepatitis C; 46% had a history of injecting drugs.[33] The authors of the report state:

> Despite Australia's strong commitment to widespread and accessible needle and syringe exchange programmes, accessible low threshold methadone maintenance, and peer education in the community at large there are few such programmes in Australian prisons. Our study documents continuing extremely high rates of transmission of both hepatitis B and C, especially among young men who inject drugs and enter prison. In particular, the high rate of continuing exposure to hepatitis B in male prisoners aged less than 30 years who inject drugs suggests that this is a group in whom spread of HIV must be considered to be simply a matter of time. This continuing spread poses an enormous challenge to our harm reduction programmes.[34]

The prevalence of Hepatitis B and C is as high as 50% in NSW, because more than 75% of the state's prisoners are gaoled for drug-related crimes and some continue to share needles in jail.[35] Gaughwin comments:

> The extent of the likely worst-case scenario might be gleaned from information which is available about the seroprevalence of hepatitis B infection among prison populations .... [U]p to almost half of some prison populations have been infected [with hepatitis serological markers]. If this occurred for HIV, the economic, administrative, social and health burdens would be profound. Far better for us to act now so that it never does. Risk behaviours are occurring in Australian prisons. If we are to avoid a catastrophe, definite action will need to be taken. We cannot just hope that the situation will get no worse than it is now.[36]

not prevent seven from injecting for the first time there and placed all those who did inject in prison at high risk of contracting infections. This is manifested by the extraordinarily high incidence of sharing needles and syringes among the 33 prison injectors.

32 Crofts *et al*, above n 10, 287; *Age* (Melbourne), 3 February 1995.

33 Crofts *et al*, above n 10, 286; *Age* (Melbourne), 3 February 1995.

34 Crofts *et al*, above n 10, 288.

35 This is according to Dr P Brown, the Chief medical officer of the NSW Corrections Health Service, cited in Zinn, above n 3, 279.

36 Gaughwin, 'Risk Behaviours', above n 11, 115. In Canada, there have recently been several reports of outbreaks of tuberculosis in prison: see, eg, *Winnipeg Free Press* (Winnipeg), 18 March 1995; Ralf Jürgens, 'TB/HIV Issues Receiving Increased Attention in Canada' and 'TB/HIV and the Law' (1994) 1(1) *Canadian HIV/AIDS Policy and Law Newsletter* 6. As Jürgens notes, the dual epidemic of HIV and tuberculosis raises many legal and policy issues, not the least of which involve the tension between voluntary approaches to public health matters as opposed to compulsion — in terms of care, isolation and obligations on the state to develop pro-

It appears that a catastrophe *is* in the making in Australian gaols.

3 *Prisoners' Action in NSW*

Prisoners A to XX inclusive v State of NSW[37] is an action brought by the Aboriginal Legal Service on behalf of prisoners in Bathurst Gaol and Long Bay Gaol in NSW, seeking 'various orders and other relief' to ensure access to condoms within prison.[38] According to the plaintiffs' lawyer, 'It is no proper part of the punishment of prisoners that their access to preventative means to protect their health is impeded'.[39] It is a human rights issue, according to the President of the Australian Federation of AIDS Organisations (AFAO).[40]

The policy of the Department of Corrective Services in NSW has been to oppose condom distribution, relying on education as a preventative measure (though, as the Minister's comments below make clear, the authorities were and are aware that high risk behaviour occurs).[41] In their statement of claim, the prisoners argued that the decision of the Commissioner of Corrective Services and the New South Wales Department of Corrective Services not to supply or permit the possession or use of condoms by male prisoners:

- was so unreasonable that it constituted an improper exercise of power;
- gave rise to a writ of habeas corpus, relating not merely to the fact but the *form* of imprisonment; or

grams. Several articles in (1993) 21 *Journal of Law, Medicine and Ethics* as well as ECAP Report, above n 4, 100 consider these issues, and the dramatic increase in the incidence of tuberculosis in some United States' prison systems. Frank Ryan, *The Forgotten Plague: How the Battle Against Tuberculosis was Won — and Lost* (1993) 413, quoted by Robert Greifinger, Nancy Heywood and Jordan Glaser, 'Tuberculosis in Prison: Balancing Justice and Public Health' (1993) 21 *Journal of Law, Medicine and Ethics* 332, 339 describes the crisis: 'The world must come to terms with the fact that the concurrence of AIDS and MDR [multi-drug resistant] tuberculosis has primed a time bomb that, in the tragic social conditions of the Third World, has already exploded.' Pagliaro and Pagliaro, above n 12, 206, state:

> [T]he prolonged incubation period of HIV infection prior to developing into full-blown AIDS and the increased medical effectiveness in dealing with the infectious complications of AIDS (eg, pneumonias, fungal infections) have contributed to the increasing co-incidence of HIV seropositive status, or AIDS, and other infectious conditions, particularly hepatitis and tuberculosis, among prison inmates. The spread of these AIDS-related medical conditions, particularly tuberculosis and hepatitis, both of which are themselves communicable diseases, pose additional concerns and reasons for addressing the issue of HIV infection and AIDS in prisons.

37 *Prisoners A to XX inclusive v State of NSW* (1994) 75 A Crim R 205 ('*Prisoners*').

38 The claim does not embrace issues involving the provision of needle cleaning apparatus or clean syringes; it is limited to the demand that condoms be provided to detainees.

39 Geoffrey Bloom, 'Prisoners Sue for Condoms — Court Battle Continues' (1994) 5(3) *HIV/AIDS Legal Link* 11. Another lawyer for the inmates states that 'the state has a responsibility to ensure prison safety ... [t]he major objections to a condom policy change in prisons comes from the prison guards. They don't want to be seen administering a system where men are having sex with each other:' quoted in 'Condoms in Prisons?', *Melbourne Star Observer* (Melbourne), 13 May 1994.

40 Tony Keenan (Australian Federation of AIDS Organisations) comments:

> If I was to say that a good approach to HIV/AIDS prevention would be to introduce compulsory testing, isolate the ones who are positive, and deny access to condoms to everyone else, then I would be taking the same approach as the prisons. And this approach is right outside the national strategy.

Quoted in 'Condoms in prisons', above n 39. NSW recently retreated from its misguided policy of compulsorily testing all prisoners for HIV: see discussion below n 161 and accompanying text.

41 See, eg, the then Minister's comments, below n 54 and accompanying text.

- constituted a breach of the duty of care owed by the Commissioner and the Department to the prisoners, which provided the basis for injunctive relief.[42]

The subject matter of the decision was procedural — the State of NSW had sought to have the prisoners' statement of claim struck out and proceedings dismissed on the grounds that the statement of claim disclosed no reasonable cause of action and that it was embarrassing and an abuse of the process of the court.[43] Justice Dunford of the NSW Supreme Court considered the three alternative bases of claims for relief and found that both traditional public law remedies and the writ of habeas corpus were inappropriate to challenge policy decisions affecting all prisoners.[44]

The negligence action was dismissed on the basis that such a claim had to be brought on behalf of individual plaintiffs, and could not be brought as a class.[45] Dunford J declined to authorise joinder of the 50 individual plaintiffs' actions, but provided that the statement of claim could be amended to allow the action to continue in the name of four inmates (to be selected by the plaintiffs).[46] In the course of his judgment, he made some quite remarkable statements in *obiter* on the flexibility of negligence:

> Although Equity in its auxiliary jurisdiction has traditionally granted injunctions to restrain the commission of various torts, it has not previously granted injunctions to restrain the tort of negligence, but there appears to be no reason why it should not do so in an appropriate case, *even without proof of damage*.[47] The power to grant injunctions would appear, since the fusion of law and equity, to extend to granting injunctions in respect of all torts: *Parry v Crooks* (1981) 27 SASR 1 per King CJ.

42 *Prisoners* (1994) 75 A Crim R 205.

43 Ibid.

44 Traditional public law remedies are discussed briefly in Part II. The plaintiffs' habeas corpus argument drew on US and Canadian authority that the writ of habeas corpus is appropriate to consider 'not only the fact of confinement but also its nature and conditions': *Prisoners*, Plaintiff's Outline of Submissions, para 4.1. One commentator states that this writ is the most interesting form of relief claimed in this suit, because of its potential ability to question the validity of all conditions of imprisonment: Bloom, 'Prisoners Sue for Condoms', above n 39.

45 *Prisoners* (1994) 75 A Crim R 205, 206.

46 Ibid. The prisoners appealed Dunford J's decision, arguing that they should be able to (i) rely on the writ of habeas corpus; (ii) rely on the Magna Carta; (iii) continue their proceedings as a class of 50 rather than amend their pleadings — and claims — to ones brought on behalf of only four prisoners. According to the Court, the latter ground of appeal was based on the argument that the prisoners wished by numbers to express solidarity, and individuals were in fear of institutional repercussions for bringing proceedings. The Court correctly — and rather strongly — notes that any repercussion or threatened repercussion would involve a serious contempt of court. The New South Wales Court of Appeal concludes that Dunford J's reasons for restricting the number of plaintiffs involved a proper exercise of discretion. These reasons were: to ensure that an appropriate variety of factual issues be litigated, that guidelines consequently be set for future litigants and cases, and that the case be managed efficiently. In result, although the New South Wales Court of Appeal dismissed all three grounds in the prisoners' appeal, its decision does not foreclose the continuation of the proceedings, as long as the litigants act in the manner directed by Dunford J. The Court concludes, 'What remains to be done is for the appellants to apply in the Common Law Division to amend their statement of claim in a way which accords with Dunford J's orders and the conclusions I have reached': *Prisoners A-XX Inclusive v State of New South Wales* (Supreme Court of New South Wales, Court of Appeal, Meagher, Sheller and Powell JJA, 8 August 1995).

47 His Honour cites the Supreme Court Act 1970 (NSW) s 66 and Meagher, Gummow and Lehane, *Equity Doctrines and Remedies* (3rd ed, 1992) para 2120.

> Accordingly, if the plaintiffs are able to establish by evidence that the failure by the department to permit their use of condoms constitutes a breach of the duty of care it owes to them, they may be entitled to injunctive relief.[48]

The *Prisoners* case, in conjunction with the existence of the documented Australian case of custodial seroconversion and widespread prevalence of Hepatitis B and C in Pentridge and Fairlea gaols (with an inevitable consequent spread of HIV), may provide the impetus necessary to initiate recommended change.

D *Government Prevarication in Australia and Inadequate Responses to Date*

The dilemma posed by the presence and transmission of HIV/AIDS in prison has been considered in Parliament by the federal Health Minister, Dr Lawrence, where she criticised prison authorities' resistance to providing condoms and establishing drug-prevention programs.[49] She has called on the States and Territories to ensure that prisoners receive the same protection from HIV/AIDS as the general community.[50] Reacting to the report of the widespread presence of Hepatitis B and C — and, by implication, HIV — in Victorian gaols,[51] Dr Lawrence sent letters to state and territory governments calling on them to introduce condoms and syringe-exchange programs in gaol. If exchange programs are not possible, bleach is to be made available for cleaning the needles

[48] *Prisoners* (1994) 75 A Crim R 205 (emphasis added). Although the implications of Dunford J's statement are considered below (with respect to the usefulness of negligence, and aspects of causation), this potentially radical reformulation of the action will not be central to this paper. Traditionally, loss — the gist of negligence — 'is an essential part of the plaintiff's ... action, which is not complete without it .... Until damage occurs in such cases no tort is committed and no damages are payable': Harold Luntz and David Hambly, *Torts: Cases and Commentary* (4th ed, 1995) 312. As Fleming states, 'merely creating a *risk* of injury is not actionable; injury must have become actual. This may inhibit speculative claims but rather discredits the pretence that tort law seeks to discourage accident-prone behaviour': John Fleming, *The Law of Torts* (8th ed, 1992) 191. To ease the establishment of loss, the plaintiff may attempt to utilise 'loss of a chance' notions in a claim lodged prior to the suffering of actual physical loss, where injunctive relief is sought. In the instant case, the Plaintiff's Outline of Submissions states at para 1.7: 'If the plaintiffs contract HIV or hepatitis in consequence of the continuing breach of the duty of the defendant, their losses will be irreparable, and damages will scarcely be a suitable alternative remedy. The plaintiffs ought not wait until they have compensable injury before they can take action in respect of the defendant's continuing breach of the duty of care.' Luntz and Hambly at 660-1 comment on the availability of injunctive relief, albeit in the context of cases involving intentional interference with the person:

> [T]he view now is that there is jurisdiction to grant an injunction to restrain the commission of any tort, but the court should exercise its discretion against granting an injunction where the tort in question is also a crime, in all but exceptional circumstances .... The orthodox view seems to be discarded in *Khorosandjian v Bush* [1993] QB 727 (CA), where the Court of Appeal appeared to accept without qualification that an injunction could be granted to prevent the commission of a tort, including a tort involving a crime of violence. If this case is followed in Australia, the injunction could be a useful remedy for some victims of harassment, including conduct constituting battery.

King CJ's comments in *Parry v Crooks* (1981) 27 SASR 1, 7 (cited by Dunford J) are critical to successfully arguing for injunctive relief for a negligent act.

[49] *Age* (Melbourne), 7 June 1994.

[50] *Australian* (Sydney), 7 June 1994.

[51] The researchers conclude, 'the spread of HIV in jails was inevitable after a major study showed hepatitis B and C were rampant in Pentridge and Fairlea prisons': *Age* (Melbourne), 3 February 1995.

that were obviously in the gaols.[52] Echoing many commentators, she stated that '[p]eople are sentenced to jail, not to be infected .... They deserve the same level of care as people outside get'.[53]

By comparison, the former NSW Minister for Corrective Services, Michael Yabsley, explained the rationale for his government's policies:

> My Government, of course, will not facilitate illicit intravenous drug use or, in fact, any type of illegal drug use amongst the prison population. It will not provide a needle exchange system or any mechanism for the provision of needles for illegal purposes. There are those who would argue that this is inhumane, that is deprives the drug user of a means to which he/she is well-accustomed and that the likelihood of HIV infection is increased by denying this facility. I totally reject that proposition. Our aim is to prevent drug use and this certainly cannot be achieved by enabling the drug user to continue with the practice while in custody. A similar situation prevails in regard to sexual practices within the prison. We are well aware that homosexual activities do greatly increase the probability of contracting the AIDS virus. We have carefully thought about issuing condoms and have rejected the idea .... The issuing of condoms in prisons promotes the possibility of violence and victimisation of those who request or receive condoms.[54]

Change has occurred in NSW with the cessation of compulsory testing,[55] and additional significant change may be imminent. A spokesperson for the Attorney-General — after Dunford J's decision in *Prisoners* — indicated that the Government would consider distribution of condoms in the future. This in itself highlights the importance and impact of the *Prisoners* claim. The spokesperson stated, however, that syringes would never be introduced, as distributing them would be akin to providing guns. Further, they do not want to be encouraging illegal activity — drug use — while in gaol.[56] In Victoria, on the other hand, a spokesperson for the Minister of Corrections has stated that not only will clean needles not be provided, but the ban on condoms will not be lifted; the government is 'not going to encourage sexual activity within prisons. A lot of sexual activity happens without consent and in many of those cases condoms are not used anyway'.[57]

The measures presently implemented to ostensibly contain the spread of HIV in Australian prisons may be summarised as follows:[58]

- all jurisdictions provide educational programs concerning prevention;
- some jurisdictions test prisoners compulsorily, others do so voluntarily;
- some prison systems segregate seropositive prisoners;

52 Ibid.

53 Ibid.

54 Michael Yabsley, 'Compulsory Testing and Integration' in Norberry *et al*, *Conference Proceedings*, above n 21, 119, 120.

55 See discussion below n 161 and accompanying text.

56 *Australian* (Sydney), 7 June 1994.

57 *Age* (Melbourne), 7 June 1994.

58 Many of these measures are considered in detail, below, in the context of whether or not these responses are 'reasonable in the circumstances'; parts of this summary are derived from Roughley, above n 13, 26 and Godwin *et al*, *Legal Guide*, above n 1.

- some jurisdictions provide cleaning agents such as bleach to prisoners;
- no state or territory provides syringes or clean needles; and
- only the ACT's Belconnen Remand Centre provides barrier products such as condoms and lubricant.

II TRADITIONAL LEGAL APPROACHES TO THE PROBLEM

Even though it may be said that prison rates of HIV infection remain lower than had been predicted, these figures leave no room for complacency. There is ample evidence that high risk behaviour occurs in gaols, and there is a strong likelihood that HIV will spread within correctional institutions. It is only the rate of spread that is subject to debate. To deny or doubt that *any* transmission of the virus occurs flies in the face of reality.[59] To ignore the fact of transmission is negligent.

Much of the remainder of this paper uses a hypothetical negligence action as the departure point for a critique not merely of the institutionalised detention regime that has blinded itself to the dangers facing its clients, but also of the political and legal bodies whose complicity makes possible and legitimates such a regime. The recognition of a legally cognisable duty of care does far more than provide a basis for an action when that duty is breached. It is a judicial pronouncement that such conduct violates community standards and expectations. As such, it provides a framework within which the traditional hysteria and political unpopularity associated with openly confronting an issue that includes prisoners, injecting drug users and same sex activities may be reconstituted as a legitimate legal (and consequently political) position.[60]

This Part briefly considers current legal approaches — public law remedies, and statute-based 'prisoners' rights' — and their inadequacies in dealing with the issue of HIV/AIDS in prisons. It then goes on to discuss, in more detail, the potential usefulness of a common law negligence action, its flexibility, role as educator and standard setter, and its adaptability to new forms of duty than other, more procedural avenues of review. Although the existence of a general duty of care owed to prisoners is relatively unproblematic, the crucial question of reasonableness, central to the negligence action, comes to the fore.

It is this aspect of the action in particular — what is reasonable? — that is pursued in Part III. This paper appraises the realistic chances of a negligence claim's success and considers the importance of such an action even if it fails.

The tension between the politically expedient and the legally enforceable forms a central theme of this paper, although it is directly related to the fundamental needs and legitimate demands of Australian prisoners. This paper, then, is a critique of current approaches to addressing the problem of the transmission

[59] Stephen Kerr, 'HIV/AIDS: Management of HIV Antibody Positive Offenders' in Fortuin, above n 3, 45, 49-50.

[60] Perhaps the most graphic example of this hysteria is the death by asphyxiation of an American HIV positive prisoner. He was being transferred in restraints from one area of the prison to another, when he choked to death on a towel that had been stuffed into his mouth. The correctional officers were afraid that he might spit on them: Theodore Hammett and Andrea Daugherty, *1990 Update: AIDS in Correctional Facilities* (1991) 32.

of HIV/AIDS in prison. In attempting to modify and broaden those approaches, it seeks to highlight some of the ways in which the common law can be utilised to help cope with and remedy new social problems.

A *Public Law Remedies*

In the *Prisoners* case, Dunford J acknowledged that the law has changed from its previous position where it was thought that statutory powers conferred on Ministers were not reviewable. According to the *Northern Land Council* case,[61] these powers must be exercised reasonably so as not to be *ultra vires*, and they may be reviewable. Further, in some circumstances, powers exercised by Ministers not under statute but under prerogative may also be reviewable.[62] However, his Honour held that this does not extend to the justiciability of broader government policy decisions which may, according to the Court, involve political, fiscal or social considerations. He found that the NSW Commissioner for Corrective Services' power to direct and manage prisons is subject to the direction and control of the Minister who is in turn a member of the Cabinet and as such is answerable to Parliament, and consequently to the electorate.

It is submitted that this argument could be used to reject any review of the exercise of ministerial power and is, at the very least, a conservative reading of the *Northern Land Council* case. One could argue that there is certainly a distinction to be made between a court's ability to review a decision made by a public servant as opposed to one made by Cabinet. However, the mere existence of a supervening power (which is not exercised) should not render the subordinate decision immune.

This general proposition is further (and far better) substantiated by the existence of s 50(1)(j3) of the Prisons Act 1952 (NSW) which empowers the Governor to make regulations relating to the distribution and use of condoms, and which has yet to be proclaimed. It is arguable, then, that the decision being reviewed was the decision not to proclaim the section. Dunford J held that:

> [Section] 50(1), Prisons Act 1952 which gives the Governor power to make regulations was amended by the Prisons (Amendment) Act 1988, no 46 s 3 and Schedule 2 para (20)(e) which inserted a new para (j3) in the subsection, namely a power to make regulations relating to the distribution and use of condoms; but s 2 of that Act provided that its various provisions should commence on a day or days to be appointed by proclamation ie by the Governor with the advice of the Executive Council: Interpretation Act 1987 s 23(2), s 14; and this particular amendment has not yet been proclaimed. The power to proclaim the commencement of the relevant amendments was not conferred on the courts, and it is not for the courts to, in effect, usurp such power.[63]

Cases where administrative law remedies supported claims by individual pris-

61 *R v Toohey; ex parte Northern Land Council* (1981) 151 CLR 170.

62 *Council of Civil Service Unions v Minister for the Civil Service* [1985] 1 AC 374.

63 *Prisoners* (1994) 75 A Crim R 205, 210. It seems likely that the plaintiffs argued that the failure to proclaim the legislation was unreasonable, although this is not clear from the Outline of Submissions.

oners were distinguished.[64] They were all said to have challenged particular decisions in relation to individual prisoners and involved no question of departmental or government policy. Such policies have been held susceptible to judicial review in Australia only where they contravene a statute or regulation.[65]

Here, arguably, lies the role of an action framed in the language of negligence.[66] An analogous approach has been adopted in the UK where it has been held that the proper remedy for cruel and inhuman punishment is neither an order for release from prison, nor an action for damages for false imprisonment, but an action for negligence.[67]

B *Prisoners' Rights*

In Victoria, the Corrections Act 1986 provides prisoners with a series of 'rights'.[68] Although no prisoner has successfully litigated on the basis of an alleged breach of one of these rights, the potential to do so exists, by way of a breach of statutory duty action.[69] However, this action would not provide redress in a case where the complaint — as here — concerns the failure to prevent the contraction of a disease, as the right to that protection is not explicitly listed among the rights granted in s 47. What prisoners arguably can do, however, is look to the common law — a negligence action — for protection. In fact, s 47(2) of Victoria's Corrections Act explicitly maintains prisoners' common law rights. It provides, *inter alia*, that '[a] prisoner's rights under this section are additional to, and do not affect any other rights which a prisoner has under an Act other than this Act or at common law'.

Prison authorities have been found liable in negligence in several Australian jurisdictions. For example, liability has been imposed for not preventing injury by one prisoner to another (as a result of the prisoner's violent behaviour).[70] Similarly, gaolers may be liable for failing to protect detainees from injuring themselves.[71]

64 See *R v Board of Visitors of Hull Prison; ex parte St Germain and Ors* [1978] 2 All ER 198; *Raymond v Honey* [1983] 1 AC 1; *Leech v Deputy Governor of Parkhurst Prison* [1988] 1 AC 533; *R v Secretary of State for the Home Department; ex parte Herbage [No 2]* [1987] 1 QB 1077; *R v Deputy Governor of Parkhurst Prison; ex parte Hague* [1992] 1 AC 154; *Williams v Home Office [No 2]* [1981] 1 All ER 1211.

65 *Vezitis v McGeechan* (1974) 1 NSWLR 718 (treatment of prisoners); *Bromley v Dawes* (1983) 34 SASR 73 (transfer within a prison); *McEvoy v Lobban* (1988) 35 A Crim R 68 (segregation of prisoners); *Re Walker* [1993] 2 Qd R 345, 349-51 (transfer to another prison).

66 *Prisoners* (1994) 75 A Crim R 205, 212.

67 *R v Deputy Governor of Parkhurst Prison; ex parte Hague* [1992] 1 AC 58, 165-7, 177 cited by Dunford J in *Prisoners* (1994) 75 A Crim R 205, 212. The NSWCA quotes this decision extensively in its consideration — and rejection — of the claim based on the writ of habeas corpus: *Prisoners A-XX Inclusive v State of New South Wales* (Supreme Court of New South Wales, Court of Appeal, Meagher, Sheller and Powell JJA, 8 August 1995).

68 Section 47 has been in force since 1 March 1988. Other states do not grant a similar list of rights.

69 Ian Malkin and Garrie Moloney, 'New Dimensions in Prisoners' Rights in Australia' in Manfred Ellinghaus, Adrian Bradbrook and Anthony Duggan (eds), *Emergence of Australian Law* (1989) 252.

70 *Dixon v State of Western Australia* [1974] WAR 659; *L v Commonwealth* (1976) 10 ALR 269; *Nada v Knight* [1990] Aust Torts Reports 67-916.

71 *Howard v Jarvis* (1958) 98 CLR 177; cf *Cekan v Haines* (1990) 21 NSWLR 296 where there was held to be no breach.

However, actions against persons acting within the scope of their duties have been precluded or limited in Queensland, Western Australia and New South Wales.[72] The precise wording of these provisions varies from one jurisdiction to another. In NSW, the Act states that no action or claim for damages lies against any person for anything done or commanded to be done for the purpose of carrying out the provisions of the Act, 'unless ... such act was done or commanded to be done maliciously and without reasonable and probable cause'.[73] As was noted earlier, NSW prisoners recently instituted proceedings against the state despite the existence of this provision.[74]

Statutory barriers to the ability to bring claims should be removed where the common law tort of negligence would otherwise be available. 'Obviously imprisonment means a loss of freedom, a deprivation of liberty; and short of the death penalty, that is the worst punishment inflicted on anyone by a democracy'.[75] Isolation from the community should be the extent of the punishment. Fogel's 'justice model', which embraces the following philosophy, should be the framework within which rights are secured: '[a] penal sanction should *only* mean a temporary deprivation of liberty .... All the rights accorded free citizens but consistent with mass living and the execution of a sentence restricting the freedom of movement, should follow a prisoner into prison'.[76]

72 Corrective Services (Administration) Act 1988 (Qld) s 62; Prisons Act 1981 (WA) s 111; Prisons Act 1952 (NSW) s 46. Despite the existence of these types of provisions, cases have been litigated, and liability found. Kirby P, in *Cekan v Haines* (1990) 21 NSWLR 296, 298, states that even though these types of provisions generally protect individual corrective service employees from liability, they may not bar an action against the public authority employer: cited in Godwin *et al*, *Legal Guide*, above n 1, 274. See Intergovernmental Committee on AIDS, Legal Working Party, *Civil Liability for Transmission of HIV/AIDS*, Discussion Paper (1992) 23, and its consideration of this issue. With the establishment of an increasing number of privately owned and managed prisons, greater potential exists for instituting proceedings; these defendants and their employees would be unable to hide behind purported statutory immunities.

73 Prisons Act 1952 (NSW) s 46(1).

74 In the *Prisoners* judgment, no mention was made of the Prisons Act 1952 (NSW) s 46, and it was not specifically cited in either the plaintiff's or the defendant's Outline of Submissions. This may be a result of several factors. The wording of the section provides a defence to employees, and arguably does not apply to the state itself. Further, according to Taylor J's decision in *Vezitis v McGeechan* (1974) 1 NSWLR 718, 720, '[i]t is to proceedings to recover damages that the prohibition is directed ... these sections have no application to the present proceedings, which are proceedings for a declaration as to the prisoner's rights.' This may explain in part why the relief sought in *Prisoners* included declarations (among other matters), even though much of the language used embraced negligence notions. Further, it may be argued more generally that even bearing in mind the wording of s 46, the defendant may well be acting without reasonable cause: if the defendant is negligent — unreasonable — then perhaps by definition it should not be able to rely on that section. The court should hear the claim, (conceivably) find negligence, and determine that the case is outside the statutory protection, with the result that the claim could not be barred. Maliciousness, however, would be difficult to establish. Norberry argues: 'where negligence on the part of prison authorities has led to the transmission of HIV by a prisoner to someone to whom a duty of care is owed, then liability should follow. Provisions such as s 46 of the Prisons Act 1952 (NSW) should be repealed': Norberry, 'HIV/AIDS, Prisons and the Law' in Fortuin, above n 3, 83, 94.

75 W Clifford, *Rights and Obligations in a Prison* (1982) 31.

76 D Fogel, 'The Justice Model for Corrections' in John Freeman, *Prisons Past and Future* (1978) 163. See Australian Law Reform Commission, *Sentencing*, Report No 44 (1988). Australia's position as to whether or not a prisoner can sue is confusing as it varies from state to state: see, eg, *Dugan v Mirror Newspapers Ltd* (1978) 142 CLR 583; Felons (Civil Proceedings) Act 1981 (NSW); Treason and Felony Forfeiture Amendment Act 1981 (NT); Public Trustee Act 1978 (Qld) s 95; Criminal Law Consolidation Act 1935 (SA) s 330; Prisoner (Removal of Disabilities) Act 1991 (Tas). Gen-

Negligence law can potentially provide a check on how well (or how badly) responsibilities are fulfilled, and it can gauge whether behaviour ought to be changed. This is particularly important in the prison context where the dependency relationship — for a prisoner's every need — is fundamental to her or his existence and survival. Even a concern for security does not provide a sufficiently convincing rationale for the denial of fundamental common law rights enjoyed by the general community. In any event, in states like Victoria, a prisoner's right to sue clearly exists — as does the potential liability of its prison authorities.

C *The Flexibility of the Common Law*

Given the increasing dangers posed by HIV in prison (which were thrown into morbid focus by the recently reported and documented Australian and Scottish cases of seroconversion in custody, noted earlier) and the failure of authorities to take simple precautions to minimise those risks, legal approaches involving public law remedies seem manifestly inadequate to the task of addressing these grave issues. What follows is an examination of the pursuit of an older, but more flexible, cause of action to attempt to achieve substantive change in correctional policy: the common law tort of negligence.

1 *The Tort of Negligence as 'Ombudsman'*[77]

Negligence law is all about balancing interests: a defendant's conduct on the one hand, and the rights of those affected by that conduct on the other. Over the last several years, negligence law has struggled to get the balance right in spheres of activity far removed from those traditionally seen to be the site of most negligent activity: at the workplace and on the roads. In these novel situations, this tort increasingly recognises and acknowledges that it can, as Linden asserts, act as ombudsman or standard-setter, and that potentially it can play a role in formulating and shaping desirable behaviour. These situations range from an Aboriginal woman's (Joy Williams') suit against welfare agencies for having removed her from her home while she was a young child,[78] to suits by three Aborigines (Alex Christian, Wayne Ryan and Sherry Lucas) against the Commonwealth for the alcoholism from which they suffered,[79] to the claim of a child

erally, restrictions on the capacity to sue have diminished; for example, the common law restriction was abolished in WA: Criminal Code 1913 (WA) s 683.

77 Allen Linden, 'Reconsidering Tort Law as Ombudsman' in Freda Steel and Sandra Rodgers-Magnet (eds), *Issues in Tort Law* (1983) 20. See also Allen Linden, *Canadian Tort Law* (5th ed, 1993) ch 1, where he discusses tort law's role as ombudsman and the ways in which it arguably serves education, publicity, deterrence and compensation objectives.

78 *Williams v Minister for Aboriginal Land Rights Act 1983 and Another* (1994) 35 NSWLR 497. This case, still the subject of litigation, was initially contested by the defendant with the argument that the claim had not been brought within the limitation period. Although Studdert J held that the plaintiff was statute-barred, this was reversed by the New South Wales Court of Appeal.

79 *Commonwealth of Australia v Eland and Christian, Ryan and Lucas* [1992] Aust Torts Reports 61-203 ('*Eland*'). Ultimately, the three Aboriginal claimants failed in their suit against the Commonwealth, for various reasons, including Studdert J's determination that because the Commonwealth was exercising a policy making function of government, it did not owe them a duty of care. He also held that there was no special relationship between the claimants and the Commonwealth.

(Vanessa Lynch) against her mother for the cerebral palsy she sustained while injured in her mother's womb as a result of her mother's negligent driving.[80]

While disagreement exists as to whether the tort of negligence reached the most desirable results or determinations in these cases,[81] what cannot be denied is that negligence law is being increasingly utilised by diverse segments of the community who would otherwise have nowhere to turn to seek and obtain legal redress. At the very least, these marginalised and disenfranchised individuals are using this tort in attempts to make significant public statements.

It is important here to stress that the fundamental aim served by the (hypothetical) negligence action discussed in the next section is not primarily one of obtaining damages for a prisoner whose seroconversion could be causally linked to a prison authority's negligence, but as a means by which institutional change might be effected. Like Joy Williams, Alex Christian, Wayne Ryan, Sherry Lucas and Vanessa Lynch, prisoners might find the pursuit of an action grounded in modern day negligence law valuable as a means to persuade prison authorities to protect them from the contraction of HIV. I am not suggesting that tort be used to bring an action for harm suffered as a result of inter-personal relationships, for example, if one partner infected the other with the HIV virus. Rather, I am arguing that negligence has a role to play in changing institutional responses to the risk of infection, making those managing our prisons accountable for their neglect. This is so despite the problems generally associated with litigation.[82] While these problems cannot be discounted or ignored, they should not be seen in a general way to overwhelm the usefulness of the negligence action, and its possible success, where the defendant prison authority is characterised as a body with particular responsibilities for the care of those over whom it has exclusive control and custody.

2 *The Tort of Negligence in the Prison Context*

The most important common law right available and relevant to prisoners — an action for damages in the tort of negligence — involves being owed a duty of care. The action offers redress if that duty is breached and the breach causes harm that is not too remote.[83]

(a) Duty of Care

A common law duty of care[84] in the prison context might be said to include

[80] *Lynch v Lynch and Another* (1991) 25 NSWLR 411. The child's claim succeeded, in a decision very much restricted to the context from which it arose: against the backdrop of compulsory third party liability insurance for motor vehicle accident claims.

[81] For example, the decision in *Eland* is critiqued in Rae Kaspiew, 'Does the Commonwealth Owe a Duty of Care to Aborigines to Protect them from Alcohol?' (1994) 2 *Torts Law Journal* 32.

[82] The problems with civil litigation and a fault-based cause of action (such as practical barriers to claims and assessment of damages issues) are dealt with generally in Intergovernmental Committee, *Civil Liability*, above n 72; see discussion below nn 259-60 and accompanying text.

[83] As was noted earlier, s 47(2) of the Corrections Act 1986 (Vic) specifically preserves common law rights. See *Jaensch v Coffey* (1984) 155 CLR 549 for Deane J's widely cited discussion of the fundamental elements of a negligence action.

[84] 'This duty is the one which, to date, has figured most prominently in discussions of the relevance of legal liability to policy development on HIV/AIDS': John Godwin, 'Rights, Duties, HIV/AIDS and Corrections' in Jennifer Norberry *et al*, *Conference Proceedings*, above n 21, 169, 170.

the notion of 'protection from disease'.[85] *Prima facie*, prison authorities without question, owe a duty of care to those in their custody.[86] Aside from the legal requirements formulated on the basis of first principles[87] (which also satisfy common sense), several authorities specifically recognise the existence of the duty to take care in circumstances of imprisonment.[88]

The existence of a duty of care — based on the relationship of custodian and detainee — would be established in these circumstances, barring one possible issue: whether the government or prison authorities' conduct emanates from a policy or planning decision, as opposed to one which might be characterised as being of an operational nature. In the *Prisoners* case, counsel for the State of New South Wales, citing *Sutherland Shire Council v Heyman*[89] and *Parramatta City Council v Lutz*,[90] argued that public authorities could not be liable for damage arising out of a policy decision. The plaintiffs argued, however, that where the duty owed to the plaintiff was unquestionable,[91] and where the action under consideration is not one of quasi-legislative character but of implementation,[92] the fact that this relates to issues of policy affords no defence.[93]

Dunford J agreed in large part with this distinction between policy and operational decisions. Importantly, he concluded (in *dicta*) that 'if the failure to take a certain action constitutes a breach of duty to an individual to take reasonable care, the defendant cannot excuse itself by claiming a policy decision has been made that such action would not be taken'.[94] As such, the published policy of the Department of Corrective Services not to allow condoms was not reviewable,

85 Cases involving contraction of diseases other than HIV have been litigated in the United States. For example, in *Lareau v Manson*, 651 F 2d 96 (1981), the court held that a failure to adequately screen newly arrived prisoners for communicable diseases, where prisoners were housed in conditions of overcrowding, violated due process rights and was 'cruel and unusual punishment for neighbouring inmates'. In particular, there have been cases involving prisoners wishing to be protected from the contraction of tuberculosis: in *Austin v Pennsylvania Department of Corrections*, 1992 WL 277511 (E D Pa), inmates successfully challenged the lack of sufficient tuberculosis control plan and treatment measures: see generally, Greifinger *et al*, above n 36. Because HIV is contracted in a manner quite different from other diseases, strategies used to prevent its spread are unique. So too are arguments raised in the context of those other diseases. Therefore, care must be taken before relying too heavily, by way of analogy, on those arguments. With respect to some of the special problems associated with tuberculosis, see discussion above n 36.

86 *Prisoners* (1994) 75 A Crim R 205, 212 citing *Cekan v Haines* (1990) 21 NSWLR 296; see, eg, *Hall v Whatmore* [1961] VR 225 and *Quinn v Hill* [1957] VR 439. See also Norberry, 'HIV/AIDS, Prisons and the Law', above n 74, 91.

87 *Jaensch v Coffey* (1984) 155 CLR 549 (Deane J); *Sutherland Shire Council v Heyman* (1985) 157 CLR 424 (Deane J); adopted by a majority of the High Court of Australia in *Cook v Cook* (1986) 162 CLR 376 and a differently constituted majority in *Gala v Preston* (1991) 172 CLR 243. Clearly, the risk of harm to this class of person is foreseeable, the authorities and detainees are in a proximate relationship (whether the nature of their proximity is physical, circumstantial or causal) and there would be no convincing policy reasons (in terms of fairness or justice, which are said to inform proximity) to deny finding a duty.

88 *Hall v Whatmore* [1961] VR 225; *Quinn v Hill* [1957] VR 439.

89 (1985) 157 CLR 424, 438, 468-9 (Mason J), 500 (Deane J).

90 (1988) 12 NSWLR 293, 309-10.

91 *Cekan v Haynes* (1990) 21 NSWLR 296.

92 Cf *Sutherland Shire Council v Heyman* (1985) 157 CLR 424.

93 *Parramatta City Council v Lutz* (1988) 12 NSWLR 293.

94 *Prisoners* (1994) 75 A Crim R 205, 213, citing with approval Kirby P in *Parramatta City Council v Lutz* (1988) 12 NSWLR 293, 310.

but the refusal of access to condoms to individual prisoners may be. It was for this reason that his Honour dismissed the group action. Such claims must be made on the basis of individual needs for access to condoms: operational rather than policy decisions.[95] This highlights an important point in the formulation of this issue, noted in the plaintiffs' submissions: there is a substantial difference between arguing that the basis for the prisoners' action is that they *should* have access to condoms in order to minimise the risk of contracting HIV/AIDS, and arguing that it is not lawful, in addition to the sentence imposed by law, to subject prisoners to a condition whereby they are deprived of the means available to private citizens to protect their health during sexual contact.[96] The difference may appear to be one of emphasis. It seems to shift the focus from prisoners arguing that they should have the right to have access to condoms to arguing about the statutory basis for their denial.

Difficulties lie in distinguishing between policy as opposed to operational decisions, despite the fact that the courts offer guidelines to do so.[97] While helpful, Mason J's guidelines do not solve the problem. The nature of the decision and how it is described may be of critical importance. In her or his favour, a prisoner may contend that in cases involving the denial of condoms or other preventative measures, prison authorities' arguments do not turn on resource availability or scarcity justifications as is often the case in disputes regarding whether decisions are policy based as opposed to operational. These are not decisions which 'involve or are dictated by financial [or] economic ... factors or constraints'.[98] However, the authorities' success in characterising their decisions as policy-making should not be under-estimated; they would surely try to categorise them as decisions involving 'social or political factors'.[99] In response, a prisoner might argue (with difficulty) that these decisions are, in fact, 'merely the product of administrative direction ... or general standards of reasonableness.'[100] Importantly, 'Mason J was careful to recognise that the scope of policy matters which are properly outside the ambit of negligence liability is narrow and that not all discretions entrusted to government agencies are excluded.'[101] It is difficult to predict how this type of issue will be resolved in a future case.

While the policy/operational dichotomy was used in *Prisoners* to cut out the

95 *Prisoners* (1994) 75 A Crim R 205, 213-15.

96 *Prisoners*, Plaintiff's Outline of Submissions, para 3.2.

97 See Mason J in *Sutherland Shire Council v Heyman* (1985) 157 CLR 424. For a similar consideration of these issues in Canada, see *Just v British Columbia* [1989] 2 SCR 1128. Cory J states at 1242: 'The duty of care should apply to a public authority unless there is a valid basis for its exclusion. A true policy decision undertaken by a government agency constitutes such a valid basis for exclusion. What constitutes a policy decision may vary infinitely and may be made at different levels, although usually at a high level'.

98 *Sutherland Shire Council v Heyman* (1985) 157 CLR 424, 469 (Mason J).

99 Ibid.

100 Ibid.

101 Luntz and Hambly, above n 48, 441. They continue at 442: 'In some instances the nature of the decision is such as to remove it altogether from the ambit of the law of negligence and to provide remedies, if any, only in public law. In others, the fact that a discretion is to be exercised is relevant to the question of proximity in its "just and reasonable" aspect'. See M Aronson and H Whitmore, *Public Torts and Contracts* (1982) 77-86 for a discussion of duty of care principles, discretion and immunity.

prisoners' claim in one respect, it did not prove fatal. Dunford J did not go so far as to rule out the plaintiffs' claims altogether. By finding that individual plaintiffs could characterise their claims in the light of the duty of care owed to them individually, their claims could still be pursued.

(b) Breach

Establishing a duty of care is the least of a plaintiff's worries in satisfying the requirements of the negligence action. More difficult may be the establishment of a breach of that duty — a failure to exercise the degree of care that is reasonable in the circumstances. Could prison authorities be held liable in negligence for failing to comply with the standard of reasonable care expected of them if they persist in refusing to provide condoms, dental dams, cleansing equipment or clean needles in gaols?[102]

Unlike previous dissimilar HIV-related litigation involving the contraction of medically acquired HIV/AIDS (where the claims focussed on what the defendant hospitals and blood bank authorities ought to have known at particular points in time),[103] in cases these days there is no doubt, factually, that potential defendants ought to know of the risk that the disease may be contracted as a result of their refusal to provide measures designed to prevent the spread of the virus. In the prison context, it is quite certain that the authorities could not only foresee the injury that could ensue, but in fact *knew* of the existence of HIV/AIDS and how it is spread in the community at large, and in gaols in particular. The community has known for over 10 years that HIV may be contracted by unprotected intercourse and sharing unclean needles. The risk is far greater than a foreseeable one; it is known. The issue, then, relates not simply to the prison authorities' knowledge of the risk of transmission, but to their actual conduct, which seems premised on wilful blindness of these recognised dangers.

The attitudes of groups within correctional services in responding to the issue of prevention of the spread of HIV in many ways reflects two very different world views. The approach of correctional and — especially, though not exclusively, conservative — government officials stresses the need to enforce regulations, the dangers of appearing to condone prohibited behaviour and the need to maintain security and institutional control. By contrast, health care workers in particular emphasise the need to implement a public health model which recognises that risky sexual activity and unsafe injecting drug use are facts of prison life and, as a result of this recognition, seek to minimise or prevent infection and disease.[104]

The central question of reasonableness — and the measures that are or are not available to prevent the spread of HIV in Australian (and overseas) gaols — is considered in detail in Part III.

[102] Godwin *et al*, *Legal Guide*, above n 1, 272.

[103] See, eg, *PQ v Red Cross* [1992] 1 VR 19; *Dwan v Farquhar* [1988] 1 Qd R 234.

[104] Cf Hammett and Daugherty, above n 60, 40.

(c) Causation

One element of the negligence action which, in reality, can frequently be difficult to prove is causation. In this context, however, satisfying this requirement may not prove inordinately exacting, although the success or otherwise of proving causation will, as always, be dependent on the facts of the particular case. Because of the latitude permitted by the doctrine itself, courts certainly have the opportunity to resolve these matters in the plaintiff's favour. However, the potential stumbling blocks to a typical prisoner's arguments, which will undoubtedly present themselves, should not be underestimated.

Common sense is the current touchstone for determination of this issue.[105] Factually, on a common sense basis (and on a balance of probabilities), the non-provision of measures which could help prevent the spread of the virus caused the harm. Based on the notion of 'but-for' causation, if it were not for the authorities' failure to provide a prisoner with clean needles, or bleach, or dental dams, or condoms (depending on the nature of the behaviour in a particular instance), would the prisoner have contracted the virus? Scientific evidence points to the fact that she or he would not have incurred the disease had the measure been available. Of course this assumes that, from an evidentiary point of view, other potentially causative factors are eliminated. This would require, for example, having conclusive proof that the individual at issue was HIV negative prior to incarceration for a period longer than the six month 'window period', and that the seroconversion occurred in gaol.

A claim would fail if evidence establishing the individual's HIV status when first imprisoned is unavailable. From a litigation perspective, the Australian detainee recently identified as having conclusively seroconverted while in prison (and those detainees suffering the same fate while imprisoned in Scottish gaols) obviously would be the kinds of plaintiff best able to succeed in a negligence action. They would argue that they suffered damage as a result of the relevant authorities' breaches. On the other hand, if Dunford J's rather robust view of the ability of the court to grant injunctive relief prior to damage being incurred — an unconventional view which seems to ignore what is traditionally said to be the 'gist of the action' — is correct, then the occurrence of seroconversion while in gaol would not be a prerequisite to bringing a claim.[106] An action for damages could be instituted to secure *preventative* measures, on behalf of an HIV nega-

105 *March v E & M H Stramare Pty Ltd* (1991) 171 CLR 506 ('*March*').

106 See discussion above n 48 and accompanying text. Importantly, while the New South Wales Court of Appeal cites Dunford J's decision on this point in some detail, they did not in any way criticise the substance of what he said. Referring to his decision, the New South Wales Court of Appeal states:

> His Honour saw no reason why in an appropriate case the Court would not grant an injunction to restrain the tort of negligence, even without proof of damage. Accordingly, if the appellants were able to establish by evidence that the failure by the Department to permit their use of condoms constituted a breach of the duty of care it owed to them, they might be entitled to injunctive relief. However his Honour pointed out that claims to mandatory injunctions by individual prisoners to restrain operational breaches of the duty of care must depend, in part, on the circumstances of the individual plaintiffs and the perceived need of such individual plaintiffs for access to condoms.

Prisoners A-XX Inclusive v State of New South Wales (Supreme Court of New South Wales, Court of Appeal, Meagher, Sheller and Powell JJA, 8 August 1995, 4).

tive prisoner who happens to be at risk of later transmission of the virus should the measures not be implemented. Indeed, in the light of Dunford J's decision in the *Prisoners' case*, it is at least arguable that no damage need be suffered, as he suggests that injunctive relief might be available in order to prevent harm.

The argument that condoms, dental dams, needle cleaning equipment or clean needles might not be used has been raised in response to calls for their introduction.[107] This does not address the question of whether or not they should be *available*, thereby empowering the individual prisoner to make the decision to use or not use them (rather than the government or the institution). If in the course of a specific action it were demonstrated that such measures would not have been used, then there are clear difficulties in establishing causation.[108] This should not, however, provide the basis for an outright rejection of the thesis that institutional change is possible through an individual case.[109]

An additional factor relevant to establishing causation is potentially problematic: was there intervening conduct which warrants the non-attribution of liability to the defendant? For example, could the authorities be relieved of responsibility because the prisoner's own behaviour might be seen to sever the linkage between the wrongful act which is a factual cause of harm (for example, non-provision of condoms, dental dams, needle cleaning equipment or syringes) and the prisoner's consequent harm? The prison authorities may argue that the scene-setting cause could not be said to be a legal cause of the prisoner's contraction of HIV.[110] They would contend that the true cause of infection is the plaintiff's own behaviour, especially where education programs regarding minimisation of the risk of contraction of the disease are provided. In response, as a preliminary point, the wrongful act is assumed to be the non-provision of tangible preventative measures, and the provision of education programs without providing barriers, for example, may be characterised as inadequate. More importantly, Mason CJ's reasoning in *March v E & M H Stramare Pty Ltd* must be considered:

> In law ... problems of causation arise in the context of ascertaining or apportioning legal responsibility for a given occurrence ... thus, at law, a person may be responsible for damage when his or her wrongful conduct is one of a number of conditions sufficient to produce that damage.[111]

107 Roughley, above n 13, 28.

108 *Quigley v The Commonwealth* (1981) 35 ALR 537. If it is improbable that the plaintiff would have used a particular safety feature, it is not negligent for the defendant to fail to supply it; Luntz and Hambly point out the interrelationship between breach and causation and the difficulties faced by a plaintiff in a case where the defendant's negligence constitutes an omission: Luntz and Hambly, above n 48, 279. Roughley states, 'Many in the community with access to bleach/sterile needles, and especially condoms, do not use them': above n 13, 28. This is, however, rather beside the point: those of us in the general community have the ability and opportunity to use these preventative measures; unlike prisoners, we are not under the care, custody and control of the state for every one of our wide-ranging, disparate needs.

109 Cf Lambrou, above n 30, 329.

110 *March* (1991) 171 CLR 506. In *Mount Isa Mines Ltd v Bates* [1972-73] ALR 635, the fact that the employee did not wear safety glasses did not amount to a new intervening act, as this was a foreseeable omission which the employer could have guarded against easily.

111 *March* (1991) 171 CLR 506, 509.

A defendant will not necessarily be relieved of responsibility simply because of the plaintiff's own conduct. While the plaintiff's action has to be considered in terms of its legal consequences, on the basis of the court's reasoning in *March* it should not in and of itself be sufficient to negate the claim. Rather, it may result in a contributory negligence finding and consequent apportionment.[112] The court clearly favours use of apportionment where the scenario warrants it. In doing so, arguments based on 'last opportunity' or 'last clear chance' are laid to rest.

Because value judgments and policy matters have an important role to play in assessing causal responsibility,[113] one can not predict with confidence how it would be attributed in a case of this nature. In the plaintiff's favour is the fact that the duty (arguably) imposed on the defendant was to protect the plaintiff from the very risk of injury that befell her or him. As in *March*, this negligence is a continuing cause of the accident, and the causal link was not broken by a new intervening act; further, the risk was clearly foreseeable. The defendant, on the other hand, would have to argue that the plaintiff's own negligence was the sole real cause of the harm, as a matter of ordinary common sense. If that were so, then issues of apportionment would not even come into play.[114]

One final matter which complicates litigation of the issue of damage is the very nature of this disease:

> If a person is infected and succumbs to the disease, there is clearly injury. The problem from a legal point of view is the situation in which the plaintiff becomes infected, but at the time of the lawsuit has not yet developed the disease. There is a very strong possibility that AIDS will be developed, but it is by no means guaranteed, nor is it certain how long the development might take.
>
> Seeking compensation for exposure to the virus is significantly different than actually developing the disease, when the actual injury is known. Furthermore, it is impossible to predict the type of illness the plaintiff will acquire as a result of contracting AIDS. It would be advantageous to wait until the actual injuries are known, so that a fully developed legal claim could be made. The danger in doing this is that the plaintiff or the defendant might not survive that long. The claim becomes more difficult to prove as time increases.[115]

112 In *March*, the plaintiff succeeded despite his having driven at excessive speed while impaired by alcohol, but he was found contributorily negligent.

113 See, eg, Mason CJ's explanation of the unfortunate decision, *M'Kew v Holland and Hannen and Cubitts* [1970] SC (HL) 20, in *March* (1991) 171 CLR 506, 510. Fleming, above n 48, 193, comments:

> As a matter of practical politics, some limitation must be placed upon legal responsibility, because the consequences of an act theoretically stretch into infinity. There must be a reasonable connection between the harm threatened and the harm done. This inquiry, unlike the first [factual causation], presents a much larger area of choice in which legal policy and accepted value judgments must be the final arbiter of what balance to strike between the claim to full reparation for the loss suffered by an innocent victim of another's culpable conduct and the excessive burden that would be imposed on human activity if a wrongdoer were held to answer for all consequences of his [or her] default.

114 *March* (1991) 171 CLR 506, 522 (Deane J).

115 L Rozovsky and F Rozovsky, *AIDS and Canadian Law* (1992) 56.

(d) Voluntary Assumption of Risk

Several obvious defences could be raised in response to a negligence action in the context of being infected with the HIV virus while in gaol. In assessing the potential efficacy of these defences, it must be borne in mind that situations of consensual behaviour should be separated from those which are non-consensual. The latter are relatively infrequent compared to the former, despite suggestions to the contrary by the tabloids, television talk shows and other popular myth-makers.

The hurdle that will, in all probability, prove most problematic to the plaintiff's case is the authorities' expected response that where the behaviour is arguably consensual, the sufferer 'voluntarily assumed the risk' of injury. Godwin states:

> Although the application of this principle of liability [duty of care] to protection of prisoners from HIV is yet to be considered by an Australian court [this was written prior to the *Prisoners* case] it is highly likely that the common law duty of care does extend to protecting uninfected prisoners from exposure to infection in foreseeable violent incidents, such as rape or needle assaults where the assailant has a history of violence. It is less likely that liability could arise under common law principles where a prisoner is infected as a result of consensual sexual or needle use activity. The common law recognises a defence of consent to the risk of the harm (*volenti non fit injuria*). The common law is unlikely to grant a remedy where the prisoner claims compensation for the results of an unlawful activity (sex or drug use) in which he or she voluntarily participated.[116]

Although admittedly problematic, this is a hurdle that is, arguably, not as insurmountable as Godwin suggests.[117] In order to establish this defence, the defendant must show that the plaintiff knew of the facts constituting the danger, appreciated the danger of the situation and freely and willingly agreed to encounter the danger.[118] Traditionally, courts have been loathe to give effect to this complete defence because of its harshness in result. Its criteria are generally interpreted so strictly that the defence is rarely satisfied.[119]

Current prison policy with regard to education may be said to attempt to address the first two requirements of the defence (with varying degrees of success).[120] Because the nature of the risk which is arguably being 'consented to' is strictly and narrowly construed, prisoners may contend that the risk they are consenting to is the use of a drug, or engagement in sexual relations. They are

116 Godwin, 'Rights', above n 84, 170.

117 However, Norberry agrees with Godwin: 'While the complete defence of voluntary assumption of risk is generally in retreat, it is suggested that the courts would look favourably on it where a prisoner commenced legal action in these circumstances': Norberry, 'HIV/AIDS, Prisons and the Law', above n 74, 93.

118 *Scanlon v American Cigarette Company (Overseas) Pty Ltd [No 3]* [1987] VR 289.

119 As Fleming notes, it is hardly ever successful: above n 48, 291.

120 See discussion below nn 148-56 and accompanying text. Fleming, ibid 300, notes:

> [t]he increasing stringency with which this requirement is being applied has probably contributed as much as anything to the contemporary eclipse of the defence. Accordingly, unless there is a clear appreciation of the hazard, the plaintiff's persistence in the face of impending danger can at most amount to contributory negligence.

not consenting to the contraction of HIV.

Whether a plaintiff 'freely and willingly' undertook the particular risk is the most contentious question in this area of inquiry.[121] An argument can be made that if a prisoner shared an unclean needle in the context of her or his addiction, such circumstances would militate against a finding that she or he 'voluntarily assumed the risk' of infection with the virus. Simply put, the addiction negates free will and volitional behaviour.[122] In situations involving consensual, unprotected sexual activity, the issue is far more complex. In the past, courts have (in admittedly very different contexts) been prepared to recognise the complexity of human will and the importance of a broad understanding of the circumstances in which decisions are made.[123]

If a court were to consider this issue, the doctrinal possibilities open to it mirror the policy stances open to prison authorities. On the one hand, a formalistic approach viewed within the legalistic framework of autonomous transcendental subjects would see consensual sex as both demonstrative and conclusive of a freedom of will antithetical to the loss-shifting mechanisms of tort law. The defence would be upheld.[124]

[121] This is a great controversy in several other contexts as well, ranging from injuries sustained by employees at their workplaces, to motor vehicle passengers and their drunk drivers. Fleming notes that the defence virtually disappeared in workplace situations, where it had been most prevalent, because the absence of true bargaining equality increases the difficulty of proving the risk was voluntarily assumed; he states that this holds true in other circumstances, and that 'the defence cannot succeed any more unless the evidence supports a genuine inference that the plaintiff consented not merely to the risk of injury, but also to the lack of reasonable care which may produce that risk': ibid 297.

[122] Merritt disagrees: 'There is a strong argument that the individual who engages in the unlawful use of drugs assumes the risk of contracting disease through the sharing of needles': above n 5, 106. Issues of addiction have arisen in other circumstances, including those relating to causation, remoteness of harm issues and the 'eggshell skull rule': see, eg, *Yates v Jones* (1990) Aust Torts Reports 67,632. With respect to the instant context — addiction and the unavailability of the voluntary assumption of risk defence — a certain degree of common sense must be employed in querying whether it is possible for true, free choice to exist when it is assumed, factually, that the plaintiff is addicted. Analogous cases involve rescuers (*Haynes v Harwood* [1935] 1 KB 146) and individuals who commit suicide (*Haber v Walker* [1963] VR 339) — under senses of compulsion. In *Kirkham v Chief Constable of the Greater Manchester Police* [1990] 2 QB 283 ('*Kirkham*'), voluntary assumption of risk was not permitted to defeat the claim. Having regard to the suicide's mental state, he could not, by his act, be said to have waived or abandoned any claim arising from his suicide; his judgment was impaired, even though he knew what he was doing, and even though his suicide was a deliberate and conscious act. By analogy, an addict's judgment is similarly impaired; it could be argued that it would be misguided to characterise her or his conduct as truly voluntary. Further, as Farquharson LJ states in *Kirkham* at 295, the defence is inappropriate where the act of the deceased said to be voluntary is the very act which the defendant was required to prevent by virtue of its duty.

[123] See, eg, *Thrussell v Handyside* (1888) 20 QBD 359, 364 (Hawkins J: 'his poverty, not his will, consented to incur the danger'); cf *Membery v Great Western Ry Co* (1889) 14 App Cas 179, 188. In *Bowater v Rowley Regis Corporation* [1944] 1 KB 476, 479-80 Scott LJ, in the context of master-servant relationships, commented:

> For the purposes of the rule, if it be a rule, a man [or a woman] cannot be said to be truly 'willing', unless he [or she] is in a position to choose freely; and freedom of choice predicates, not only full knowledge of the circumstances upon which the exercise of choice is conditioned, in order that he [or she] may be able to choose wisely, but the absence from his [or her] mind of any feeling of constraint, in order that nothing shall interfere with the freedom of his [or her] will.

[124] Merritt states, 'Where the sexual activity is consensual, it is difficult to conceive of a situation where the institution would be liable for the transmission of HIV': above n 5, 110. Commenting on the possibility that a case could be brought for failure to provide protection from sexual assault, Ham-

On the other hand, an approach that considered human action (and prison policy) as existing not in a vacuum, but connected to and informed by the actions of others and the broader context of those actions, may be more open to accepting that an argument of voluntariness is perhaps an overly-simplistic (and incorrect) way in which to address this question.[125] Moreover, if this were linked to the argument outlined above — that is, that what is being discussed is not merely the right to have access to condoms, but the power of prison authorities to deny access to them[126] — then this could form the basis of arguments negativing the defence.

Of course, the authorities and perhaps the public may have little sympathy for a plaintiff who engages in risky behaviour. But that person is not asking for anyone's sympathy. Rather, she or he is demanding reasonable, responsible conduct by her or his custodian. And the vulnerability of a detainee by comparison to the power enjoyed by prison management cannot be ignored where the plaintiff's 'free and willing' behaviour is at issue.

(e) Contributory Negligence

The authorities may also rely on the contributory negligence defence. This partial defence, which is easier to prove than voluntary assumption of risk, could quite plausibly affect the HIV-infected prisoner's claim. Some of the arguments which would be raised here would be somewhat similar to those used as part of the voluntary assumption of risk defence.

Could the prisoner's own act of practicing unsafe sex or using injecting drugs with unclean instruments be considered a failure to take care with respect to her or his own safety? It is possible that a court might make such a finding, especially in the light of the fact that damages could be apportioned as between the authorities and prisoner.[127] To do so, however, involves an unrealistic assessment of the true dynamics of prison circumstances.

Some commentators have stated that courts are likely to hold that the plaintiff has a responsibility (to herself or himself) not to become HIV infected or exposed to the virus. The guiding principles of the National HIV/AIDS Strategy might be cited in support of this.[128] While this correctly assesses what a court would do in a situation involving contraction of HIV where a 'typical' interpersonal relationship is involved, the fact of imprisonment may generate a

mett concludes that prison authorities should not be held to be insurers of absolute safety to inmates and can only be held to a standard of reasonable care; if the act were consensual, he states that as long as the authorities provided education and training to prisoners about the way in which the virus may be transmitted, then the voluntary assumption of risk defence would be operative: Hammett *et al*, above n 5, 61.

125 Recognising the complexity of sexuality issues, Grimsley, above n 11, 4, states:

> Because sexuality is so deeply embedded as a part of a person's masculine or feminine identity and self-concept, and because sexual beliefs, values and behaviours are mostly the result of complex culturally and contextually specific learning, attempts to influence beliefs and behaviours in this area need to go well beyond the provision of information about safe sex practices. With heterosexual men in particular this represents a real challenge for education programs.

126 See discussion above n 96 and accompanying text.

127 The ability to apportion responsibility was of critical importance to the court's reasoning and decision in *March* (1991) 171 CLR 506; see discussion above n 112 and accompanying text.

128 Godwin *et al*, *Legal Guide*, above n 1, 263.

different result. It might be argued that there is less opportunity for an individual detainee to truly take care for her or his own safety, as the prisoner is virtually totally dependent on the authorities — including officers, the governor, Director-General of Corrections and Government — for her or his care.

For this defence to succeed, the purported lack of care for the prisoner's own safety must contribute causally to the injury or harm suffered. The plaintiff's own negligence will only be prejudicial to the claim if it were causally relevant to the injury, in the sense that but for her or his own negligence, she or he would not have been harmed. The connection must be between the harm suffered and that aspect of the plaintiff's conduct which is indeed wrongful.[129]

Of importance in the circumstances of HIV/AIDS is the fact that contributory negligence is not available as a defence to wrongful death claims in Victoria, but may be relied upon in other jurisdictions.[130]

(f) Illegality

Unilateral illegality does not necessarily preclude recovery. According to Latham CJ in *Henwood v Municipal Tramways Trust*,

> there is no general principle ... that a person who is engaged in some unlawful act is disabled from complaining of injury done to him [or her] by other persons, either deliberately or accidentally .... It cannot be held that there is any principle which makes it impossible for a defendant to be liable for injury brought about by his [or her] negligence simply because the plaintiff at the relevant time was breaking some provision of the law.[131]

A remedy could, however, be denied on the following basis:

> [I]n every case the question must be whether it is part of the purpose of the law against which the plaintiff has offended to disentitle a person doing the prohibited act from complaining of the other party's neglect or default, without which his [or her] own act would not have resulted in injury.[132]

[129] Fleming, above n 48, 279. In the context of sexual activities in gaol, because dental dams and condoms are not provided (generally), the act which would be causally relevant as a 'failure to take care with respect to one's own safety' — or 'wrongful' — would be the sexual activity per se. The defendant 'need only show that the plaintiff failed to take such precautions as a reasonable person would have taken for his or her own protection': Luntz and Hambly, above n 48, 357. That is, since condoms and dental dams are not in fact provided, prison authorities will argue that it is unreasonable for prisoners to engage in unsafe sexual activities. Some prison legislation prohibits sexual activities in gaol (except where specifically permitted; for example, conjugal visits); see discussion below, at 451.

[130] Wrongs Act 1958 (Vic) s 26(4).

[131] *Henwood v Municipal Tramways Trust* (1938) 60 CLR 438, 446 ('*Henwood*'). Fleming writes, 'Generally speaking, the mere fact that the plaintiff happened to be engaged in something unlawful at the time of his [or her] injury is no disqualification in tort'; 'nor is the need to deter unlawful conduct nowadays considered so urgent that it is better public policy to make the offender in effect an outlaw by depriving him [or her] of tortious redress': above n 48, 305. In cases where there is joint participation in an illegal activity, courts sometimes resist finding liability, for various reasons. One rationale is that there is said to be no relationship of proximity between defendant and plaintiff (informed by policy considerations) with the consequence that no duty of care is owed: *Gala v Preston* (1991) 172 CLR 243. Joint illegality is an inappropriate argument in a case where a prisoner engages in risky behaviour and the defendant refuses to prevent the potential consequences of that behaviour; the parties can not be said to be acting in concert.

[132] *Henwood* (1938) 60 CLR 438, 460 (Dixon and McTiernan JJ).

Like most legislation creating offences,[133] prison acts and regulations prohibiting sexual activities and drug use in gaols (or possession of contraband) do not manifest an intention to deny a civil remedy to persons committing such infringements. Rather, they presumably are intended to assist authorities' efforts to manage and administer prisons.[134]

Illegality arguments would, in all likelihood, prove to be attractive to defendant authorities and perhaps to courts. They could be raised in cases involving illegal use of injecting drugs while in gaol,[135] and in those jurisdictions where prohibitions on sexual activities in gaols are prohibited.[136]

Illegality should fail as a defence in its own right, because of the rule in *Henwood* as well as the narrow scope given to it as a defence in jurisdictions similar to Australia. For example, in *Hall v Hebert*[137] the majority of the Supreme Court of Canada states that the availability of the illegality defence is very narrowly circumscribed. According to Cory J, it should generally be confined to the contractual sphere. Furthermore, it generally frustrates the satisfaction of tort law's aims. McLaughlin J states that the fundamental concern is the preservation of the integrity of the legal system:

> [T]here is a need in the law of tort for a principle which permits judges to deny recovery to a plaintiff on the ground that to do so would undermine the integrity of the justice system. The power is a limited one. Its use is justified where al-

133 Luntz and Hambly, above n 48, 509.

134 There may be doubts as to the efficacy of these measures, let alone the appropriateness of some of them.

135 Examples of provisions — relevant to drug use — which prohibit and attempt to ban articles and activities, but which do not demonstrate any relevance to the availability (or otherwise) of civil claims, include the following: Prisons Act 1952 (NSW) s 37 (it is an offence to bring or attempt by any means to introduce into any prison a drug); s 37A (a person who introduces a syringe into a prison or attempts to introduce a syringe into a prison, or who supplies a syringe to a prisoner who is in lawful custody, is guilty of an offence and liable to imprisonment for a term not exceeding two years); Corrective Services Regulations 1989 (Qld) reg 29(b) (it is a breach of discipline to possess an article or thing the possession of which is not directly or impliedly authorised); reg 29(o) (it is a breach of discipline to use or administer a drug); Correctional Services Act Regulations 1985 (SA) reg 37 (prisoners are forbidden to administer or consume an unauthorised substance); Corrections Regulations 1988 (Vic) reg 74(c)-(e) (prisoners commit prison offences if they (a) traffic in an unauthorised article or substance; (b) possess an unauthorised article or substance; (c) take or use alcohol, a drug of dependence or an unauthorised substance or article).

136 There are a range of misguided provisions purporting to prohibit sexual activities in gaol, including: Correctional Services Act Regulations 1985 (SA) reg 20 (prisoners are prohibited from engaging in any act of sexual intercourse with a prisoner); reg 161 of the Prisons (General) Regulation 1989 (NSW) (a prisoner must not act in an obscene manner or wilfully and obscenely expose his person in the presence of another prisoner or of a prison officer); Corrective Services Regulations 1989 (Qld) reg 29(e) (it is a breach of discipline to behave in an offensive, obscene or indecent manner). In a case involving Tasmanian male prisoners engaged in sexual activity, which is a 'crime against nature' under the Tasmanian Criminal Code, illegality arguments could conceivably be raised. However, the authorities would have some difficulty relying on the Tasmanian statute as it violates international law obligations and has been overruled by the Commonwealth. For an analysis of the Tasmanian sodomy laws, see Wayne Morgan, 'Identifying Evil For What It Is: Tasmania, Sexual Perversity and the United Nations' (1994) 19 *MULR* 740. Arguments as to why prohibited sexual activities in gaols should no longer be banned, in the light of the availability of condoms in Canadian prison and harm reduction strategies, are discussed below nn 192-5 and accompanying text.

137 *Hall v Hebert* (1993) 101 DLR (4th) 129. In *Kirkham* [1990] 2 QB 283, the Court of Appeal rejected the contention that granting relief in a claim directly arising out of a person's suicide would 'affront the public conscience or shock the ordinary citizen'.

> lowing the plaintiff's claim would introduce inconsistency into the fabric of the law, either by permitting the plaintiff to profit from an illegal or wrongful act, or to evade a penalty prescribed by criminal law. Its use is not justified where the plaintiff's claim is merely for compensation for personal injuries sustained as a consequence of the negligence of the defendant.[138]

On the basis of this reasoning, illegality should be held to be an inappropriate defence in the context of the commission of prison disciplinary offences because a prisoner neither profits from her or his infringement of the prison regime's rules, nor are penalties evaded in doing so. In reality, however, the plaintiff's illegal conduct may, nevertheless, be utilised as part of a contention that no duty of care exists or that matters of social utility at the breach stage weigh heavily in the authorities' favour because of the kind of activity at issue. In and of itself, however, it should not, either in theory or practice, be permitted to operate successfully as a specific defence. It is legally irrelevant, and should not be permitted to defeat the plaintiff's claim.[139]

(g) Statute-Barred

Some claims might run the risk of being statute-barred. Legislation in each state and territory determines the period within which an action must be instituted. This ranges from a three to six year period, with most states and territories providing plaintiffs with the opportunity to apply for an extension of time. In a case involving HIV/AIDS, a claimant must act with haste in bringing proceedings once damage or harm has been sustained.[140] This obviously can be problematic where the plaintiff is unaware of her or his condition, due to the lengthy period in which she or he might feel and appear healthy, despite being infected (and therefore 'harmed').[141] In a case of this nature, proof of knowledge of injury or harm is critical.

III A Question of Reasonableness

At the heart of the negligence action discussed here is the question of what, on the part of prison authorities, constitutes reasonable behaviour. It is this touchstone of the tort that provides the legitimation for its loss-shifting remedies, and the foundation of its role as 'ombudsman'. It is, moreover, this aspect of the action that is most significant (whether or not it succeeds), in that it requires authorities to abandon moralising and breast-beating arguments, consequently compelling them to engage in a dialogue embracing notions of responsibility,

138 *Hall v Hebert* (1993) 101 DLR (4th) 129, 168.

139 Jürgens states: 'The fact that prisoners put themselves at risk of contracting HIV by engaging in sexual activity and drug use, both prohibited in prisons, is not a sufficient excuse for not acting. This has been understood outside prisons, where needle exchanges have been set up with government approval and funding': Ralf Jürgens, 'Prisoners and HIV/AIDS' (1995) 1(2) *Canadian HIV/AIDS Policy & Law Newsletter* 2.

140 Assuming Dunford J's novel approach to damage is not followed: see above n 48.

141 Victoria's Limitation of Actions Act 1958 is noteworthy for the relative generosity of its terms as the limitation period runs from when the claimant first has knowledge of harm: s 5(1A). Western Australia is the only Australian jurisdiction which does not provide courts with the discretion to extend the limitation period.

practicality and confrontation of harm and danger.[142]

Commenting on the Victorian Corrections Department's legal framework and statutory obligations, as well as the correctional philosophy adopted by the Department, the Director-General of the Office of Corrections, Peter Harmsworth, states that the 'guiding principles' in the context of HIV/AIDS in prison are:

1 prisoners with HIV should not be further punished while in prison;
2 they should have ready access to specialist services and treatments normally available in the community;
3 these should be based on the concept of individual management designed to meet the prisoners' individual needs; and
4 they should not be subject to discrimination in the prison system.[143]

These important principles, while laudatory with respect to caring for those already infected with the virus, do not adequately address the need to implement desirable preventative measures. He comments:

> There is also the well-accepted common law responsibility of *duty of care* by prison staff. Duty of care requires that the Office of Corrections exercises reasonable care for the safety of prisoners in custody, and ensures that their health and well-being is protected. The critical question for the Office of Corrections (and all correctional administrators) is therefore, what action is *reasonable* in the circumstances to prevent prisoners from contracting the AIDS virus.[144]

The Director-General is correct: the significant issue in this type of case — as in all negligence cases — is 'What is the reasonable response to the risk, in the circumstances?' This is determined by findings of fact, which depend on the circumstances of the particular case before the court. Compared to the difficulties a plaintiff often encounters in attempting to establish the defendant's failure to act,[145] in this type of case the fact of unreasonableness seems more readily provable.

Problems arise when correctional requirements of custody and control are

[142] Vaid, above n 14, 248, comments:

> Several obstacles have blocked the efforts of many prison administrators to develop a balanced response to the problem presented by AIDS in prison. These include hysteria about the illness, the political unpopularity of sexual activity and drug use in prison, inadequate financial resources, overcrowding, and the fundamental paternalism and chauvinism of the criminal justice system.

[143] Peter Harmsworth, 'HIV/AIDS in the Victorian Prison System' in Norberry *et al*, *Conference Proceedings*, above n 21, 125, 127. For a listing of various treatments and services available to persons in the general community with or at risk of HIV/AIDS, see Beverley Schurr, 'Prisoners Rights: Treatment, Testing, Accommodation and Privacy of Documents' in Norberry *et al*, *Conference Proceedings*, above n 21, 181, 185. She cites a 1988 Federal Government policy discussion paper concerning AIDS patients' needs: Department of Community Services and Health, *AIDS: A Time to Care, a Time to Act* (1988) 74-5.

[144] Harmsworth, above n 143, 127.

[145] An example of a case in which there was a formidable burden facing the plaintiff is *Thompson v Johnson and Johnson Pty Ltd* [1991] 2 VR 475. The plaintiff had to demonstrate the precautions which were reasonably to have been implemented by the defendant; matters well within the enterprise's expert knowledge, but difficult to adduce and establish from the plaintiff's position of weakness as an individual litigating against a multi-national corporate defendant. On the need for an onus of proof reversal in certain types of cases (like that of Ms Thompson), see Leslie Bender, 'Changing the Values in Tort Law' (1990) 25 *Tulsa Law Journal* 759.

permitted to overwhelm the objective of disease prevention. '[S]ecurity concerns and the notion of punishment inherent in the prison system can be serious obstacles to effective prevention of HIV/AIDS in prisons'.[146] Because of the gravity of the matters at issue, a strong public health and harm reduction approach to the problem must be taken.[147]

A *Education*

Education, available in all Australian jurisdictions, is seen by many to be the best way of confronting HIV issues in prisons and containing the risk of the virus' transmission.[148] It 'is the only prison HIV prevention measure currently acceptable to all stakeholders'.[149] However, the commitment of resources and the nature of education programs varies considerably.[150]

> The most effective form of prevention is of course the adoption by all parties in prisons of proper hygiene control and safe sexual and drug usage practices. The first step in ensuring this is education and training of all parties, so that they are informed of the risks and the best possible preventative methods.[151]

Canada's Expert Committee on Aids and Prisons makes several recommendations concerning education. The Committee calls for the improvement of existing educational programs for inmates and staff by including more input from external, community based experts or organisations. It also recommends that programs should be comprised of more active, participatory forms of education.[152] It comments favourably on several Australian educational initiatives, including New South Wales' HIV Peer Education Program, suggesting that Canadian institutions emulate some of these schemes.[153]

The report emphasises that the special plight of women prisoners requires

146 ECAP Report, above n 4, 3.

147 Ralf Jürgens and Norbert Gilmore state that this is the approach recommended by the ECAP *Final Report*: 'Canadian Expert Committee on AIDS and Prisons releases final report' (1994) 5(3) *HIV/AIDS Legal Link* 12. See, eg, Bloom, 'Prisoners Sue for Condoms', above n 39. W Hall, deputy director of the National Drug and Research Centre has called for the introduction, on an experimental basis, of a one-on-one needle exchange scheme and the distribution of condoms in gaols: Christopher Pore and Katherine Gibscott, 'Lawrence calls for HIV prison action', *Australian* (Sydney), 7 June 1994.

148 Some US administrators have gone so far as to argue *against* the provision of education on the pretence that education about safer sex would cause increased panic or increased illicit sexual activity: Lambrou, above n 30, 345. Vaid states that politicians have been slow to allocate funds to combat the spread of the disease because of the unpopularity and political vulnerability of the two groups who constitute the majority of AIDS sufferers: gay individuals and intravenous drug users. Prison managers do not want to be seen to be endorsing deviant 'lifestyles', and thereby find it difficult educating prisoners about the very practices their regulations proscribe: above n 14, 248.

149 Judith Robinson, 'Peer Education: Leading the Way in Australian Prisons' (1994) 8(6) *National AIDS Bulletin* 26.

150 Ibid.

151 Kerr, above n 59, 59; see also Grimsley, above n 11, 1. In England and Wales, attempts to contain the spread of the virus are made primarily through education. This includes having new prisoners view videos on HIV and AIDS: Steve Connor, 'Testing with consent' (1995) 310 (No 6975) *British Medical Journal* 278.

152 ECAP Report, above n 4, 50; Jürgens and Gilmore, above n 147, 12.

153 ECAP Report, above n 4, 49; see Robinson, above n 149, 26, where she describes several Australian initiatives in detail.

particular attention. There is a need to provide education and prevention information specifically targeted to women inmates. Relevant issues include contraception, pregnancy, HIV transmission from mother to child, safer sex activities and women's health problems. Programs should be implemented that will help empower women prisoners and decrease their vulnerability to abuse in general and to HIV infection and drug use in particular, and peer and community input are needed.[154]

In addition, specifically targeted educational programs must be devised for Aboriginal prisoners. Initiatives by and for Aboriginal inmates, that recognise their special needs and cultural values and promote their health, must be organised. As with all effective educational programs, there is a need to generate and incorporate a significant amount of community and peer input.[155]

But education alone is an inadequate response to the risk of infection. Education and training programs must be supplemented by more concrete preventative measures that will have immediate impact and will provide prisoners with the opportunity to alter their behaviour. Moreover, '[t]here seems little point in mounting educational programs which encourage prisoners to take responsibility for their actions and then refuse them the means to do so in the form of condoms or cleaning agents for drug injecting equipment'.[156]

B *Testing and Segregation*

ACT and Victorian prisons have an official policy of voluntary blood testing, and in Victoria, the compliance rate is 99%.[157] The Northern Territory, Tasmania

154 ECAP Report, above n 4, 113.

155 Ibid 118. Heilpern and Egger state that the three factors that exacerbate the risk of Aboriginal offenders contracting HIV in gaol are: (i) the over-representation of Aborigines in Australian prisons; (ii) the generally lower standard of health of Aboriginal prisoners, who have higher rates of Hepatitis B infection, and (iii) the inappropriateness of many HIV programs for Aboriginal communities, as they are devised and delivered by and for white Australians: Department for Community Services and Health, *AIDS in Australian Prisons — Issues and Policy Options* (1989) 21.

156 Hans Heilpern and Sandra Egger, 'HIV/AIDS in Prisons' in *HIV Infection and AIDS: Present status and future prospects for prevention, treatment and cure* (Proceedings of the 1991 Annual General Meeting of the Australian Academy of Science) (1991) 71, 78. Grimsley, above n 11, 18, asserts that

> [t]he risks that exist in a prison environment and the means that prisoners and staff require to support and maintain new behaviours cannot be provided through education alone. Correctional departments need to implement appropriate humane policies and procedures that will enable risk behaviour reduction and minimise the potential risks within the environment.

By way of contrast, Vaid takes a minimalist approach, suggesting that an education program could operate as the prison administration's best defence to liability suits: providing information about transmission and prevention satisfies the duty to warn prisoners of risks of HIV and enables the effective operation of the voluntary assumption of risk defence: above n 14, 246. Hammett, above n 5, 119, echoes Vaid's suggestion, stating that

> institutions might be liable for negligence in failing to provide, at a minimum, information about the facts of HIV transmission and possible methods for preventing transmission. Although needle users should be responsible for their own behaviour, it is untenable to hold them accountable when they are ignorant of consequences.

157 Simon Lake, 'HIV in Gaol' (1992) 17 *Alternative Law Journal* 20. Lake notes that '[t]he Corrective Services Department has simply failed to provide any benefits from their testing regimen in terms of having a comprehensive up-to-date management program for those who do test HIV-positive'. With a testing rate of 99%, one might well speculate on the true nature of this 'voluntariness', particularly where testing is encouraged by prisoners' custodians.

and South Australia compulsorily test all admissions, with re-testing after three months. WA tests those said to be in a high risk HIV transmission group, and Queensland is most stringent, testing all prisoners compulsorily upon reception — without pre-test counselling — after three months, then every year, and prior to discharge.[158] In 1990, NSW enacted the Prisons (Medical Tests) Amendment Act, to provide for the compulsory testing of the NSW prison population for HIV. Ironically, the NSW Crown Solicitor, advising the Minister for Corrective Services as to the content of the duty of care in the context of HIV and prisons, stated that it embraced the detection of the incidence of HIV infection, prevention of the spread of the infection, and provision of appropriate treatment.[159] The most critical elements necessary to the fulfilment of its obligations, such as the provision of condoms and clean needles, were ignored in favour of the pursuit of the most fruitless but politically attractive measure: compulsory testing. Godwin states:

> It is a commonly held misconception that HIV testing is a public health measure. With no other measures in place, it is not. Testing alone achieves nothing. It just satisfies some that something is being done. It goes nowhere in addressing the real issues of prevention and care. When made compulsory and without measures which enable prisoners to prevent the spread of HIV (that is, distribution of condoms and needle cleaning solutions and access to drug use rehabilitation programs), it is likely to be a counter-productive measure. At the same time as the NSW Government passed legislation making it compulsory for the prison population to be tested, it reaffirmed its decision not to distribute condoms in prisons.[160]

NSW recently abandoned its compulsory testing program in favour of a voluntary one,[161] but it, like other Australian states, has yet to embrace the most widely recommended reasonable responses to the risk of HIV transmission. The simplistic response to the problem of HIV in prison by governments which, on the one hand, test prisoners but, on the other, do nothing by way of providing recommended measures to prevent contraction of the virus is indicative of a

158 See Wendell Rosevear, 'Crime, Punishment and Prophylaxis' (1994) 8(6) *National AIDS Bulletin* 11. According to a report released by the Queensland AIDS Council in December 1994, cited in (1994) 5(4) *HIV/AIDS Legal Link* 23, many prisoners are incarcerated for less than three months, so HIV is not detected, creating a false sense of security for prisoners and prison officers. The report calls for the desegregation of HIV positive prisoners and non-compulsory HIV testing. Canada's voluntary testing program is widely supported: '[t]his policy is consistent with the general principle governing HIV-antibody testing in Canada, according to which "HIV antibody testing should only be done when voluntary, that is with informed consent". It is also consistent with provincial prison policies and practice and with the *World Health Organization's Guidelines on HIV Infection and AIDS in Prisons*': ECAP Report, above n 4, 23.

159 Godwin, 'Rights', above n 84, 171.

160 Ibid 172.

161 Zinn, above n 3, 279. See also Geoffrey Bloom, 'Voluntary Testing in NSW Prisons' (1994) 5(3) *HIV/AIDS Legal Link* 12. Jürgens notes that the regime, which tested all inmates upon reception and prior to release, had been widely criticised by experts, who questioned what it sought to achieve and why the accepted arguments in favour of voluntary testing outside prisons did not apply equally in gaols: 'In the final analysis, it was probably the regime's high costs and few benefits that led to its being scrapped': Ralf Jürgens, 'Australia: Compulsory Testing Regime Ended in NSW' (1995) 1(3) *Canadian HIV/AIDS Policy and Law Newsletter* 4.

narrowly conceived and politically motivated approach.[162] It does not embrace measures which would effect necessary behavioural change. Presumably perceived to be electorally and industrially wise, this approach is premised on a denial of the capacity of a government to address harm minimisation head-on, preferring instead to assume a moralistic stance. By affording greater importance to political expediency than to the welfare of those whom its decisions affect, prisoners are placed in positions of higher risk of infection, and are actively prevented from taking responsibility for safe sexual and drug use behaviour.[163]

One other measure implemented by several jurisdictions is the segregation of inmates with seropositive status.[164]

> A policy of integration of prisoners who have HIV in the general prison population exists in New South Wales, Tasmania and South Australia. In Queensland and Victoria, prisoners who have HIV are placed in segregated accommodation with prisoners who have a history of intravenous drug use. Segregation of prisoners who have HIV occurs in Western Australia and the Northern Territory.[165]

While jurisdictions which segregate seropositive prisoners may contend that they have acted reasonably to prevent infection of others in their custody, this argument is not particularly persuasive. Firstly, it minimises the effect of the three to six month 'window period', as a result of which the seropositivity of an infected individual can not be accurately ascertained unless they are tested repeatedly.[166] Secondly, the rapid turnover of the prison population also renders segregation ineffective. Finally, the reasonableness of a segregation strategy may be questioned in the light of the wide disparity of its use across jurisdictions and the fact that the nature of HIV and the way in which it may be contracted — unlike tuberculosis, for example — deems segregation an unnecessary and unwarranted mechanism by which to contain the spread of the virus.

If, as a result of testing positive, a prisoner is segregated, everyone in the prison will know his or her status. As Rosevear notes, '[t]his predisposes to stigmatisation and isolation'.[167] Further, 'segregation also promotes denial in the general prison population, as evidenced by comments such as, "They have got

[162] See Godwin, 'Rights', above n 84, 172.

[163] Heilpern and Egger, 'HIV/AIDS in Prisons', above n 156, 77. Kelly, above n 14, 156, comments on the similarly misguided English situation:

> The Government has refused to distribute either condoms or clean needles to inmates. It is estimated that 25 to 33 per cent of English long-term prisoners are involved in a gay relationship. There is also much evidence that there is an ample supply of illegal drugs within prisons, but few needles and thus much sharing of needles. The Government has been criticised for complacency in minimising both the number of HIV prisoners, the widespread homosexual activity, and the use of drugs within prisons .... While the Government has argued that distributing condoms might encourage high risk sexual behaviour, experts such as Una Padell have argued that while condoms are not a panacea, 'if they reduce risk even by 50 per cent in anal sex, then why not make them available?'

[164] Some of this information is derived from the summary by Roughley, above n 13, 26. This is not intended to be an examination of the many issues relevant to HIV positive prisoners' conditions of detention.

[165] Godwin *et al*, *Legal Guide*, above n 1, 272.

[166] This is, in fact, the case in some jurisdictions, noted above n 158.

[167] Rosevear, above n 158, 11.

HIV, they are gay, they are segregated, so I can't get it"'.[168]

Discussing the situation in Queensland, Rosevear notes that because the segregation unit is in a maximum security (and 'protection') prison, HIV positive prisoners have to serve their sentences in a maximum security environment despite having 'classifications' which do not warrant that type of custody.[169] These factors combine to exacerbate the stress of imprisonment and of living with the disease.[170]

A segregation policy is unreasonable because it transforms the fact of having the virus — itself something most people would find difficult enough to cope with — into the equivalent of an additional custodial punishment. Contracting HIV should be irrelevant to conditions of detainment which, while they are not theoretically and officially a sentence, in reality manifest themselves as such.

Most important, perhaps, is the fact that Australia rejected segregation (and compulsory testing) in the community generally, on the grounds that they contravene optimal harm reduction strategies. The best measures available to control the spread of the disease are those involving education and alterations to some types of behaviour, through the use of prophylactic measures. The same arguments apply to the prison setting.[171]

In Western Australia, the Equal Opportunity Tribunal recently found that that state's policy of segregating HIV positive prisoners was in breach of its Equal Opportunity Act.[172] Rather than terminate the policy, the government responded to the Tribunal's decision by making a regulation which exempts prisons from complaints under the Act by persons with an infectious disease.[173]

C *Concrete, Tangible Harm Reduction Measures*

It has been suggested that the following measures be provided in order to prevent transmission of the virus in gaols:

- easily accessible information and equipment available to inmates and staff for infection control procedures, such as bleach and latex gloves;
- clean needles and syringes supported by a policy and practice that threatens no reprisals against injecting drug users;
- provision of safe disposal facilities for injecting equipment;
- condoms; and

168 Ibid.

169 Ibid.

170 Ibid.

171 In the general community, 'strategies for slowing the epidemic must depend almost exclusively on preventing transmission through mass behavioural change. Thus, the public health approach to AIDS has focused on education, counselling and voluntary testing': Ronald Bayer, Nancy Dubler, Lawrence Gostin, 'The Dual Epidemics of Tuberculosis and AIDS' (1993) 21 *Journal of Law, Medicine and Ethics* 277. Lambrou suggests that in the US, part of the motivation for restrictive prison responses such as mass screening and segregation is the fear of liability to inmates or officers who contract the disease: above n 30, 347. Remarkably, this fear has precipitated these types of inappropriate responses, rather than effective widely-endorsed harm reduction measures.

172 Michael Alexander, 'Western Australia to End Segregation of Positive Prisoners' (1994) 5(3) *HIV/AIDS Legal Link* 1.

173 Ibid.

- sexuality education programs that openly, non-judgmentally and explicitly talk about institutional sexual behaviour, and address issues concerning possible barriers to practising safe sex for both men and women.[174]

In legal terms, the refusal to provide these preventative measures amounts to conduct falling below the standard of care expected of the reasonable custodial authority. It is a careless response (or, rather, non-response) to a foreseeable risk of harm. Of course, even knowledge of a risk of injury is not in itself a reason to find a breach, let alone liability. As Mason J states in the leading authority, *Wyong Shire Council v Shirt*,[175] several other factors must be considered in assessing the standard of care expected of the reasonable prison authority against which their conduct can be measured, to ascertain whether a failure (in the legal sense) has occurred. For example, the following factors — each admittedly value-laden and not truly capable of measurement — must be considered: the probability of the risk materialising, the gravity of the risk if it were to materialise, the existence of practicable precautions that could have been taken to avoid the foreseeable risk and the social utility of the conduct under consideration.[176] These elements are all, implicitly, critical to the success or failure of the action.

Contracting the virus while in custody is not improbable and the injury is as grave as one could imagine. Further, the measures presently under consideration can be provided relatively easily; the cost is negligible.[177] Of greater significance in a case of this nature might be matters described by McHugh JA (as he then was) as 'soft factors'. Negligence is not merely an economic cost/benefit equation. Immeasurable 'soft' values such as community concepts of justice, health, life and freedom of conduct have to be taken into account. Nonetheless, it is generally a powerful indication of negligence that the cost of a precaution is small compared with the consequences of a breach, even when the risk of occurrence also is small.[178] These soft factors (including health and well-being), like those embraced by the traditional 'calculus' balancing act, weigh heavily in favour of a prisoner's contention that she or he has been wronged. On the other hand, the authorities might contend that a different perception of 'soft factors' as

174 Grimsley, above n 11, 18.

175 (1980) 146 CLR 40.

176 Learned Hand J's well known, always utilised, but sometimes unhelpful 'calculus of negligence', from *United States v Carroll Towing Co* 159 F 2d (1947), reflects an analysis of the economics of risk creation and loss shifting. More important, perhaps, are McHugh JA's comments in *Western Suburbs Hospital v Currie* (1987) 9 NSWLR 511, 521-3.

177 In *Cekan v Haines* (1990) 21 NSWLR 296, 313-14 the New South Wales Court of Appeal considered the bearing economic considerations may have when assessing the standard of care expected of prison authorities. Godwin states that the existence of a growing body of research material on the prevalence of HIV risk behaviours in prisons suggests that governments have been placed on notice of 'the obvious risk of injury'. Further, where research material points to the value of relatively cheap measures which reduce the risk of HIV transmission, for example, by providing condoms, the economic arguments suggest that authorities expose themselves to liability if HIV transmission continues to occur within prisons: Godwin *et al*, *Legal Guide*, above n 1, 275.

178 *Western Suburbs Hospital v Currie* (1987) 9 NSWLR 511, 523. This comment seems in line with the decision of the New South Wales Court of Appeal in *Inverell Municipal Council v Pennington* [1993] Aust Torts Reports 81-2344 ('*Inverell*'), in that the low cost of a precaution that could have been taken in a case like *Inverell* — erecting warning signs — was seen to be virtually conclusive in finding breach. This is, arguably, akin to the imposition of strict as opposed to fault-based liability.

well as matters of social utility involved in managing their institutions — including fears of industrial strife and concerns about worker-management relations — weigh in their favour.[179]

1 *Provision of Condoms, Dental Dams and Lubricant?*[180]

Is it unreasonable to fail to provide prisoners with condoms, dental dams and water-based lubricant?

> Condoms do not totally protect against the AIDS virus, but when used correctly, significantly reduce the risk of HIV transmission. Condoms are not presently available in Australian prisons. A major impediment to date has been the attitude of prison officers who fear that condoms will be used as weapons or to conceal contraband in body cavities. While homosexual acts between consenting adult males in private have been decriminalised in all jurisdictions except Tasmania, such sex between prisoners remains illegal in some jurisdictions under prison regulations. In addition, it is sometimes argued that consenting homosexual sex between prisoners remains an offence because prisons are public rather than private places. In favour of condom availability, it can be argued that the state has a responsibility to protect prisoners' lives, and that as institutional sex cannot be prevented, inmates should be able to practise it safely. Condoms are made available in five United States correctional facilities, and few problems appear to have been reported.[181]

Some additional factors have been suggested as reasons for the non-provision of condoms and dental dams in gaol. These include a denial of the existence of homosexual sexual activity in prisons and the belief that their availability will encourage homosexuality, and that officers and unions will resist their introduction.[182]

Some of the most objectionable justifications for refusing to provide barriers in gaols reveal a remarkable naïveté about homosexuality, and demonstrate wholesale ignorance about issues of sexual orientation, preference and identity. The suggestion that the provision of condoms will encourage homosexuality is remarkable in that it conjures up images of missionaries seeking to convert

179 See discussion below nn 256-8 and accompanying text.

180 Although educational efforts explaining how the use of condoms and lubricant help contain the spread of HIV during male to male anal intercourse or male to female vaginal or anal intercourse have been fairly successful, these campaigns seem to have been relatively less successful explaining how dental dams may also be used. Moreover, commentators often neglect to include dental dams among the measures recommended to help prevent the virus' spread. Dental dams, made of latex, help keep sexual partners safe from contraction of HIV and other sexually transmitted disease, during the course of oral/vaginal or oral/anal sexual activities.

181 Chappell and Norberry, 'Policy Trends', above n 3, 37. Condoms are not foolproof in preventing HIV transmission. They can break and slip during intercourse, and they should be used with lubricant: Pagliaro and Pagliaro, above n 12, 207. This is a matter which a responsible and reasonable preventative program would ensure is communicated to detainees in their education programs. With respect to dental dams, the Intergovernmental Committee on AIDS, Legal Working Party's Discussion Paper states that the availability of dental dams in female prisons where lesbian sex and injecting drug use exist is advisable for the same reasons as those relevant to the supply of condoms to male prisoners: Intergovernmental Committee on AIDS, *Therapeutic Goods*, above n 2, 33 citing Tracie Walsh, 'Women Prisoners and HIV/AIDS' in Norberry *et al*, *Conference Proceedings*, above n 21, 269.

182 Intergovernmental Committee on AIDS, *Therapeutic Goods,* above n 2, 34-5; cf Heilpern and Egger, above n 156, 76.

unbelievers to their beliefs. A sexual orientation is not acquired by means of enticement, through rites and rituals similar to those involved in religious conversions. Sexuality is part of identity; a state of being. Moreover, the empirical evidence (which confirms common sense) reveals that sexual activity, some of which is risky, does take place in gaol. It is futile to argue that it does not. Further, there is no evidence that condoms have been used to smuggle contraband or utilised as weapons in those prison systems where they have been provided.

Until relatively recently, no state or territory prison provided condoms or dental dams, but changes have occurred. These include the provision of condoms and lubricant in the ACT's Belconnen Remand Centre since 1992.[183] At present it is the only correctional facility in Australia which officially provides detainees with access to condoms.

One way of assessing what is a reasonable practice — albeit not conclusive of this determination — is examining what others in similar circumstances do in response to a risk. The World Health Organisation's (WHO) 1993 Guidelines state, 'since penetrative sexual intercourse occurs in prison, even when prohibited, condoms should be made available to prisoners throughout their period of detention'.[184] Recent figures from WHO regarding HIV/AIDS in prison show that 23 of the 52 prison systems sampled allow condom distribution. Significantly, no country with a policy of providing condoms in gaols has reversed the policy.[185]

The five American prison or local gaol systems which make condoms available to inmates are Mississippi, Vermont, New York City, San Francisco and Philadelphia.[186] In France, condoms are issued in prison pharmacies and wards, and they are also available in Swiss prisons.[187] In Germany, all prisons provide condoms.[188] By way of contrast, no programs exist for the distribution of condoms in Israeli[189] and Thai[190] gaols. In India, where it is believed the HIV positive population in the general community will reach four million by the end

183 See discussion below nn 250-2 and accompanying text.

184 World Health Organisation, *Guidelines on HIV Infection and AIDS in Prison* (1993) 3. The Council of Europe also states that condoms should be made available to prisoners: Council of Europe — Recommendation 1080 (1988) on a co-ordinated European health policy to prevent the spread of AIDS in prisons, paras 14A(i) to 14A(viii): cited in ECAP, *HIV/AIDS in Prison: Background Materials* (1994) Appendix 2, 45.

185 ECAP Report, above n 4, 55.

186 John Roberts, 'US: Injecting drug misuse is rare in prisons' (1995) 310 (No 6975) *British Medical Journal* 281.

187 Alexander Dorozynski, 'France: one in five prisoners rejects voluntary HIV test' (1995) 310 (No 6975) *British Medical Journal* 281.

188 Helmut Karcher, 'Germany: Approach varies widely between states' (1995) 310 (No 6975) *British Medical Journal* 282: it is estimated that between 1% and 3% of German prisoners may be HIV positive and that many of them probably became infected while in gaol.

189 The chief medical officer of the Israeli prison service rationalises the non-distribution of condoms (and clean syringes), stating, 'we don't want to legitimise homosexuality or drug misuse, and in fact prisoners have not asked for them': Judy Siegel-Itzkovich, 'Israel: All prisoners have voluntary HIV test' (1995) 310 (No 6975) *British Medical Journal* 282, 283.

190 Paul Hunt, 'Thailand: one hospital for HIV positive prisoners' (1995) 310 (No 6975) *British Medical Journal* 282.

of 1995, a group of independent doctors recommended provision of condoms in prisons. However, gaol and police authorities audaciously claim that the overcrowded and cramped gaol conditions deter same sex activity; that homosexual activity is 'virtually non-existent', and that because homosexuality is a criminal offence, prisoners cannot be legally provided with condoms. Doing so, they argue, would be aiding and abetting the commission of an offence.[191]

Canada's Expert Committee on AIDS and Prisons recommended that condoms, dental dams and water-based lubricant be easily and discreetly accessible to inmates, and protective measures for staff be improved.[192] In fact, as a result of the commendable decision of the Canadian Solicitor-General, condoms and dental dams were made available in Canadian federal gaols as of January 1992, prior to the Committee's report. This policy was 'one of the most important steps toward instituting effective measures to prevent HIV transmission in correctional settings'.[193] Each Canadian federal penitentiary has established its own system for making barriers available.[194]

Although many of ECAP's recommendations have been adopted, a few noteworthy ones have not. For example, the Committee was concerned that because inmates feared being discovered committing institutional offences, they may engage in consensual sexual activity furtively, not taking the time required to practice safer sex. It therefore recommended that consensual sexual activity in prison be removed from the category of institutional offence (and not be considered an activity that would jeopardise security). According to the Committee, this recommendation discourages unsafe behaviour and does not encourage sexual activity.[195] Unfortunately, in response, Correctional Service of Canada

191 Meenal Mudur, 'India: Campaigners urge check on spread of HIV' (1995) 310 (No 6975) *British Medical Journal* 280.

192 ECAP Report, above n 4, 58, 89-90; Jürgens and Gilmore, above n 147, 12.

193 ECAP Report, above n 4, 55. The report also states, at 4:

> Implementing condom distribution in penitentiaries has not resulted in any documented negative impact or adverse impact; indeed, it appears to have had a beneficial impact. It has opened discussions about sexual activity and about preventing disease in penitentiaries. In addition, it has signalled how seriously CSC [Correctional Service Canada] is taking the threat of HIV transmission, and its commitment to promote and protect the health of inmates and prevent infection among them.

194 Ibid 55-8. These range from distributing them to every prisoner and leaving supplies in living units in some gaols to limiting their distribution to health-care services. Dental dams are made available to female inmates but access to lubricant varies greatly from one penitentiary to another. ECAP recommends several changes in order to improve barrier distribution. It also suggests that upon entry to gaol, inmates should be provided with 'health kits' which contain (among other things), condoms, dental dams, water-based lubricant, educational materials about sexually transmitted disease and disinfectant; the kits should be offered to inmates upon release, and be available in each family visiting unit. Some provincial institutions provide condoms, although the means by which they do so varies; in most institutions, they are provided upon request through medical services. However, policy directives do not always translate into reality: for example, at least two rural Manitoba gaols do not provide condoms even though they are required to do so under the directives of the provincial Department of Corrections (information derived through an interview with a practising barrister and solicitor, 28 February 1995). Provincial institutions in Prince Edward Island, Nova Scotia, New Brunswick, Newfoundland and Saskatchwan do not provide condoms.

195 Ibid 59. ECAP considers issues involving non-consensual sexual activity. The Committee emphasises the need to prevent sexual assault; identify sexual 'predators' and inmates who may be vulnerable to sexual abuse; effectively prosecute inmate sexual assaulters and remove or segregate them from the general inmate population; closely supervise and protect those who may be vulnerable to

refused to remove the current prison prohibitions against consensual sexual activity between inmates.[196] Implementing a policy of providing barriers in gaols while at the same time regulating against and punishing the behaviour which necessitates the provision of the preventative measures sends mixed messages to prisoners. The refusal to remove engagement in sexual activities from the category of institutional offences negates some of the positive features of the Service's otherwise praiseworthy harm reduction strategy.

Notwithstanding his acknowledgment of duty of care responsibilities in the context of prisoners' safety, well-being and health care,[197] Victoria's Director-General of Corrections maintains a stance devoid of commitment to the need to implement wide-ranging, necessary initiatives:

> Condoms are currently not distributed within Victorian prisons. The availability of condoms within prisons is a controversial issue that has attracted considerable debate both politically and industrially .... There is no doubt that the issuing of condoms is a matter that will be the subject of ongoing discussion at both a political and industrial level.[198]

He could well add that these 'discussions' will also be held at the 'legal level'. It is inevitable that a 'test case' will soon be instituted by a prisoner who has seroconverted while in gaol, and who would have used condoms or dental dams as protection had they been available. He or she will litigate against the authorities for their failure to satisfy the reasonable level of care owed to him or her, in their care, custody and control, by refusing to provide one of the few preventative measures known to limit the spread of the disease she or he contracted, and which are available to the general community: condoms or dental dams.[199] Even if condoms or dental dams were provided, non-provision of water-based lubri-

sexual abuse; and educate inmates (by other inmates) about abuse and the fact it will not be tolerated; provide single cell accommodation for all inmates: ibid 60-2.

196 Jürgens and Gilmore, above n 147, 12.

197 See discussion above nn 143-4 and accompanying text.

198 Harmsworth, above n 143, 129-30. Although condoms are not distributed in Victorian prisons, they are included in a release package developed by the Victorian Association of Care and Resettlement of Offenders, which is provided to all released prisoners as part of standard discharge procedures. The Department of Corrections has published an information booklet with details concerning the availability of condoms — as part of a trial in three gaols with residential visit facilities — and bleach to sterilise needles: The Intergovernmental Committee on AIDS, *Therapeutic Goods*, above n 2, 35. The Committee notes that 'The proposed provision of condoms in NSW prisons in 1990 met with vehement opposition from the prisons officers' associations, who threatened strike action in opposition to the proposal'; see 'NSW Govt rules out condoms in gaols', *Sydney Morning Herald* (Sydney), 14 June 1990. An example of a responsible response to this public health crisis (despite prison officers' objections), occurred in Philadelphia, where 'Mayor Wilson Goode heeded advice by the city's Health Commissioner and overruled a decision by prison board members, by ordering a condom distribution plan for the city's jails': Lambrou, above n 30, 332; Lambrou also advocates making condoms available. She argues at 354 that 'the prison system must adopt a policy of realism, rather than moralistic wishful thinking. Finally, the public must recognise that AIDS is a health problem and not a moral issue'.

199 In this context, note Kirby P's statement in *Parramatta City Council v Lutz* (1988) 12 NSWLR 293, 310: 'When a duty of care is found to exist, a failure to exercise a statutory power said to be relevant to the cause of negligence in the operational process is not to be excused merely because the ultimate decision to exercise the power may be classified as a policy one.' Note, however, that in *Prisoners*, the negligence action may, nevertheless, fail as a result of the same argument that caused the public law action to fail. This is the argument that the breach may be characterised as the failure to proclaim s 50(1), and not the non-provision of condoms *per se*.

cant, or difficulties in access to any of these measures, arguably could be said to be unreasonable.[200]

2 *Injecting Drugs: Provision of Needles or Syringes? Provision of Cleaning Equipment?*[201]

Is it unreasonable to fail to provide prisoners with clean needles, syringes or cleaning equipment (such as bleach)?

The one fact no one can genuinely dispute or deny is that illegal drugs can be found in our gaols.

> The presence of illicit drugs within correctional institutions is testimony both to the ingenuity of inmates and to the limitations of institutional security. It also demonstrates the ineffectiveness of administrative or criminal sanctions to deter this behaviour within correctional institutions.[202]

Despite the fact that all jurisdictions spend a great deal of effort trying to stop the use of drugs in gaols (for example, by means of searches of prisoners, visitors and staff, restrictions on access visits, and drug testing to identify and discipline drug users) drug use remains.[203] In its study of HIV infection in Scottish gaols, Strathclyde University's Addiction Research Group concludes that the prison system widely recognises that a goal of drug-free gaols is not realistic, and 'to suggest otherwise, and to develop a future strategy on such a basis, would be misleading and detrimental to ensuring stability within the prison population'.[204] As Kerr notes, until prison systems can state with confidence that injecting drug use has been minimised from its environment, it is prudent that other strategies are implemented.[205]

Different options are available by way of response to the problem of drugs in prison and the risk of contracting HIV infection. The most sensible approach for many reasons that include, but go beyond, the public health issues associated with HIV transmission, is one advocated by the Intergovernmental Committee on AIDS Legal Working Party in its Discussion Paper. It states: '[g]iven the very high risk of unsafe injecting within the prison system, keeping as many drug offenders out of the gaols should be seen as an important element in strategies to

200 See Intergovernmental Committee on AIDS, *Therapeutic Goods*, above n 2, 34: 'The *National HIV/AIDS Strategy* recommends that condoms should be freely and anonymously available to all prisoners'. Noting that many countries already provide condoms in gaols, that they have been introduced into the ACT's Belconnen Remand Centre, and that provision to allow for their availability already exists in the NSW Prisons Act, even though this subsection has not yet been proclaimed, Chris Puplick states: 'Again I believe this is simply a matter of time': Chris Puplick, 'Assessing Current Directions in Legislation' (unpublished paper, HIV/AIDS Law, Policy and Directions: National Legal Conference, Melbourne, October 1993, para 6.9).

201 Tattooing and piercing are two other high risk behaviours which occur in gaol. They raise somewhat similar issues and require responses which in some ways parallel those relevant to the use of injecting drugs. These issues, options and recommendations are canvassed in the ECAP Report, above n 4, 79-81. One of the most important recommendations is the provision of tattoo and piercing equipment and supplies for authorised use in prisons.

202 Merritt, above n 5, 106. ECAP states, 'it is clear to ECAP that it is unrealistic to presume that drug use in prisons will stop or that drug injection will cease': above n 4, 74.

203 Kerr, above n 59, 59-60.

204 Christie, above n 30, 279.

205 Kerr, above n 59, 60.

limit the spread of HIV'.[206] Other options, some of which are themselves characterised as radical, range from the distribution of clean needles and syringes to the continued prohibition of drug-taking equipment. In between these extremes are suggestions for the expansion of methadone and other rehabilitation schemes, education of inmates with respect to how they should clean injecting equipment, and the provision of bleach for cleaning needles and syringes.[207] Grimsley comments:

> In Australian communities HIV prevention education, needle and syringe exchanges, methadone programs and the availability of drug treatment services have had a significant impact and have decreased the rate of unsafe injecting practices by users. This same impact is needed in relation to unsafe using practices amongst prisoners.[208]

By way of summary, no Australian state or territory facility has an official needle exchange programme, although materials to clean syringes have been available in NSW prisons since January 1990. Other facilities, in Victoria for example, have commonly had such cleaning agents available, although they are not provided specifically for the purpose of cleaning syringes.[209] Methadone is available in NSW and is provided on a significantly reduced basis in Victoria, Queensland, South Australia and Western Australia; it is not provided in Tasmania and the Northern Territory.[210]

Arguments against making clean drug injecting equipment or bleach available tend to focus on the assertion that their provision would be seen to condone illegal drug use and that these measures could risk officers' safety.[211]

206 Intergovernmental Committee on AIDS, Legal Working Party, *Legal Issues Relating to AIDS and Intravenous Drug Use*, Discussion Paper (1991) 66-7. ECAP Report, above n 4, 6 agrees:

> Reducing the number of drug users who are incarcerated in federal penitentiaries is one possible way that HIV transmission in prisons may be lessened. Many of the problems created by HIV infection and by drug use in prisons could be reduced if alternatives to imprisonment, particularly in the context of drug-related crimes, were developed and made available. As the World Health Organization has stated, '[g]overnments may ... wish to review their penal admission policies, particularly where drug abusers are concerned, in the light of the AIDS epidemic and its impact on prisons.

See the report of the Department of Community Services and Health Working Panel on Intravenous Drug Use and HIV/AIDS, *Consultation Paper No 4* (1989). It calls for the minimal use of imprisonment to punish criminal behaviour of intravenous drug users and HIV infected persons generally.

207 Chappell and Norberry, 'Policy Trends', above n 3, 37-8.

208 Grimsley, above n 11, 3.

209 Godwin *et al*, *Legal Guide*, above n 1, 272.

210 Methadone is available in some Australian prisons. This complies with the WHO recommendation to the effect that prisoners who were on methadone maintenance in the community should have that scheme available to them once in gaol. However, this excludes prisoners who are not yet on the program, but who want to participate in it. Dolan, commenting on the NSW methadone program which serves 600 inmates, notes that it reduces needle sharing and the spread of disease; however, 2000 additional prisoners cannot get on the program, because 'if you do not come into prison on methadone, you do not get on it': quoted in Zinn, above n 3, 279. Prisons in Canada, by contrast, rarely prescribe methadone to inmates; ECAP recommends that the options for the care and treatment of drug users include access to methadone programs: above n 5, 72-3, 79.

211 Intergovernmental Committee on AIDS, *Therapeutic Goods*, above n 2, 35. Bleach had been available generally in Canadian gaols for a long time without any suggestion of it being a threat to institutional security until it became associated with sterilisation of injection equipment: ECAP Report, above n 4, 67. ECAP notes an additional reason given in opposition to the provision of bleach: it is suggested it may encourage non-users to experiment with injection drug use.

> In Australia, official needle and syringe exchanges exist outside prison, despite the fact that the use and possession of prohibited substances is an offence. Arguments against needle exchange or distribution in prison are as follows. Needles can be used as weapons. There have been reports of HIV found in blood taken from needles and syringes. The risk of HIV infection, therefore, exists. However, it should be emphasised that the rate of HIV infection as the result of needlestick injury is low — less than 1 per cent in the case of a single needlestick exposure. Some also argue against a needle exchange program in prisons because use of prohibited drugs is illegal and prisoners would be thereby encouraged to persist in the same behaviour which may have lead to their arrest and conviction.[212]

As Canada's Expert Committee on AIDS and Prisons notes, '[b]y reducing the spread of HIV infection among them [injection drug users], the work of needle exchanges in the community has been one of the major contributors to the prevention of the spread of HIV infection in prisons'.[213] The same strategy should be implemented in our gaols. However, at present in Australia, it seems unlikely that widespread needle exchange programs will be introduced.[214] The NSW Minister for Justice, John Hannaford, states that there is no chance that a needle exchange program will be introduced.[215] Yet 'the failure to provide clean needles to prisoners who injected drugs made prisons giant shooting galleries for needle-sharers, increasing the risk of spreading the AIDS virus'.[216]

Prisoners'-rights groups reject the argument that clean needles pose a security risk, contending that prisoners wanting to use violence against guards already have many means available to them to do so. Although this is not, admittedly, an attractive argument, it is realistic. Providing sterile injection equipment would probably reduce the risk by eliminating dangerous handmade syringes which are hidden in gaols. If issuing needles was a more open process, there would be less concern about security and violence.[217]

In its 1993 *Guidelines on HIV Infection and AIDS in Prisons*, the World Health Organisation recommends that in those countries where clean syringes and needles are made available to injecting drug users in the general community,

212 Chappell and Norberry, 'Policy Trends', above n 3, 37-8. The authors state, 'Drug use in prison remains a problem, and it is therefore in the interests of both prisoners and prison officers that needles and syringes are clean.'

213 ECAP Report, above n 4, 121.

214 In fact, NSW specifically enacted the Prisons (Syringe Prohibition) Amendment Act 1991, which imposes increased penalties for the introduction or supply of syringes in gaols; this proscription was quite unnecessary, in that prison legislation has always included penalties for contraband: Chappell and Norberry, 'Policy Trends', above n 3, 23. See discussion above nn 134-6 and accompanying text.

215 Zinn, above n 3, 279. As noted earlier, the Minister's spokesperson stated that '[w]hat you're basically doing is giving prisoners a weapon. It's just like giving them a gun': *Australian* (Sydney), 6 November 1994.

216 Canadian public health expert, Dr C Hanson, went on to state that 'it won't be long before we have an inmate who can actually bring ... authorities to court over exactly that (exposure to risk)'; 'It [a prison] is a closed environment ... where the state is responsible for the health and safety of the inmates': 'Doctors fail to diagnose AIDS illnesses', *Sunday Age* (Melbourne), 6 November 1994.

217 Cited in ECAP Report, above n 4, 70. According to Kerr, above n 59, 60-1, '[a]dvocates of needle exchange programs argue that "provided it was strictly a needle exchange program, no additional needles need be placed into circulation"'.

consideration should be given to providing clean injecting equipment to prisoners who request these measures during detention and on release.[218] As was noted earlier, Switzerland is the only country where an experimental syringe exchange program is available in prison, despite the WHO recommendation. It was instituted at Berne's Hindelbank women's penitentiary and a gaol in Oberschöngrün, and other Swiss prisons make chlorine available with instructions explaining how to clean needles.[219] In 1992, a needle exchange program was in operation in a New South Wales prison, albeit illegally.[220]

Providing sterile injection equipment 'will be inevitable', according to ECAP; this is partially due to the doubts now raised about the efficacy of bleach.[221] The Committee concludes, however, that sterile injection equipment cannot be made available immediately, in part because of its lack of acceptability to prison authorities, staff, inmates and the public. Exactly how it can be made available in a safe and confidential manner is seen to be a difficult matter at present.[222] The report recommends that research be undertaken in order to identify means and develop measures which will reduce risk of transmission of the virus and other harms arising from injection drug use, including access to clean injecting equipment.[223] It also recommends that bleach be made available to inmates, and that drug users have access to methadone. Some of these recommendations have not been adopted:[224] the Canadian Department of Correctional Service has said that it will not make full-strength household bleach available to all inmates, nor will it provide methadone maintenance or pilot needle exchange programs in

218 World Health Organisation, 'Guidelines', above n 184, 4. The Council of Europe has asked States 'to allow, in the last resort, clean, one-way syringes and clean needles being made available to intravenous drug abusers in prison': Council of Europe — Recommendation 1080 (1988) on a co-ordinated European health policy to prevent the spread of AIDS in prisons (1988) paras 14A(i) to 14A(viii): cited in ECAP Report, above n 4, 71.

219 Dorozynski, above n 187, 281. For a detailed discussion of the Swiss project see Ralf Jürgens, 'HIV Prevention Taken Seriously: Provision of Syringes in a Swiss Prison' (1994) 1(1) *Canadian HIV/AIDS Policy and Law Newsletter* 1; see also Ralf Jürgens, 'Switzerland: Prison Needle Exchanges Declared Judicially Admissible' (1995) 1(3) *Canadian HIV/AIDS Policy and Law Newsletter* 2. He also states at 3: 'Because abstinence in prisons is not achievable, prison establishments must, according to the report's authors [Swiss Federal Department of Justice] adapt their internal health policy'.

220 According to Kate Dolan, 'Response to ECAP's Working Paper', 14 October 1993, cited in ECAP Report, above n 4, 69.

221 See discussion below n 242 and accompanying text.

222 ECAP Report, above n 4, 77-9; Jürgens and Gilmore, above n 147, 12. An element of creativity is required in order to respond reasonably to the problem of drug use and risk of HIV transmission in gaols. For example, the Intergovernmental Committee on AIDS Legal Working Party states in its Discussion Paper that 'vending machines may assist in prisons where drug use is reportedly high and prison staff are reluctant to distribute needles': Intergovernmental Committee on AIDS, *Therapeutic Goods*, above n 2, 29. In its Final Report, the Working Party recommends that governments give further attention and consideration to the evaluation of this strategy — not just with respect to machines in prison but more generally in the community: Intergovernmental Committee on AIDS, Legal Working Party, *Final Report* (1992) 75. By way of summing up what is reasonable in the context of preventing the spread of the HIV virus among our gaols' intravenous drug users, Scottish researchers conclude, '[t]he effort and imagination that has already been expended on preventing HIV transmission among injectors outside the prison setting should be afforded to the prevention of spread of infection inside': Taylor *et al*, above n 31, 292.

223 ECAP Report, above n 4, 77-9; Jürgens and Gilmore, above n 147, 12.

224 Similarly, the recommendation that sexual activity in prison be removed from classification as an institutional offence was rejected, noted above nn 195-6 and accompanying text.

gaols.[225]

In summary, Canada's uncharacteristically timorous position (in this context) is as follows. Injection equipment, such as needles and syringes, are not available and are classified as contraband, with possession considered an institutional offence.[226] Bleach is treated similarly, but its status may soon change. Although bleach is not available officially to inmates of federal penitentiaries, it may be secured by means of access to kitchens and laundries.[227] Methadone treatment, as a substitute for opiate use, is not available in Canada's Federal institutions.[228]

In Denmark, it has been 'conservatively' estimated that there are 250 new cases of HIV infection among prisoners every year, amounting to 7% of the total prison population. This has been almost entirely connected to drug misuse (as condoms have been widely available for years).[229] Denmark's National Health Board has called for the introduction of a needle exchange scheme, which is not available to prisoners but is readily available to the general community. The main problem is that 'it is hard to convince prison staff to accept the double morality that, when drugs are forbidden, prisoners should be provided with the means that makes it less dangerous to use them .... Many Danish people find this inconsistent and unacceptable'.[230] In France, neither syringes nor cleaning materials are provided because officially drug use does not exist.[231] Berlin has implemented a pilot program in which kits for cleaning syringes, but not syringes, are issued to inmates.[232] No program exists in Thailand[233] or Israel[234] by which needles or cleaning equipment are distributed.

In recommending the provision of bleach in order to sterilise drug use equipment, Australia's *National HIV/AIDS Strategy* notes that it is currently available for purposes other than cleaning injecting equipment in NSW, Victoria and the ACT.[235] Bleach is available in a number of prison systems, including Spain and Switzerland, and some systems in Belgium, Luxembourg, the Netherlands, some

225 Jürgens and Gilmore, above n 147, 12. Bleach is available in one prison, as part of a pilot study. In May 1995, CSC indicated it may reverse its decision not to provide bleach. In 1991, when Canada's Minister of Health and Welfare recommended that clean needles or bleach be made available to federal inmates, the Solicitor-General rejected the suggestion: ECAP Report, above n 4, 69. The Prisoner with HIV/AIDS Support Action Network criticises Correctional Service Canada's refusal to adopt several of ECAP's most important recommendations: '[the CSC] has chosen to ignore the issue of injection drug use and the high risk of HIV transmission through needle use within the prison context. How can CSC admit that there is a drug problem in the prisons and still refuse to even try a pilot needle exchange program for prisoners? This contradiction will cost lives': Jürgens and Gilmore, above n 147, 12.

226 ECAP Report, above n 4, 63.

227 Ibid. It is available as a general cleansing agent in some provincial gaols.

228 Ibid.

229 Margaret Dolley, 'Denmark: Opinion is divided' (1995) 310 (No 6975) *British Medical Journal* 280.

230 Ibid 280.

231 Dorozynski, above n 187, 281.

232 Karcher, above n 188, 282.

233 Hunt, above n 190, 282.

234 Siegel-Itzkovich, above n 189, 283.

235 Intergovernmental Committee on AIDS, *Therapeutic Goods*, above n 2, 35.

African countries and at least one Central American state.[236] In response to evidence of transmission of the disease in Scottish gaols, prisons throughout the country are being supplied with sterilising tablets to allow prisoners to clean needles and syringes, and on admission, each prisoner is now given information about the risks of injecting drugs.[237]

In a pilot program in NSW, disinfectants in the form of tablets, and subsequently liquid bleach, have been made available. This program was the subject of a study by Kate Dolan in which she considers the accessibility of the cleansing agents and the efficacy of the program.[238] Despite the large number of inmates who did clean needles, there were some who did not. Dolan cites several open-ended responses from inmates concerning accessibility to bleach, the most telling and critical of which follow:

> If you ask the clinic (for Milton tablets) your name is put down, you're targeted as a drug user and the screws are on your back, giving target urine samples and numerous cell searches (27 year old prisoner) ....
>
> Get serious — this is Corrective Services we're talking about [in response to 'why couldn't you get Milton tablets?']; we get nothing, keep pressuring the bastards to prevent the spread of AIDS in prison (38 year old prisoner).[239]

Dolan concludes that: disinfectants should be available to all inmates routinely rather than on request; cleansing instructions should be revised to comply with those of the Australian National Council on AIDS; and compulsory testing for HIV (where it exists) should be replaced with voluntary testing for HIV and other transmissible diseases including Hepatitis B and C.[240]

Gaughwin suggests that because of the present uncertainty concerning the implications and consequences of providing clean needles, it would be appropriate to at least provide bleach and adequately instruct prisoners to use it before

236 ECAP Report, above n 4, 67. The World Health Organisation recommends its availability in countries where it is available to injecting drug users in the community: 'Guidelines', above n 184, 4.

237 Christie, above n 30, 279.

238 Dolan, 'Evaluation', above n 2, 6. The programme commenced with 'Milton Tablets' (generally used in the sterilisation of babies' bottles), available from prison medical staff, officers or other inmates on request and at no charge. Inmates were instructed to use the '2x2x2' method for syringe cleaning, where a syringe was to be flushed twice with water, twice with the cleaning agent, and twice more with water. Liquid bleach was introduced in NSW prisons in October 1992, with the intention of completely replacing the disinfectant tablets. The disinfectants were available from prison staff, prison officers, and other inmates upon request, for no charge. The study reveals that one-third of respondents (all male) stated that they had easy access to either disinfecting tablets or liquid bleach in the four weeks before the survey (and tablets were easier to obtain than bleach); however, ease of accessibility varied greatly among the 12 prisons studied. For example, in eight jails, few had easy access; although it was difficult for some inmates to obtain disinfectants, over two-thirds said they could do so when needed; although disinfectants were used most often to clean their cells, 20% used them to clean injecting equipment; and virtually all respondents who had shared needles also cleaned them (94%): Dolan, 'Evaluation', above n 2, 7-8.

239 Dolan, 'Evaluation', above n 2, 12-13. Others include: 'I don't know who to see to purchase them [Milton tablets]' (33 year old prisoner); 'Gaol will not give us [Milton tablets]. Help us' (32 year old prisoner); 'I would not go up to a prison officer for Milton tablets.' (35 year old prisoner); 'The government needs to look into the gaol systems about safe HIV activities to issue condoms and clean needles soon' (33 year old prisoner).

240 Dolan, 'Evaluation', above n 2, 13.

and after injecting, thus reducing risk to themselves and officers who accidentally prick themselves while searching for contraband. As he puts it, 'a certain amount of pragmatism is called for in the current climate of risk'.[241] On the other hand, Kerr's approach involves recommending the provision of bleach to inmates, but doing so in a manner too far removed from the openness the circumstances demand:

> There is some evidence that suggests injecting drug users will utilise needle cleaning agents. It is recommended that those prison systems where injecting drug use is known to occur make bleach freely available. This can be achieved without specifically identifying bleach as being for needle cleansing only, thus avoiding any unnecessary political or industrial relations problems.[242]

While the concession that bleach be made available is essentially a welcome one, doing so without providing explicit explanations as to how to use it is a misguided and untenable proposition.

'Prisoners know about AIDS and are concerned for themselves but they need responsible assistance from those who control and manage them to lessen their risk of infection.'[243] Among other strategies, effective management and regulation requires the 'provision to prisoners of the optimal opportunities to reduce risk to themselves'.[244] The concerns voiced recently about the efficacy of bleach as a preventative measure call into question its reasonableness as such.[245] As a consequence of these concerns, the only adequate response to the risk of HIV transmission may be the one that seems (to some) hardest to swallow: do on the inside what is done on the outside — provide clean needles and syringes.[246]

D *Conclusion on Reasonableness*

If Australian prison authorities were to argue that they are acting in a manner similar to other similarly placed institutions, and therefore could not be found in

241 Gaughwin, 'Risk Behaviours', above n 11, 114. Further, '[c]ondoms are in the same category as bleach. They present no hazard to staff or prisoners and should be widely distributed.'

242 Kerr, above n 59, 61.

243 Gaughwin, 'Risk Behaviours', above n 11, 114.

244 Ibid 115. See Robert Benson, 'AIDS in Prison: Are We Doing the Right Thing?' (1987) 13 *New England Journal on Criminal and Civil Confinement* 269, 289. 'The simple denial of the problem of injection drug use within correctional institutions will likely result in increased sharing of HIV contaminated injection equipment among inmates and the resultant increased spread of HIV infection': Pagliaro and Pagliaro, above n 12, 208.

245 ECAP Report, above n 4, 68-9. The Report notes that increasing doubt has been raised concerning the effectiveness of bleach in destroying HIV; uncertainties also exist regarding whether bleach destroys Hepatitis B, and decontaminates Hepatitis C: 'the effectiveness of bleach as a biological agent has been seriously questioned.' Dolan notes that during the course of her study, a US meeting was held at which opinions had changed regarding the usefulness of bleach: although serious doubts were raised about its effectiveness, one study disclosed that HIV was totally inactivated by undiluted household bleach at all tested exposures of 30 seconds or longer. The Australian National Council on AIDS then revised their guidelines on syringe cleaning: 'flush the syringe twice with water, fill the syringe with full strength bleach (5.25% sodium chloride) and agitate it for 30 seconds and flush twice with water': Dolan, 'Evaluation', above n 2, 7.

246 Some respondents to ECAP's Working Paper 'criticised the Committee's reliance on bleach as a way to reduce exposure to HIV and other infections, and concluded that making bleach available must be regarded as an insufficient intervention': ECAP Report, above n 4, 69.

breach of their obligations to those in custody, this contention should be given short shrift. Poor practices do not excuse failures to do what a reasonable person or enterprise ought to do in the circumstances.[247] Complying with what other prisons do is not necessarily an adequate answer to the allegation of carelessness, and while reliance on the existence of similar conduct may be helpful, it cannot be held to be conclusive or determinative of the matters at issue.[248]

Admittedly, in the prison management context, what other institutions do in terms of preventative measures may be given greater weight than might otherwise be the case in other kinds of negligence situations because of the nature of prison administrators' responsibilities. Nevertheless, it would not be untenable for a fact-finder (perhaps influenced in part by community standards and suggested necessary responses to serious public health issues) to hold that the conduct of virtually all Australian gaols falls below what could reasonably be expected of them.[249]

Indeed, the initiatives at the ACT's Belconnen Remand Centre provide salient examples to contest what authorities elsewhere might proclaim as the attainable 'standard of the trade' in Australia. Its programs also undermine the assertion that the provision of condoms or bleach is impractical or dangerous. The Belconnen Remand Centre has been distributing HIV/AIDS prevention kits since December 1992,[250] as well as providing education programs. The ACT's published policy on HIV/AIDS in correctional facilities[251] focuses on education and minimisation of risk. Although needle exchange is not offered (with a justification based on minimising risk of injury to staff), community-based remandees are advised of the existence and location of needle exchange facilities in the community.[252]

Notwithstanding the fact that there is, of course, a substantial difference between a remand centre like Belconnen and a high security prison, the steps taken

247 *Rogers v Whitaker* (1992) 175 CLR 479.

248 In *Mercer v Commissioner for Road Transport & Tramways (NSW)* (1936) 56 CLR 580, 589, Latham CJ states: '[t]he mere fact that a defendant follows common practice does not necessarily show that he [or she] is not negligent, though the general practice of prudent men [and women] is an important evidentiary fact. A common practice may be shown by evidence to be itself negligent.' In *Knight & Ors v Home Office & Anor* [1990] 3 All ER 237, 242-3, the Court states (despite not finding negligence),

> [w]hile general practice in the prison service is a factor to be taken into account, I accept that the plaintiffs could succeed even if the current practice approved in the prison service had been followed in every respect .... It is for the court to consider what standard of care is appropriate to the particular relationship and in the particular situation.

249 Note *Cekan v Haines* (1990) 21 NSWLR 296, regarding cost factors and the role they play. Practices elsewhere including those in the US, were examined by the court (with respect to prison structure).

250 The prevention kits contain one bottle of bleach with a label which says 'three steps to clean a fit: 2 x 2 x 2'; three packets of bleach; two 'Wet Stuff' water-based lubricant; two 'Nuda' condoms; and 'literature'. This reading material includes instructions on how to use condoms; alcohol and drug information services telephone numbers; a list of HIV/AIDS services in the ACT; a diagram on how to clean fits; a NSW pamphlet on Safe Sex and AIDS; a cartoon aimed at 'straights' called 'wanna get on? without getting AIDS' and a cartoon aimed at 'straights' called 'tonight's the night' and a one page handout about Hepatitis. Replenishment of the kit's contents is available from medical staff.

251 *ACT Corrective Services Policy on HIV/AIDS* (October, 1993).

252 Detainees are advised that the practices that may spread HIV/AIDS are not condoned and are, where appropriate, illegal.

at Belconnen nevertheless provide an example of an Australian correctional facility that has rejected the position of strict enforcement of regulations in favour of a policy that recognises the potential for harm *regardless* of prison policy, and seeks a constructive, reasonable engagement with the problem rather than a denial of its existence.[253]

The ACT's initiatives come close to realising many of the policies recommended as most appropriate in reasonably responding to contain the risk of the virus' transmission in penal institutions. In a sense, they demonstrate the kinds of measures the courts will hopefully suggest are necessary to satisfy the authorities' legal duty of care.[254] And yet they are far removed from the realities of what is actually taking place elsewhere in Australia, and what certain prison managers and officers say they would tolerate.[255]

In 1990,[256] one senior Victorian prison administrator stated that he believed that under the Victorian Act there is no right to a reasonable standard of protection from disease, including the HIV virus. However, one could conceivably set minimum standards of protection using unit management guidelines.[257] On the subject of needle exchanges to prevent the spread of HIV, he stated that he was in no way in favour of needle exchange as part of this protection, as that would be aiding and abetting the commission of a crime, and would amount to condoning drug taking. Further, the idea of bleach satchels being made available, even through the department, is 'bullshit' — what they should be doing is getting rid of the drugs, 'not providing for a safe way to use the drugs. This is not such a good idea at all'. His view with respect to the provision of condoms was somewhat different. He stated that although they posed a risk — smuggling concealed substances in them — he acknowledged that homosexual relationships take place in the gaol, and this fact did not surprise anyone there. As prisoners are consenting adults, he believed these activities should not matter. Ultimately, he did not comment conclusively on whether condoms (as opposed to clean needles) should be made available within the gaol and seemed somewhat equivocal about their availability.

Another senior administrator stated that the issue of condoms was raising 'hassles' industrially. The bleach issue caused 'minor waves', but they *are* providing bleach in the prison. He believed that, generally, what they can do is

253 The decision to distribute condoms was the 'result of an administrative direction pursuant to an agreement with the custodial officers' union (Public Sector Union) rather than as a result of legislative or regulatory change': Godwin *et al*, *Legal Guide*, above n 1, 272.

254 Although many commentators would argue that a needle or syringe exchange program is the only reasonable way to meet the risk of harm to intravenous drug users.

255 Although, as noted above (text accompanying n 209), bleach (for example) is available in several Australian institutions, and is sometimes surreptitiously used for the purposes of cleaning injecting equipment.

256 During 1990, several administrators and officials working in Victorian rural jails were interviewed as part of a project concerning prisoners' rights. Comments relevant to this paper, disclosed during personal interviews, are included in the text following this note. Governors and other officers were asked whether prisoners had the right to be reasonably protected from disease. In responding to this question, they canvassed issues concerning prevention and containment of HIV transmission.

257 'Unit management' is a managerial philosophy now in place in Victorian prisons, whereby prisoners are given a greater role in their own governance and decision-making, with a view to providing them with more humane containment and protection of their dignity, as well as boosting staff morale.

provide education for officers and inmates. He again noted that the issue of condoms was an industrial nightmare. He commented: '[p]ersonally, I don't know what the furore is all about'.

As to whether or not institutions were required to provide prisoners with a reasonable standard of protection from disease, two officials from the now decommissioned Geelong prison stated that they could not guarantee there would be no rape, gay sex, and Hepatitis B: '[p]roviding condoms, and needle exchange programs are "crap" and "bullshit".' They stated that if they gave prisoners needles, they would be condoning drugs coming into the gaols because prisoners would want something to go in them; 'it is just not on.' There would be pressure on visitors coming into the gaols who would have to be strip searched to get at the syringes. If you introduce needles into the gaols then you should also be saying that the substances are legal. They contended that you would never have a prisoner coming to them for condoms because the prisoner would be 'saying something about himself'. Also, it would be difficult finding officers willing to clean up the condoms. They stated that it is impossible to introduce something like that into the gaol, and they would not be used even if there were thousands of them in boxes.[258]

Having canvassed the arguments against the introduction of condoms, barriers, clean needles and bleach, the Legal Working Party of the Intergovernmental Committee on AIDS correctly concludes that the 'perceived problems do not outweigh the pressing public health objective' of providing measures known to prevent the spread of infection.[259] In its *Final Report*, it states:

> Governments should ensure that residents of correctional and other institutions (eg for people with intellectual or psychiatric impairments) have similar access to HIV/AIDS prevention measures as the rest of the Australian community. These institutions should take steps to fulfil their legal duty of care to clients in relation to HIV/AIDS by making condoms and other barrier products and bleach widely available, coupled with appropriate and ongoing HIV/AIDS education and policy development .... The Working Party recommends that the

258 Several additional offensive comments made during the course of this interview have been omitted.

259 Intergovernmental Committee on AIDS, *Therapeutic Goods*, above n 2, 35. Lake, above n 157, 20 states:

> While the encouragement of safe sexual practices via the use of condoms and clean syringes has been the cornerstone of AIDS prevention and control in the general community, in gaols in every jurisdiction in Australia [until recently in the ACT] condoms and clean syringes have been prohibited. This is in spite of the fact that male-to-male sex is not illegal in the community nor is the use of many types of intravenous drugs. The 'moral' objections have been maintained in the closed environments of prisons.

By way of contrast, Kerr, above n 59, 46-7 suggests some (less than convincing) justifications for the authorities' resistance:

> Many of the larger Australian prisons are in nineteenth century buildings and operate with outmoded facilities and pressures on resources. Ensuring proper custody and care of prisoners is never an easy matter, and correctional administrators face a host of critical issues other than HIV infection .... Many commentators on HIV/AIDS in Australian prisons provide a view of the issue from the luxury of not having to institute the reforms they recommend. Such views do not have to deal with the fundamental forces that shape prison policy. While it is expedient to ignore, belittle, or argue that these forces must be resisted, it does little to explain why and how prison policy in the controversial HIV/AIDS area is formed.

> provision of such items to minimise the risk of HIV infection be considered in conjunction with the duty of care to prisoners or clients in such institutions.[260]

The consequences of not providing effective, inexpensive preventative measures, where the risk of eventual death is real, not fanciful, are too grave to generate much empathy for prison managers, regardless of the pressures they face, including those of an industrial nature. In fact, it may be argued that because of the special relationship prison administrators have with inmates, their duty to those under their care is heightened.

The refusal to implement the most efficacious, widely recommended harm reduction measures constitutes culpable conduct. This is even more the case now that there is growing evidence of increasingly responsible measures being implemented, admittedly in a rather *ad hoc* fashion. These range from Belconnen Remand Centre's approach, to some of the changes undertaken in Canadian and European prisons, to the availability of bleach in several Australian gaols.[261] These recent initiatives point to the fact that, at least with respect to the provision of condoms, dental dams and bleach, doing so is possible, and it is being done. Similarly, treatment which denies a prisoner access to measures otherwise enjoyed by the general community which are capable of preventing contraction of HIV/AIDS justifies the imposition of liability.

CONCLUSION: THE VALUE OF THE COMMON LAW (AND ITS LIMITS)

The question usually asked with respect to instituting a claim in negligence is, 'will the complainant bringing the negligence action succeed?' But success in the traditional sense is not entirely the issue in this novel type of case arising from these circumstances. The purpose and value of instituting proceedings, and considering the possibility of judicial recognition of a duty of care and its breach, is not limited to the case of the unfortunate individual who actually suffers the damage that is the subject of the complaint. Rather, the educative function of tort law lies in its ability to set higher standards of behaviour, with a view to improving conditions of detainment. Presumably, it is upon this basis that Dunford J embarked upon a radical new direction for an action framed in negligence terms, by suggesting that a remedy may lie (and an injunctive remedy at that) where there has been no actual physical damage as such to a particular individual; potential harm would be sufficient.

The need for the actual imposition of a substantial damages award becomes less imperative in this context than might be the case in a more typical scenario. Even if prisoners were to fail in their litigation, at least the expenses facing the

260 Intergovernmental Committee on AIDS, *Final Report*, above n 222, 76. It includes sterile injecting equipment among those measures that ought to be provided to prevent spread of the disease (at 33).

261 The available responses, each of which has its own particular degree of efficacy in confronting and containing the risk of HIV transmission in jail, lie along a continuum. Some are more valuable than others. For example, providing condoms with water-based lubricant and instructions is more effective than condoms alone. Providing condoms alone, however, is more valuable than not providing any barrier (and simply pretending the risky behaviour does not exist): see Bloom, 'Prisoners Sue for Condoms', above n 39. Organisations such as Australian Federation of AIDS Organisations have long stated that that condoms and bleach must be provided to inmates to prevent HIV transmission.

prison authorities in having to defend (a series of) claims of this nature may prove to be factors weighty enough to tip the balance in favour of necessary change. Perhaps an appeal to the bottom line[262] — authorities' concern over costs associated with defending litigation as well as payment of potential damages awards — will persuade them to amend their policies.[263]

Of course, this does not ignore and is not intended to minimise matters such as the cost and expense facing the litigants themselves. Nor is it intended to ignore an important factor in all litigation involving HIV, that 'a person who is actually suffering from AIDS ... may not have the physical or emotional strength to instruct counsel, attend discovery proceedings and be subjected to the rigour of a trial.'[264] Moreover, as Norberry points out, a prisoner's opportunity to enforce

> common law duties is curtailed by limited access to legal aid, and probably by their own reluctance to become involved in legal disputes with their custodians. In the case of prisoners with HIV/AIDS it may be additionally unattractive because of the stresses associated with involvement in legal proceedings.[265]

Yet to make a statement, some individuals may be willing to endure the rigours of the litigation process. Furthermore, if injunctive relief were possible, the proceedings could at least be instituted by an individual not yet suffering from the debilitation caused by the disease. However Bloom, commenting favourably on the potential usefulness of a writ of habeas corpus in the *Prisoners* case, criticises the remedy available by way of an action for damages in negligence: '[i]n the rhetoric of all HIV/AIDS policy in Australia, prevention is the only answer where there is no cure. Damages could never put the HIV positive prisoner back in the position he or she was in before infection.'[266] He adds that providing condoms is more appropriately dealt with by legislation than court action.[267]

While this is true, one can not lose sight of several facts. Unfortunately, it is unlikely that the writ of habeas corpus will be given the broad application desired, as traditionally it has had little impact on prison policy. The New South

262 Cashman argues that appealing to the 'bottom line' may be the best solution to resolving cases of product liability harm: Peter Cashman, 'Toxic Torts and Mass Disasters: The Bottom Line — How Corporate Counsel Condemn Consumers and Create New Forms of Forensic Farce for Litigation Lawyers' in Ellen Beerworth (ed), *Contemporary Issues in Product Liability Law* (1991) 81, 100.

263 Lake, above n 157, 22, states:

> It appears that corrective services departments and governments in general will not radically change their policies until they are convinced that the spread of HIV/AIDS in prison presents a great danger to the wider community. There is, however, some hope in convincing governments that present policies are going to cost them a considerable amount of money if prisoners can mount negligence actions against them. This is especially so in cases where prisoners who tested negative on entry to prison can prove they seroconverted whilst in prison.

264 Rozovsky and Rozovsky, above n 115, 54.

265 Norberry, 'HIV/AIDS, Prisons and the Law', above n 74, 92-3.

266 Bloom, 'Prisoners Sue for Condoms', above n 39, 12.

267 There is no valid reason for delay in the light of law reform reports and experts' advice regarding provision of condoms. Bloom cites the Puplick report as strongly supporting this measure: 'there is no question of balance in relation to the provision of condoms in prisons — the case for their availability is overwhelming and the failure to make them available is absolutely contradictory to proper public policy': ibid 12, citing the New South Wales HIV/AIDS Legal Working Party, *The Courage of Our Convictions — HIV/AIDS: The National Strategy and the laws of NSW* (1993) 121.

Wales Court of Appeal dismissed habeas corpus arguments in the *Prisoners* appeal after canvassing UK, Canadian and American decisions. It also dismissed, rather summarily, contentions premised on the contravention of the Magna Carta. In this case, the only arguments which remain intact are those based on negligence (notwithstanding the failure of the 50 prisoners' appeal with respect to the class of plaintiff which could appropriately bring the claim against the authorities). While legislation is the best means by which preventative measures can be instituted, the negligence claim can provide a catalyst to reform. By and of itself, the tort action may not compel the introduction of the suggested and required initiatives. However, in conjunction with other strategies, it is of assistance. Our politicians seem to be paying attention to the claim itself, quite apart from the actual decision (and other potential proceedings).[268]

Litigating a claim, or the threat of doing so, can be a fruitful way of effecting improvements.[269] Moreover, instituting an action may be the only means by which significant changes to the authorities' behaviour, reflected by raised standards, can even be attempted. The duty of care concept is one to which legislators and corrections administrators must at least have regard when formulating policy options, including the development of HIV prevention strategies.[270] This is more pronounced if there is a possibility of liability being imposed. Even if an action fails, it has value: for example, attention has been brought to the problem by virtue of media reports, and policies may change as a result of embarrassing publicity, with pressure possibly brought to bear on prison authorities to try to address the public health concerns in a serious manner. Few other options are available.[271]

It is through the kind of publicity now generated by a claim such as *Prisoners* (regardless of whether or not it actually succeeds) that some politicians hint that change may be imminent. Perhaps they finally perceive that the dangers at issue should be characterised as an urgent public health matter to which harm minimisation principles must be applied, despite the marginalisation of the groups at risk.

Community responsibility lies at the heart of the problem.[272] If we, as a com-

268 See discussion above n 56 and accompanying text.

269 Norberry discusses the value a duty of care can have in policy development (if not in terms of enforceable rights): Norberry, 'HIV/AIDS, Prisons and the Law', above n 74, 89.

270 Godwin, 'Rights', above n 84, 171.

271 Mosoff comments on the public interest approach to litigation in Canada:

> A successful piece of litigation, defined as obtaining the relief sought from the Court, may not provide the immediate 'success' expected in solving the problem. Indeed, it may backfire by the way that a judicial pronouncement is interpreted. Similarly, an unsuccessful piece of litigation may not mean a failure for the objectives of the client. Public interest groups know that the important site for implementing judicial pronouncements is not in the courtroom but in the bureaucracy .... Different systems may be more politically vulnerable to change so that the risk of 'losing' the litigation is tempered by the increased profile of the issue because of the litigation.

Judith Mosoff, 'Do the Orthodox Rules of Lawyering Permit the Public Interest Advocate to "Do the Right Thing?": A Case Study of HIV-Infected Prisoners' (1992) 30 *Alberta Law Review* 1258, 1271. See also Susan Jacobs, 'Legal Advocacy in a Time of Plague' (1993) 21 *Journal of Law, Medicine and Ethics* 382.

272 Writing extra-judicially, President Kirby states:

munity, are to continue institutionalising offenders, this must be realised in conjunction with prisoners' rights to certain protections. Where prison authorities fall short of adequately providing these protections, prisoners have the prerogative to bring legal claims for their non-delivery.

Regardless of the actual and realised success of those claims, the fact is that morally the Government has a long way to go towards fulfilling at least the basic requirements demanded of them. Providing condoms and setting up needle exchange programs would demonstrate a genuine commitment (and not a budget-breaking one) to reasonably care for those whom the courts have seen fit to incarcerate:

> [P]risons have responsibilities and power to make a substantial contribution to stemming HIV transmission. To accept such responsibility will require courage and the insight that they do not exist in a world which is apart from the communities in which they are located and that they need to address with their communities the welfare of prisoners both while they are in prison and while they are outside.[273]

With respect to Australia's efforts to combat HIV/AIDS, the Minister for Justice, Duncan Kerr, paints a rather too rosy picture:

> [T]he history of HIV/AIDS in Australia can be viewed as a triumph for community *and* government co-operation .... Australia forged a largely cooperative response, based on the need to include all groups, no matter how stigmatised and marginalised they had been from the political process. There were substantial revisions of policy — notably the decision to implement needle and syringe exchanges. This decision alone slowed the spread of the virus into the young drug using population, and into the wider heterosexual community .... Of course, one person with HIV, one Australian dying of AIDS, *and one new in-*

> We must ready ourselves, as a civilised community, to ensure that prisoners are not unnecessarily exposed to acquiring a fatal condition whilst in prison. If we do not take proper steps, we will stand condemned as irresponsible and morally negligent in the safekeeping of prisoners .... In the potential incubator of prisons those true problems derive from the established modes of transmission of the HIV virus .... Advice, education and counselling ... must be given. But for those who cannot, or will not, take such advice, practical steps must also be taken. These include the availability of condoms and of cleaning agents or bleach to prisoners .... We owe it to the prisoners — but if this is unconvincing, we owe it to the community — to protect prisoners from infection whilst in prison. This requires radical steps before it is too late .... The infection of a person who is in the custody of society, because that person does not have access to ready means of self-protection and because society has preferred to turn the other way, is just as unpalatable [as, for example, the infection of an officer by a prisoner]. As a community we must take all proper steps to protect prison officers and prisoners alike. By protecting them we protect society.
>
> Michael Kirby, 'WHO Global Commission, AIDS Recommendations and Prisons in Australia' in Norberry *et al*, *Conference Proceedings*, above n 21, 7, 19.

273 Gaughwin, 'Risk Behaviours', above n 11, 117. ECAP states that preventative measures undertaken now to prevent the spread of HIV infection will benefit the whole community. Prisoners' human rights must be respected (except for those limitations demonstrably necessitated by the fact of incarceration) and they are entitled to protection from contracting diseases. Governments and administrators need to face up to the risk of the spread of HIV, and any measure to protect prisoners also protects staff, as lowering the prevalence of infections means that risk of exposure is lowered. Measures to protect prisoners are based on sound public health policy — prisoners generally rejoin the general community after short periods of incarceration, so in order to protect the general population, HIV/AIDS prevention measures have to be available in the prisons as they are on the outside: ECAP Report, above n 4, 121.

> *fection* with [the] virus, is a defeat, not a victory. But I think we can take at least modest comfort that the overall direction of our response has been correct.[274]

As the recently reported Australian case of seroconversion while in custody demonstrates,[275] our gaols have been shown conclusively to be the home of at least one such 'defeat'.

Australia's unusually conservative stance is frustrating and demoralising. In other ways and contexts, Australia has undertaken important initiatives in its attempts to contain the spread of HIV/AIDS and in its development of programs to treat those with the disease — a non-judgmental, non-partisan, sophisticated approach.[276] The same cannot be said of its response to the risk of HIV transmission in prisons. For example, while Canada and many other states have demonstrated that the widespread provision of condoms, dental dams and lubricants in the prison system is possible, Australia — otherwise in the forefront of combating the spread of the disease — seems to date to be lagging behind these significant and progressive overseas developments. With respect to the non-provision of syringes or clean needles, Australia's response appears to be on par with several other similar jurisdictions. Arguably, however, the provision of clean needles (perhaps as a last resort, unpalatable as the practice may be to some interested parties) seems more plausible now than ever as a consequence of recognising the danger in not doing so.

If a negligence action — or series of actions — can help demonstrate to the Australian public and authorities what is possible and reasonable in the circumstances by way of response to the risk of HIV spread in gaols, then instituting proceedings will have proven worthwhile.

However, as noted earlier, one of the real problems with utilising negligence as it is traditionally understood (and not as suggested by Dunford J in *Prisoners*) is that damage is required: harm must have been suffered. Because the harm cannot be theoretical, this may have hindered potential litigants from instituting proceedings.[277] By disgracing ourselves with the realisation of a documented case of custodial seroconversion, harm has been allowed to occur. The gist of the action exists. An after-the-fact remedy can now be pursued, if the sufferer wishes to do so.[278]

The problem is real. Only the most irresponsible authorities and governments would persist, at their own potential legal peril, in refusing to provide measures which would prevent this grave harm. Courts are now in a position of being able

274 Duncan Kerr, 'Current Government Offensive' in *HIV/AIDS: Law, Policy & Directions* (1993) 2.1-2.2 (emphasis added).

275 See discussion above nn 25-9 and accompanying text.

276 As Lake, above n 157, 22 states:

> I have painted a bleak picture of the management of HIV/AIDS in Australian corrective systems. Whilst Australia leads the world in areas of prevention and care such as needle exchange provisions, public education and community care for people who are HIV-positive, our efforts in managing the pandemic in prisons should be criticised. Complacency is an enemy as is the reluctance of corrective services departments to encourage public debate of their policies.

277 Although this did not stop the litigants in *Prisoners* from claiming relief, it may cause their claim to fail.

278 And if the facts of this individual's case arguably fit the other requirements of a negligence action.

to legally condemn the authorities' inaction.[279]

Perhaps the plea of one prisoner, once detained at Geelong prison, deserves our attention:

> The community as a whole have too [*sic*] get involved and into jail system and child institutions and make things work for the better for everyone. We as human beings are all more or less born the same. Something has happened too [*sic*] make us being here [*sic*]. Well what about bringing us out as better people or the same person before we ended up in this place. It's very wrong and a large scale of neglect by all partys [*sic*] involved in this system and flow on organisations that revolve around this Department.[280]

[279] See Pagliaro and Pagliaro, above n 12, 209. The Director of the National Centre for Epidemiology & Population Health agrees. See Douglas, above n 21, 25:

> The Australian community ignores this urgency [the spread of HIV in prisons] at its own peril .... A lesser of two evils approach recognises that illegal activities are going on in prisons and that prisoners ought to have both the knowledge and the capacity to protect themselves against HIV infection.

[280] Provided in written form as part of a 1990-91 survey of prisoners detained in rural Victorian jails.