

Mandatory

Disease Testing

Options Paper
September 2018

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Executive Summary

In August 2017, a NSW Parliamentary Committee Inquiry report into violence against emergency services personnel recommended the NSW Government consider introducing legislation to allow mandatory disease testing of people whose bodily fluids come into contact with police and emergency services personnel.

In February 2018, the NSW Government Response committed to consider the issues involved in establishing a legislative scheme and agreed to release an options paper for stakeholder consultation.

This options paper delivers on the NSW Government's commitment to canvass the legal, ethical, operational and financial issues involved in considering whether, and how, a mandatory disease testing scheme could be implemented in NSW.

In most circumstances, it is likely people whose bodily fluids come into contact with an emergency services worker would consent to a blood sample being taken for testing, provided they are counselled by a health care worker. If the exposure occurred in circumstances where a person has committed an offence against an emergency services worker, that person may be less likely to consent to being tested, despite counselling.

The efficacy of testing and the risks and benefits to emergency services personnel exposed to bodily fluids need to be carefully weighed against the impact on individuals who may be required to be mandatorily tested. Both the source person and the emergency services worker need to be assessed, counselled, and managed by a health care professional. Privacy of their health information is an important consideration. Consideration also needs to be given to the economic impact of such a scheme on government.

Considering these issues, this paper identifies the following potential options for reform:

- **Option 1** – improvements to agency policy and practice to ensure emergency services personnel are promptly assessed, counselled and managed by a health care professional with access to specialist advice immediately following an exposure to potentially infectious body fluids.
- **Option 2** – changes to agency policy to allow the source person to be assessed, counselled and asked to consent to a sample being taken for testing by a health care professional.
- **Option 3** – a consent-based scheme, with an option for a court ordered mandatory disease testing.
- **Option 4** – a scheme that would apply where an offence has been committed, with mandatory disease testing ordered by a senior police officer.

The options may be considered as standalone options, or could be combined with one or more of the other options.

How to make a submission

Should you wish to make a submission in response to any of the issues in this paper (including the desirability or otherwise of mandatory disease testing, or your view on reform options), please submit written comments to:

mdtsubmissions@justice.nsw.gov.au

Submissions must be received by close of business **31 October 2018**.

Please note that all submissions will be treated as public, unless otherwise advised. If you wish for your submission to be treated as confidential, please clearly identify this when you make your submission.

1. Background

1.1 *Parliamentary Inquiry Report*

On 12 May 2016, the NSW Legislative Assembly Committee on Law and Safety (“the Committee”) resolved to conduct an inquiry into violence against emergency services personnel.

The Committee received 35 submissions from across the community and held three days of hearings.

On 8 August 2017, the Committee released its report, making 47 recommendations and 13 findings for the NSW Government’s consideration.

The bulk of the Committee’s recommendations related to procedures and practices to improve the safety of hospital staff and Ambulance NSW personnel.

Recommendation to explore mandatory disease testing

Relevant to this options paper, the Committee expressed concern about emergency services personnel being exposed to the risk of serious diseases in the course of their duties.

The Committee:

- noted that coming into contact with another person’s bodily fluid is a confronting experience that can cause concern and stress for the affected emergency services worker due to the potential for serious disease infection;
- noted that other jurisdictions have schemes permitting mandatory disease testing, in order to promote the welfare of emergency services personnel. Schemes operate in Western Australia, South Australia, Queensland and Victoria, with each differing in its application and operation. An analysis of the legislation in other jurisdictions is at **Appendix A**;
- considered the argument put forward by the Police Association of NSW that a mandatory disease testing scheme would afford the affected emergency services worker greater certainty and peace of mind regarding the possibility of infection; and
- acknowledged that immediate testing would not be conclusive, but considered it could be of comfort to the emergency services worker during the ‘window period’, and provide more information for the worker and their health care professional when determining the best course of clinical management and counselling.

The Committee Report:

- **recommended** the NSW Government consider introducing legislation to allow mandatory disease testing of people whose bodily fluids come into contact with police and emergency services personnel, in consultation with affected stakeholders (*Recommendation 47*); and
- **found** that the power to conduct mandatory disease testing should only be able to be possible in circumstances where there is a risk of transmission of listed diseases. The legislation should clearly define the factual circumstances in which there is a risk of transmission of listed disease and this definition should be based on up to date medical evidence (*Finding 13*).

1.2 Government Response to Inquiry recommendations

On 8 February 2018, the NSW Government tabled its Response to the Committee's Report and its 47 recommendations. The Response was also published on the NSW Parliament website.

In response to Recommendation 47, the NSW Government agreed to convene a cross-agency working group to develop an options paper to canvass the legal, ethical, operational and financial issues involved in the implementation of a mandatory disease testing regime. The Government committed to seeking submissions from stakeholders by mid-2018.

Documents relating to the Committee's inquiry, including terms of reference, submissions, hearings, the report, and the Government Response can be found at the following link:

<https://www.parliament.nsw.gov.au/committees/inquiries/Pages/inquiry-details.aspx?pk=2395>

1.3 How was *this paper developed*?

Consistent with the Government Response, a cross-agency working group was formed to consider relevant issues and to develop this options paper for stakeholder consultation.

Development of the options paper included reviewing mandatory disease testing schemes in other jurisdictions, considering the policies of agencies employing emergency services personnel, gathering data in respect of workplace incidents, reviewing medical evidence on transmission of infectious diseases, and considering scheme design elements for potential models for NSW.

The working group comprised of senior representatives from the Department of Justice (including Corrective Services NSW), NSW Health, the NSW Police Force, and the Department of Premier and Cabinet.

2. Risk of exposure and infection

2.1 *Emergency services personnel can be exposed to bodily fluids as part of their work*

Emergency services personnel, including police officers, paramedics, firefighters, and correctional officers can be exposed to bodily fluids as part of their everyday duties.

There are a number of circumstances where emergency services personnel may come into contact with another person's bodily fluids in the course of their duties. This could include while offering medical assistance to an injured person, during an altercation, while attempting to effect an arrest, during crowd control activities, or during a rescue operation.

Some instances of contact between emergency services personnel and another person involve the deliberate application of bodily fluid, such as where the emergency services worker is assaulted. In other cases, the contact may be accidental or unintended, such as during a rescue or during the provision of first aid.

In all cases, the exposure has occurred because of the emergency services worker's attendance as part of their job, which may involve engaging in difficult and dangerous situations in order to protect the health and safety of others.

It is important that emergency services workers have access to immediate assessment, counselling and management by a health care professional after exposure to potentially infectious bodily fluids.

Table 1 shows data in relation to the number of incidents of bodily fluid exposure involving emergency services personnel.

Table 1

Agency	TOTAL incidents of exposure to bodily fluids (Per Year Average)	SUBSET – incidents involving human bite or needle stick injury (Per Year Average)
NSW Police Force¹	450	60
Corrective Services NSW²	130	16
NSW Rural Fire Service³	1	0
Fire & Rescue NSW⁴	20	1
NSW State Emergency Service⁵	1	0
NSW Health⁶	2,218	1,627

¹ Per year average over a four-year period (source: NSW Police Force)

² Per year average over a two-year period (source: Department of Justice)

³ Total of four members exposed in connection with one incident (source: NSW Rural Fire Service)

⁴ 76 exposure incidents, plus one incident involving a bite/needle stick injury, over the period 2014 to date (source: Fire & Rescue NSW)

⁵ Average over a three-year period (four incidents over the past three years) (source: NSW State Emergency Service)

⁶ Per year average over the period July 2013 to June 2017 (source: NSW Health)

2.2 Infectious diseases of concern are HIV, hepatitis B and hepatitis C

Advice from NSW Health is that the diseases of concern include the blood borne viruses of HIV, hepatitis B and hepatitis C. While these diseases can be prevented and can now be treated, if they are not, they may lead to serious health problems.

For other communicable diseases that might spread from person to person via contact with bodily fluids, there is generally no useful screening method, infections are likely to declare themselves in a short period of time and are not usually lifelong. The risk that a person whose bodily fluids come into contact with an emergency services worker is infectious with a serious condition other than HIV, hepatitis B or hepatitis C is very low.

While faeces, urine, vomit and saliva may present a risk of certain bacterial and other infections, in general they do not present a meaningful risk for blood borne viral infections. The risk for blood borne virus infection is essentially limited to exposure into broken skin or mucous membrane to fluids such as blood or semen. The risk for hepatitis B is negligible for a person who has been effectively immunised.

Classifying HIV, hepatitis B and hepatitis C as diseases of concern is also consistent with:

- NSW Health's internal policy on management of health care workers who are exposed to bodily fluids;
- work health safety incident notifications in accordance with the *Work Health and Safety Act 2011* and with requirements to notify SafeWork NSW in the case of certain incidents, treatment and infections relating to HIV, hepatitis B and hepatitis C; and
- the diseases of concern in other Australian jurisdictions that have implemented mandatory disease testing. Two jurisdictions have prescribed specific diseases in their legislation (Victoria and Western Australia), and these are HIV, hepatitis B and hepatitis C.

2.2.1 Prevalence of HIV in NSW is low and HIV diagnoses are declining

- There is no vaccine for HIV. HIV infection cannot be cleared by the body and infection is for life. However, when a person with HIV infection complies with treatment they are not infectious to others.
- Around 0.1 per cent of the NSW population is living with HIV.
- NSW Health data shows a decline in new HIV diagnoses, with 2017 seeing the lowest count on record; HIV testing is high and continues to increase; and treatment coverage is high.
- The NSW HIV Strategy 2016-2020⁷ has the goal of virtually eliminating HIV transmission in NSW by 2020, by increasing testing, treatment and expanding access to the HIV prevention pill, pre-exposure prophylaxis (PrEP) for HIV for people at high and medium risk of HIV infection. Prior to April 2018, PrEP was only accessible through a clinical trial, but it can now be accessed at any community pharmacy with a GP prescription.

⁷ <http://www.health.nsw.gov.au/endinghiv/Publications/nsw-hiv-strategy-2016-2020.PDF>

2.2.2 Prevalence of hepatitis C in NSW is low and is declining

- While there is no vaccine for hepatitis C, new hepatitis C treatments are now available which are safe and highly effective in treating the disease. It is now possible to eliminate hepatitis C as a public health concern.
- Around 1 per cent of the NSW population is living with chronic hepatitis C. Rates of hepatitis C infection within prison populations are about 30 – 40 times higher than that of the general population.⁸
- The NSW hepatitis C Strategy 2014-2020⁹ focuses on scaling up hepatitis C testing and treatment. Since the introduction of new treatments in March 2016, which are highly effective at curing the infection, 26 per cent of the estimated 81,000 people with chronic hepatitis C in NSW have been treated.

2.2.3 Prevalence of hepatitis B is low and vaccination coverage in NSW is high

- Vaccination is very effective in preventing hepatitis B.
- Around 1 per cent of the NSW population is living with chronic hepatitis B in NSW.¹⁰
- Vaccination coverage in NSW for hepatitis B is high. In 2016-17, the hepatitis B childhood vaccination coverage was 96 per cent, and 98 per cent for Aboriginal children.

2.3 *What is the risk of infection from an exposure incident?*

The overall risk level for transmission depends on several factors including:

- the type of bodily fluid to which the person is exposed e.g. blood, saliva, vomit
- the mechanism of exposure e.g. needle stick
- the amount of bodily fluid
- the body surface onto which the exposure occurred e.g. broken skin, mucous membrane
- the likelihood that the source person is infectious
- the exposed person's immunity and other relevant health status.

The Australasian Society for HIV, Viral Hepatitis and Sexual Health Medicine (ASHM) has produced useful fact sheets about the blood borne virus risk for emergency services personnel.¹¹

⁸ Correctional Officers and Blood-Borne Viruses, Australasian Society for HIV, Viral Hepatitis and Sexual Health Medicine, 2013

⁹ <http://www.health.nsw.gov.au/hepatitis/Publications/hepatitiscstrategy.pdf>

¹⁰ <http://www.health.nsw.gov.au/hepatitis/Publications/hepatitisbstrategy.pdf>

<http://www.health.nsw.gov.au/hepatitis/Documents/2016-annual-data-report.pdf>

¹¹ <https://www.ashm.org.au/products/product/1976963390>

The following table is taken from the ASHM fact sheet. It indicates the following risks when the source person is known to be infectious:

Table 2. Risk of HBV, HCV and HIV Transmission From a Known Positive Source			
Exposure type	Known Positive Source Status		
	HBV+	HCV+	HIV+
Blood contact with broken skin, mouth or eyes ■ e.g. Punch from bleeding person to body causing break in skin ■ Large blood splash, e.g. arterial bleed ■ Blood contact to mouth from giving mouth-to-mouth resuscitation if no protective equipment used	moderate	low	low~
Needle stick injury and other penetrating injuries ■ e.g. Cut by a blade which recently penetrated another person ■ Recently used needle penetrating skin	very high#	high^	moderate*
Saliva in mouth or eyes and bites that break the skin	very low	zero	zero
Blood and saliva to intact skin and skin-to-skin contact	zero	zero	zero

~ Risk of HIV from blood contact to broken skin is estimated by US CDC at less than 1 in 1000 chance

Risk of HBV from needle stick injury estimated at 1/3

^ Risk of HCV from needle stick injury estimated at 1/30

* Risk of HIV from needle stick injury estimated at 1/300

zero = less than 1 in 1 000 000

3. How are exposure incidents managed?

3.1 *There is currently no mandatory testing of the source person*

For an exposure incident involving a health care worker employed by NSW Health, NSW Health staff currently have the capacity to request a patient consent to disease testing, but the patient cannot be obliged to provide a sample. Further information on this is below at section 3.2.

Outside of NSW Health, other emergency services personnel do not currently have the capacity to request a person to consent to disease testing.

There is currently no ability in NSW to require or compel the source person from whom the bodily fluids originated be tested for infectious diseases.

3.2 *Personnel follow workplace policies and may consult a doctor*

Exposure to bodily fluids is a work health and safety issue. The assumption for emergency services personnel is to treat all blood and bodily fluids as potentially infectious.

Organisations that employ and deploy emergency services personnel (including volunteers) have policies and procedures in place to minimise the likelihood of exposure incidents occurring. This includes the provision of personal protective equipment (e.g. gloves), removal of hazards, and standard procedures about how to respond to particular scenarios to minimise risks and maximise safety.

If an incident occurs where an emergency services worker has been exposed to bodily fluid, the affected worker should follow relevant agency policy. It is recognised that there may be differences in these policies and their implementation among relevant agencies.

Following an incident, emergency services personnel should generally:

- take immediate first aid steps such as washing the exposed area;
- notify the agency of the occurrence of the incident; and
- seek prompt assessment, counselling and management from a health care professional with access to expert advice.

While the emergency services worker may be tested for infectious disease transmission, HIV, hepatitis B and hepatitis C may not present in the test results during the 'window period'. The 'window period' for HIV is up to 3 months while for hepatitis B and C it can be up to 6 months.

Emergency services workers can experience considerable stress during the window period. The prompt assessment, counselling and management of an exposed worker by a health care professional is very likely to help reduce this stress. Workers may also be advised to start certain treatment whilst in the window period, such as post exposure prophylaxis (PEP), which is very effective at preventing HIV and hepatitis B, although the drugs used for HIV PEP may sometimes cause side effects such as nausea and fatigue.

NSW Health policy

The NSW Health policy for health care workers (including paramedics) potentially exposed to HIV, hepatitis B and hepatitis C has comprehensive risk assessment and health management procedures¹².

Appendix B depicts the process for managing an exposed health care worker under this policy.

Health care professionals assess the risk of infection to the health care worker from a blood borne virus based on a range of factors, as outlined at section 2.3.

The health care professional will counsel the health care worker on their likely risk of infection, based on the risk assessment. If their risk is assessed as not negligible:

- options for treatment that prevent HIV infection and hepatitis B (if the worker is not immune) are considered. This includes PEP to prevent HIV and preventive doses of hepatitis B immunoglobulin and vaccine to prevent infection;
- further testing that may be required to determine whether or not infection has occurred; and
- the risk level for family members and other close contacts.

The NSW Health policy also includes testing of the source person, but only with that person's informed consent, including that the results be provided to the exposed worker. If consent is not provided by the source person, testing cannot occur.

Importantly, risk assessment occurs regardless of whether the source person is tested and regardless of whether the source person tests negative, as it is possible the source person may have been infected recently before their tests become positive (window period). Because of the window period, it can never be known for certain at the time of testing whether the source person is infectious.

¹² http://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=PD2017_010

4. Options for reform

Four potential reform options are proposed for consideration. The reform options include improvements to current policy and practice as well as options to test the source person of the bodily fluids.

Testing the source person is an additional step that may be possible following an exposure incident. Whether or not testing of the source person occurs, the affected emergency services worker should concurrently take steps to:

- follow their agency's work health and safety policies; and
- seek medical advice, risk assessment counselling and management following an incident.

The options may be considered as standalone options, or could be combined with one or more of the other options. The options 'on a page' are at **Appendix C**.

4.1 Option 1 – Improvements to current agency policy and practice

In considering whether mandatory disease testing should be introduced in NSW, the working group identified that mandatory disease testing of the source person is not the only means by which the fears and health concerns of emergency services personnel may be allayed.

It is suggested that agencies employing emergency services personnel review their current policies and procedures regarding exposure incidents to identify potential improvements to the early management of an incident, the medical information provided to the affected worker and provision of appropriate early counselling. This could include:

- Encouraging hepatitis B vaccinations for all emergency services personnel. Currently agencies vary as to their policies regarding vaccination for hepatitis B, for example NSW Health requires hepatitis B vaccination as a condition of employment.
- Ensuring emergency services personnel are promptly assessed, counselled and managed by a health care professional immediately following an incident to assist in determining the level of risk of transmission and in providing prompt peace of mind for the worker concerned.
- Increasing awareness among emergency services personnel of existing resources that can be accessed following an exposure incident. NSW Health funds the NSW Blood and Body Fluid Exposure Phonenumber (1800 804 823). NSW health care, paramedical and emergency services workers who sustain a needle stick injury and/or occupational exposure to blood and body fluids can call the Phonenumber. A doctor or nurse provides expert advice including:
 - risk assessment
 - management strategies
 - documentation
 - prophylaxis information
 - support
 - referral.

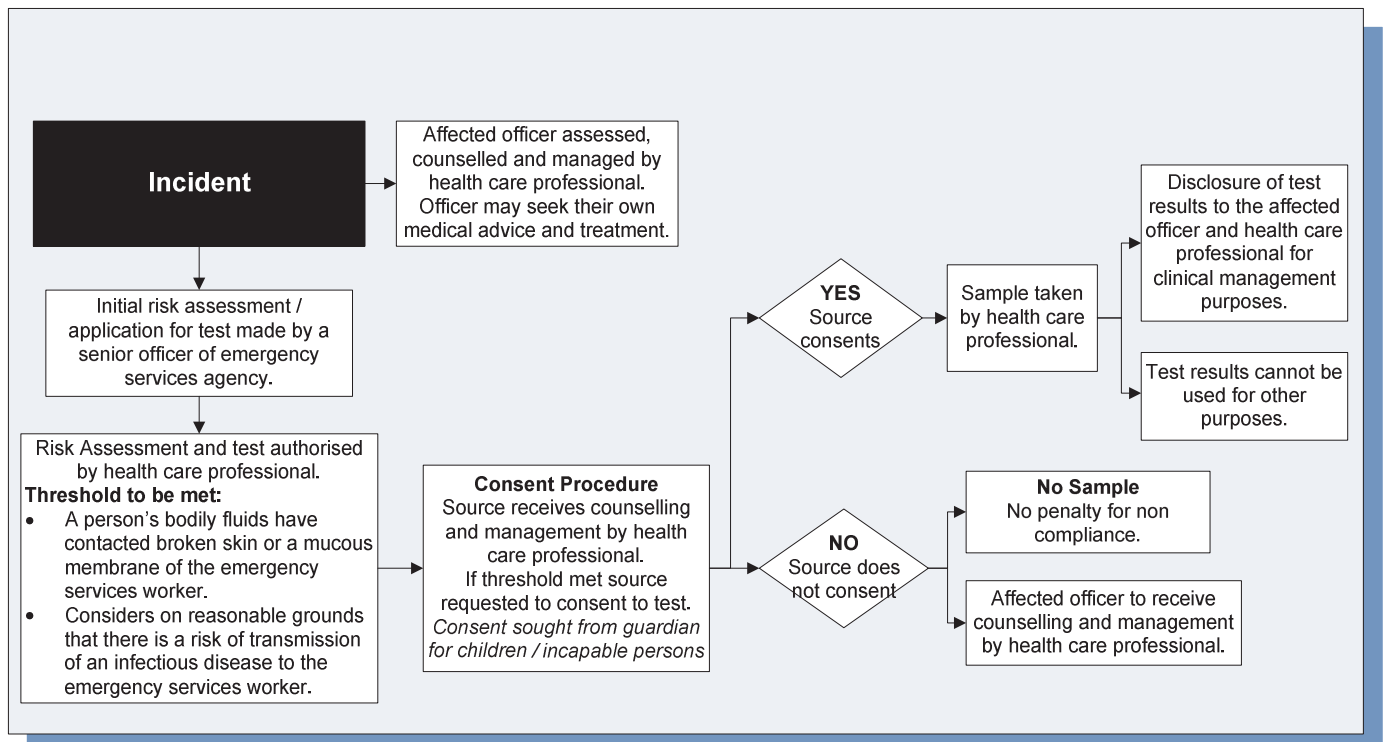
Appendix D provides case studies from the Phonenumber. The Phonenumber does not take calls from the general public, who are advised to consult their GP, medical centre or hospital Emergency Department.

4.2 Option 2 – Testing by consent

This option would seek to gain the consent of the source person to voluntarily have a sample taken and tested following an exposure incident. As the model is consent based, there may arise situations where a sample is not taken, however this would be rare in exposures that are not deliberate.

This non-legislative option would change the status quo by extending the current practice for NSW Health employees to other emergency services personnel. There would be no change for NSW Health employees.

Option 2 – summary	
Is legislation required?	✗
Can testing be sought if the contact was accidental?	✓
Does a health care professional make a risk assessment?	✓
Is the source person asked to consent?	✓
Can a person refuse to be tested?	✓
Are test analysis and disclosure of results restricted?	✓



Option 2 – Testing by consent	
Steps	Activity
Incident	An identified person's bodily fluids come into contact with the broken skin or mucous membrane (e.g. eyes, nose, mouth) of the relevant emergency services worker.
Application for test	A senior officer of the relevant emergency services agency conducts an initial (high level) risk assessment and, if warranted, makes an application to a health care professional for the source person of the bodily fluids to undergo testing.
Risk assessment and counselling (is test required?)	<ul style="list-style-type: none"> • A health care professional assesses the risk of transmission and counsels the exposed emergency services worker. • Risk assessment process will be set out in policy, similar to the current NSW Health policy on Management of Health Care Workers Potentially Exposed to HIV, hepatitis B and hepatitis C. This includes consideration of injury type and bodily fluid type as part of the risk assessment process. • The health care professional must form the view that: <ul style="list-style-type: none"> ○ The person's bodily fluids have contacted broken skin or a mucous membrane of the relevant emergency services worker; AND ○ There are reasonable grounds there is a risk of transmission of HIV, hepatitis B or hepatitis C to the emergency services worker.
Test authorisation	<ul style="list-style-type: none"> • If the health care professional determines the risk threshold is not met, the source person will not be asked to consent to testing. • If the risk threshold is met, the source person's health care professional is approached by the emergency services officer's health care professional to request that the source person voluntarily undertake testing and agree to limited disclosure of test results. • The source person receives counselling and management by health care professional. • An informed consent procedure would apply to ensure the source person has informed consent including an understanding of why the request has been made, the purpose of testing, and use/disclosure of results. A consent form must be signed by the source person. For children and incapable persons, consent will be required from a parent, guardian or carer.

Consent given	<ul style="list-style-type: none"> • The sample is taken by a health care professional. The sample is analysed for HIV and hepatitis C. If the emergency services worker is not immune to hepatitis B, the sample will also be tested for hepatitis B. • Test results are disclosed to health care professional for clinical management purposes, including disclosure of result to the affected emergency services worker. Test results cannot be used for other purposes.
Consent not given	<ul style="list-style-type: none"> • If the source person does not consent, a sample cannot be taken. • Affected emergency services worker to receive counselling and management by health care professional.

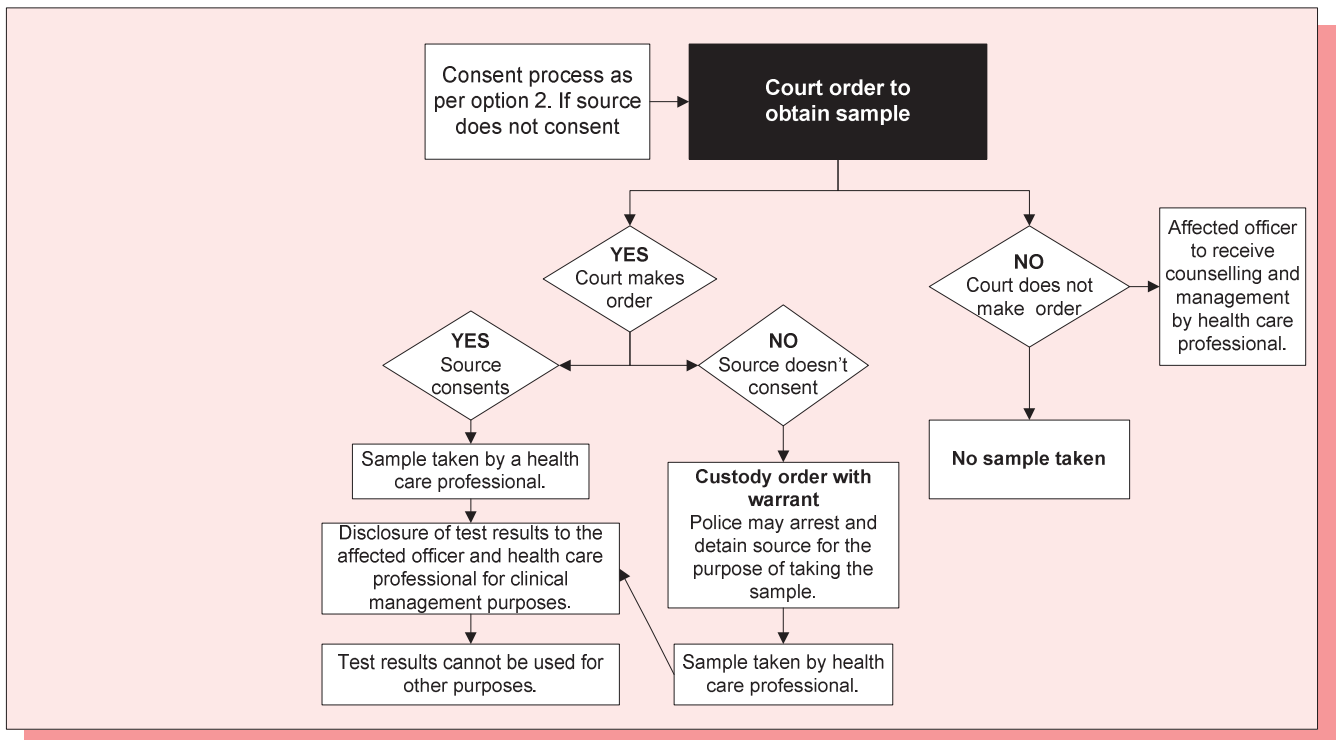
Advantages and disadvantages of this option

- No legislation is necessary – a consent model can be implemented on a policy basis.
- Testing by consent does not impose on the rights of any person. No person will be asked to do anything against their wishes, or be penalised for not acquiescing to testing. A person’s autonomy and right to make informed decisions about their body and medical care is maintained.
- The risk assessment, consent process and counselling is conducted by a health care professional. Health care professionals are best placed to determine risk of disease transmission.
- It is anticipated that a sample would be obtained in almost all cases. It is anticipated a ‘reasonable person’ would agree to be tested, particularly for unintended exposure incidents where the source person is a victim who has received assistance from the emergency services worker.
- The source person may refuse to consent to testing, and their sample would not be taken. Counselling and risk assessment of the emergency services worker (including the offer of preventative treatment) would still occur regardless.
- The affected emergency services worker may experience increased stress in the case where the source person has been requested to consent to testing, and refuses to be tested. On the other hand, the emergency services worker may experience increased stress if he/she is then made aware that the source person does have a blood borne virus infection.
- There may be practical difficulties with identifying and testing the source person if they are not in a hospital or other medical care setting.

4.3 Option 3 – Consent-based testing with option for court order

This option would seek to gain the consent of the source person to voluntarily have a sample taken and tested (as per option 2). Under option 3, an avenue is provided where, if the source person refuses to consent, following the incident threshold being met, a court may order that the source person undergo testing. This option may only apply in the case of deliberate incidents, as it is anticipated other source people are very likely to consent.

Option 3 – summary	
Is legislation required?	✓
Can testing be sought if the contact was accidental?	✓
Does a health care professional make a risk assessment?	✓
Is the source person asked to consent?	✓
Can a court make an order?	✓
Can a person be detained for the purpose of taking the sample?	✓ ¹³
Are test analysis and disclosure of results restricted?	✓



¹³ Only if a court makes an order, and the person does not comply

Option 3 – Consent-based testing with option for court order	
Steps	Activity
Incident	As per Option 2
Application for test	As per Option 2
Risk assessment and counselling (is test required?)	As per Option 2
Test authorisation	As per Option 2 In addition, the consent process would include an explanation to the source person that refusing to provide consent may result in a court order being sought.
Consent given	As per Option 2
Consent not given	<ul style="list-style-type: none"> • The relevant emergency services agency may apply to a court for a court order for the source person to undergo mandatory disease testing. • If a court determines not to make an order, no sample may be taken. • If a court makes a mandatory disease testing order: <ul style="list-style-type: none"> ○ Where the source person <u>complies</u> with the court order, their sample is taken by a health care professional. The sample is analysed for HIV, and hepatitis C, and for hepatitis B if the emergency services worker is not immune to hepatitis B. Test results are disclosed to the health care professional for clinical management purposes, including disclosure of result to the affected emergency services worker. Test results cannot be used for other purposes. ○ Where the source person <u>does not comply</u> with the court order, the relevant agency may apply to the court for a custody order with warrant. Police may apprehend and detain the source person for the purpose of taking the sample. Their sample is taken by a health care professional. The sample is analysed for HIV, and hepatitis C, and for hepatitis B if the emergency services worker is not immune to hepatitis B. Test results are disclosed to the health care professional for clinical management purposes, including disclosure of result to the affected emergency services worker. Test results cannot be used for other purposes.

Advantages and disadvantages of this option

- Legislation will be necessary to implement this option.
- The risk assessment is conducted by a health care professional. Counselling and seeking consent from the source person will likely be done by the source person's doctor. Health care professionals are best placed to determine risk of disease transmission.
- The advantages of the consent process still apply, and informed consent is the basis for seeking testing. It is anticipated that a sample would be obtained in most cases, as most people would agree to be tested.
- There may be practical difficulties with identifying and testing the source person if they are not in a hospital or other medical care setting.
- The option to seek a court order provides an avenue to seek a sample, even where the source person has initially refused on a consent basis, following a risk assessment.
- While it is expected that the step of seeking a court order will be unnecessary in all but a small number of instances, court-ordered testing removes the autonomy of individuals to choose to consent to medical procedures carried out on them, and for their health information to be private (although only restricted disclosure would be permitted).
- Apprehending and detaining a person for the purpose of taking a sample is a serious step. While it is a last resort, this may be seen as a particularly harsh step in the case of a person who committed no offence at the time of the exposure incident.

4.4 Option 4 – Senior police officer ordered testing following offence

This option would only apply where the exposure incident occurred in the context of the source person committing an offence, including an offence in custody in a prison setting. This option allows a senior police officer to make a mandatory disease testing order, following a risk assessment. There are two alternatives within Option 4 for who should conduct the risk assessment:

4(a) The senior police officer;

OR

4(b) A health care professional.

Stakeholders may wish to provide feedback as to whether a senior police officer or health care professional should conduct the risk assessment.

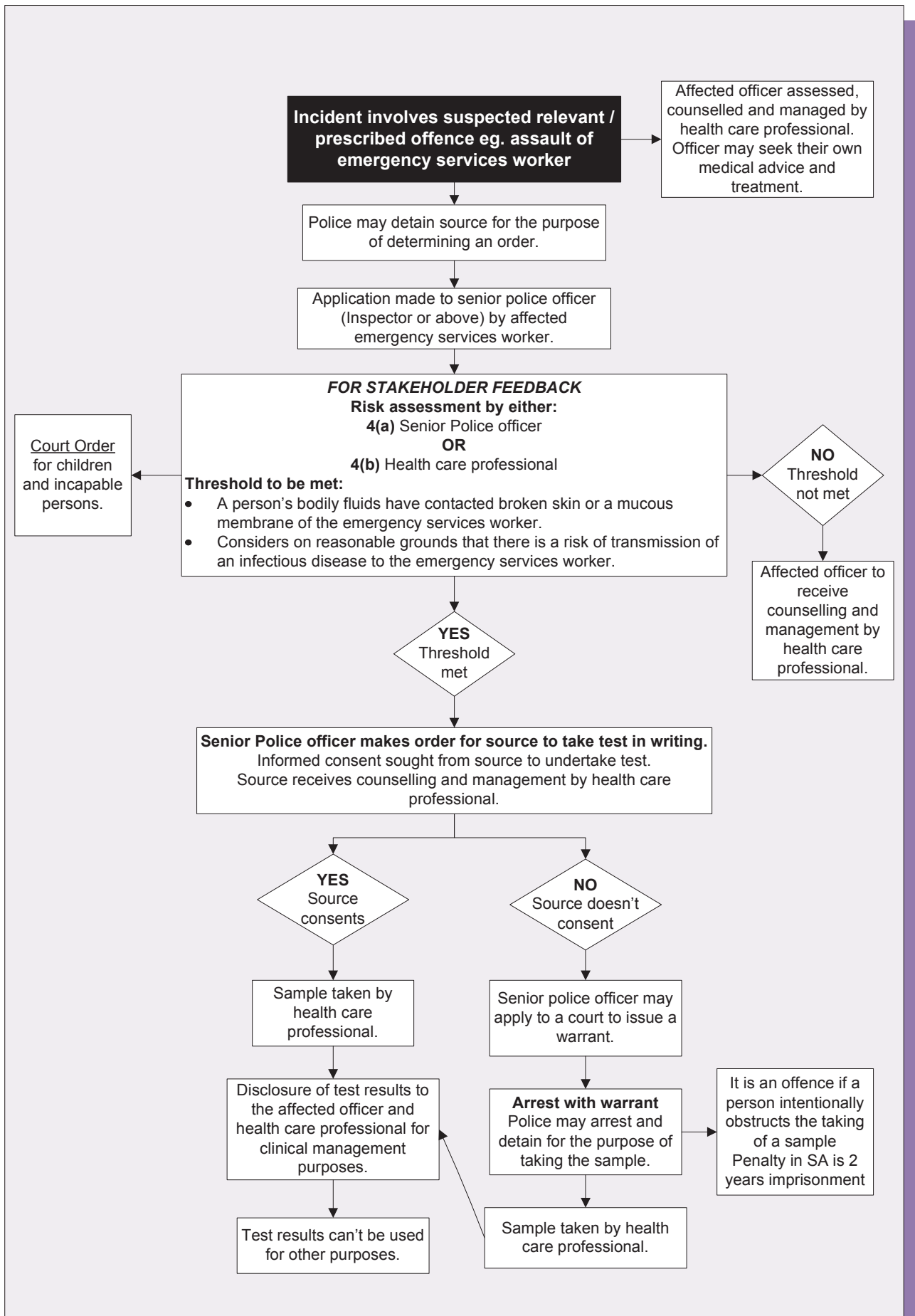
Option 4 – summary	
Is legislation required?	✓
Can testing be sought if the contact was accidental?	✗
Does a health care professional make a risk assessment?	? ¹⁴
Can a senior police officer make an order?	✓ ¹⁵
Does the source person have an option to refuse testing?	✗ ¹⁶
Are there special procedures for vulnerable people?	✓ ¹⁷
Can a person be detained for the purpose of taking the sample?	✓
Are test analysis and disclosure of results restricted?	✓

¹⁴ There are two alternatives presented for who might conduct a risk assessment: a senior police officer; or a health care professional

¹⁵ In connection with an offence/lawful apprehension, and following risk assessment

¹⁶ The source person will be asked to voluntarily undertake a test in accordance with the order

¹⁷ A court order must be sought for children and incapable persons



Option 4 – Senior police officer ordered testing following offence	
Steps	Activity
Incident	<ul style="list-style-type: none"> • An identified person’s bodily fluids come into contact with the broken skin or mucous membrane (e.g. eyes, nose, mouth) of the relevant emergency services worker. • The incident involves a suspected offence or has occurred during the lawful apprehension and detention of a person. For example, the exposure may occur during an assault on the emergency services worker, or while a police officer is arresting a person. • The incident involves an offence in custody or use of force in a prison environment.
Application for test	<p>The affected emergency services worker may apply to a senior police officer (at the rank of Inspector or above) for consideration of an order for the source person to undergo mandatory disease testing.</p> <p>For incidents in a prison environment, consideration may be given to application to the prison governor or a Senior Assistant Superintendent.</p> <p>Police may detain the source person for the purpose of determining an order, including conduct of a risk assessment.</p>

<p>Risk assessment (is test required?)</p>	<ul style="list-style-type: none"> • Two alternatives for risk assessment are put forward for consideration and feedback: <ul style="list-style-type: none"> a) A senior police officer (rank Inspector or above) assesses the risk of transmission; OR b) A health care professional assesses the risk of transmission. • For incidents in a prison environment, consideration may be given to the prison governor or a Senior Assistant Superintendent assessing risk of transmission, rather than a senior police officer. • Risk assessment process will be set out in policy, similar to the current NSW Health policy on Management of Health Care Workers Potentially Exposed to HIV, hepatitis B and hepatitis C. This includes consideration of injury type and bodily fluid type as part of the risk assessment process. • The person conducting the risk assessment must form the view that: <ul style="list-style-type: none"> ○ The source person’s bodily fluids have contacted broken skin or a mucous membrane of the relevant emergency services worker; AND ○ There are reasonable grounds there is a risk of transmission of HIV, hepatitis B or hepatitis C to the emergency services worker.
<p>Test authorisation</p>	<ul style="list-style-type: none"> • If the person conducting the risk assessment determines the risk threshold is not met, testing will not be authorised. • The affected emergency services worker receives counselling and management by health care professional. • If the risk threshold is met and it is determined the incident occurred in connection with a suspected offence or whilst lawfully apprehending and detaining the source person, a disease test order is issued in writing to the source person by the senior police officer. The order will outline why the direction is being given, what action is required of the person, and the consequences if they do not have a sample taken. • An informed consent process should be undertaken with the source person to undertake testing. The source person receives management by a health care professional.

Person complies	<ul style="list-style-type: none"> • The sample is taken by a health care professional. • The sample is analysed for HIV and hepatitis C, and for hepatitis B if the emergency services worker is not immune to hepatitis B. • Test results are disclosed to the health care professional for clinical management purposes, including disclosure of result to the affected emergency services worker. Test results cannot be used for other purposes.
Person does not comply	<ul style="list-style-type: none"> • The Police Force may apply to the court for an arrest warrant. • If granted by the court, police may arrest and detain the source person for the purpose of taking the sample. • It is an offence if the person obstructs or hinders the taking of a sample. • The sample is taken by a health care professional. The sample is analysed for HIV and hepatitis C, and for hepatitis B if the emergency services worker is not immune to hepatitis B. • Test results are disclosed to the health care professional for clinical management purposes, including disclosure of result to the affected emergency services worker. Test results cannot be used for other purposes.

Advantages and disadvantages of this option

- Legislation will be necessary to implement this option.
- The model provides a strong likelihood of obtaining a sample from the source person where a risk assessment has determined that this is warranted.
- An order could be made by a senior police officer without the delay of going to court.
- Police may already have arrested and detained a person, which may simplify the process of authorising and enforcing a mandatory disease test order.
- A risk assessment conducted by a senior police officer (or senior correctional officer) offers practical advantages. However, they do not possess the medical expertise offered by health care professionals.
- Senior police officer testing orders could be seen as police dispensing additional 'punishment' for offenders.
- Even if a senior officer makes an order, a health care professional may refuse to do a test if they do not think it is required, and if the source person physically refuses to be tested, a health care professional will not undertake sample collection.
- There is no appeal process for a test order issued by a senior police officer (unless an appeal mechanism is included as part of the model).
- The arrest and detention of a person for the purpose of taking a sample is a serious step. However, it is a last resort, and it is possible this may be considered appropriate due to the exposure occurring in the context of an offence.
- This option will have practical application mainly to police officers, with limited application for other emergency services personnel unless they are the victim of an offence such as assault.
- Testing ordered by a senior police officer removes the autonomy of individuals to choose to consent to medical procedures carried out on them, and for their health information to be private (although only restricted disclosure would be permitted).

5. Scheme design – key issues

5.1 Who is defined as emergency services personnel?

Emergency services personnel is a broad category and consideration needs to be given to which of these personnel should be covered under any proposed scheme, for example:

- A member of the NSW Police Force
- Correctional officers and other prison-based and correctional staff
- Other law enforcement officers (for example those included in the definition of law enforcement officers under the NSW *Crimes Act 1900*)
- Ambulance officers/paramedics
- Other frontline health care professionals
- A member of Fire & Rescue NSW (FRNSW)
- A member of the NSW Rural Fire Service (RFS)
- A member of the NSW State Emergency Service (SES)
- A member of the NSW Volunteer Rescue Association
- A member of Marine Rescue NSW.

Most of the above are paid employees, although some are volunteers, such as in the RFS and SES.

The potential risk of exposure to bodily fluids is higher for some types of personnel. The types of personnel covered may also impact the operational and practical implementation of the scheme, such as how a test may be sought and authorised.

Any scheme would only apply to emergency services personnel during the course of their duties. It would not apply to off-duty personnel.

Other jurisdictions vary as to what personnel are included in their mandatory testing schemes. Further information is at **Appendix A**.

5.2 Should both 'deliberate' and 'accidental' incidents be covered?

There are a number of circumstances where emergency services personnel may come into contact with another person's bodily fluids in the course of their duties, both accidental and deliberate.

On face value, it should not matter how the exposure occurred, only that it has occurred and there is a resulting health concern.

However, whether exposure arose from a deliberate or accidental act is an important consideration in whether or not to mandate testing for certain people because:

- It is very likely that in accidental exposures, with appropriate counselling, the source person will consent to being tested.
- There are likely to be different community attitudes and expectations around whether it is appropriate to compel any person to undergo testing. Whether it is appropriate to compel a person to undergo testing when they have committed an offence, such as assaulting a police officer, is very different to a victim or a person who has not committed any offence, such as a person injured in a car crash.
- Offenders or those who are suspected of criminal activity are highly unlikely to consent to testing. They are likely to be required to be compelled to provide a sample through an order process (non-consent based), supported by some means of enforcing that order.

Schemes in the majority of other jurisdictions (Western Australia, South Australia and Queensland) have the requirement for an offence to be suspected or committed before a test can be authorised. Exposure to bodily fluids in accidental situations does not trigger mandatory disease testing. Victoria is the only jurisdiction with a scheme that does not rely on commission of a relevant offence.

5.3 *How is risk assessed to determine if the source person should be tested?*

5.3.1 Not all contact with bodily fluid should trigger testing – only where there is a risk of disease transmission

The Parliamentary Committee was of the view that the power to conduct mandatory disease testing should only be triggered in circumstances where there is a risk of transmission of listed diseases. The Committee found that any legislation should clearly define the factual circumstances in which there is a risk of transmission of listed disease, based on up to date medical evidence.

Testing a source person should not be permissible following an incident that is assessed as carrying no risk of infection. This was a key issue of concern in submissions to the Committee.

As noted earlier, not all contact with bodily fluid has the potential to transmit HIV, hepatitis B and hepatitis C. Bodily fluids on unbroken skin for example will not result in transmission of these diseases.

In Queensland and Western Australia, mandatory disease testing is only permitted where bodily fluid may have been transmitted or has been transferred via broken skin or a mucous membrane. For example, a person's saliva on unbroken skin is not permitted to authorise a test in those jurisdictions.

It is proposed this same minimum threshold also apply in NSW. That is, mandatory disease testing would not be permissible where bodily fluid has contacted unbroken skin, or that has not contacted a mucous membrane such as a worker's eyes or mouth.

What do we mean by 'bodily fluids'? Hepatitis B, hepatitis C and HIV are spread by blood and other bodily fluids containing blood. The focus on these diseases and how they are transmitted is at section 2.2.

5.3.2 A matrix of bodily fluid type and incident type could be used for risk assessment

Section 2.3 details factors for consideration in any risk assessment, where different risks apply depending on the bodily fluid type and injury/incident type.

A risk matrix detailing exposure type, such as that outlined in the ASHM fact sheet (see section 2.3), could be utilised by officials tasked with making risk assessments to guide them about when risk may exist and when testing may be appropriate.

This would be similar to the process in South Australia, where a risk matrix developed by health professionals is referred to by police in determining whether there is a risk of transmission of disease in a particular circumstance, and therefore whether a test is warranted.

5.3.3 Who should make risk assessments?

Health care professionals are qualified to make assessments of medical risk of disease transmission. This is the approach taken in Victoria, where an authorised medical practitioner makes the risk assessment of disease transmission.

An alternative approach in other jurisdictions is to allow a police officer or court to authorise a test. In those jurisdictions, legislation and policy is designed to assist non-medical professionals by focusing on the factual circumstances of the exposure, including defining bodily fluid, defining relevant diseases, stipulating contact with broken skin or a mucous membrane, and providing guidelines for risk assessment based on medical advice.

5.4 Who may authorise testing?

5.4.1 Should a consent procedure apply?

In an ideal world, simply requesting a person to consent to testing would be all that would be needed to obtain a sample.

This already occurs on a policy basis for NSW Health staff. A similar consent-seeking capacity could be extended as a matter of policy to other emergency services personnel.

Particularly where the contact with bodily fluids was unintended, it is envisaged that a reasonable person would provide consent to being tested and for these results to be communicated back to the emergency services worker concerned.

However, at times the kinds of incidents emergency services personnel – particularly police – attend are not amicable, and in such cases, whilst the person should be afforded the opportunity to consent, it is likely that a person would refuse to be tested.

The concept of ‘a mandatory’ testing scheme implies that people should not be able to ‘opt out’ of testing.

For these reasons, a mechanism that directs or orders people to undergo testing may be required.

There are a range of approaches taken in other jurisdictions, including orders by a senior officer, court orders, and orders made by a medical practitioner.

It is not appropriate that the affected emergency services worker should themselves have the power to request or order a test be undertaken.

5.4.2 Should a senior police officer have the power to order a test?

Because most of the incidents where a person may refuse consent to testing are likely to occur in the context of criminal or anti-social behaviour, a possibility is that a senior police officer could authorise a mandatory test where an offence has been committed or suspected of being committed.

The senior officer making the order must not be the worker who came into contact with bodily fluids.

In Western Australia and South Australia, where an offence-based scheme applies, a senior police officer of the rank of Inspector or above may make a mandatory disease testing order.

In NSW, senior police officers (of or above Sergeant or Inspector rank) are empowered to make certain orders including public safety orders; forensic procedures on suspects and certain offenders; and provisional/interim apprehended violence orders.

For incidents occurring in a correctional environment, consideration may be given to:

- Utilising or accessing existing health information about an inmate, which may obviate the need for further testing.
- The possibility of a power to make orders for testing being given to the governor of the prison or a Senior Assistant Superintendent within Corrective Services.

The ability of a senior police officer to make an order would minimise the time between the incident and test authorisation, consistent with the intent of a mandatory disease testing scheme to provide peace of mind to affected emergency services personnel. Any such powers granted to police can be confined by legislative drafting and provide for any checks and balances that the community may expect.

All patients who undergo medical procedures are entitled to be informed and to ask questions prior to the procedure. Counselling by a health care professional ensures proper assessment and management of a person with a blood borne virus, to ensure their health is maintained, and they understand how to prevent infecting other people.

Hence it may be more efficient for the risk assessment and test authorisation to be the role of a health care professional. It is also necessary for a health care professional to be involved when the blood sample is collected.

Even if a police officer makes an order, a health care professional could refuse to do a test if they do not think it is required, or if a source person physically refuses to be tested.

5.4.3 Should a court have the power to order a test?

In Queensland, a senior police officer may apply to a court to order mandatory disease testing. Court orders are also a feature of the Western Australian scheme if the person to be tested is a child or incapable person. Court orders are of course also utilised in NSW for a range of matters.

Court ordered mandatory disease testing would provide an independent assessment and judgement as to whether a testing order is warranted having regard to all the circumstances and medical advice, and provides additional oversight and safeguards to the making of orders. For example, appeal processes would likely be a feature of a court-ordered scheme.

However, the court process is not immediate, and this option increases the time between the incident occurring and the test authorisation. Delays in testing frustrate the goal of mandatory disease testing to provide the affected worker with welfare advice and peace of mind as soon as possible.

Due to these factors, if a court order is considered as an option, then the process would require a court to consider an application within a short timeframe.

5.4.4 Should a health care professional have the power to order a test?

Health care professionals are best placed to make an assessment about risk of transmission of disease. Health care professionals would already be involved in the aftermath of bodily fluid exposure, by providing medical assistance for physical injuries or providing counselling following bodily fluid exposure. Any sample collection and testing would also be conducted by a health care professional.

An order for testing by a health care professional has the potential to be better received by the source person compared to the other options. This could increase the likelihood that the source person would provide consent to testing.

In Victoria, the Chief Medical Officer (or delegate who is an authorised senior medical officer) may make test orders. In NSW, authorised health care professionals may make public health orders in certain circumstances where there is a risk to public health.

There may be some practical difficulties with this approach, mainly around how health care professionals would identify persons to be tested after an incident if the source person is not in a health setting, and what would happen where the source person does not comply with a test order.

5.4.5 Could a combination of these approaches be used, depending on the circumstances?

A combination of the above approaches may be desirable, to cater for a range of divergent circumstances.

For example, a combined option that provides a consent process, but also has capacity to seek a court order if a person refuses consent; or a combined option that allows senior police officer orders, but not in the case of children and incapable persons, where a court order would be needed. A combination of approaches may also be appropriate for 'escalating' enforcement of an order if the source person does not comply with a test order.

5.5 How could people be required to comply with a test order?

5.5.1 Does a 'mandatory' disease testing scheme mean a sample is always obtained?

A *mandatory* disease testing scheme suggests there should be some mechanism to promote compliance, and that the law mandates compliance. The aim of the scheme is that a sample is taken and analysed to assist the welfare of the emergency services worker.

However, an important question is whether it is acceptable that – whilst incentives and penalties may be applied – it is possible at the end of the day that a sample may not be obtained.

Potential ways a scheme could be designed to ensure compliance with testing are discussed below.

5.5.2 Should there be an offence for non-compliance?

One way to encourage compliance is to impose an offence for not complying with a testing order, or for hindering or obstructing a sample being taken.

It should be noted that an offence and penalty for non-compliance, while encouraging compliance, does not guarantee a test will be conducted. A person may simply refuse to comply with a testing order and suffer the penalty.

Consideration would need to be given to an appropriate maximum penalty, at a sufficient level as to encourage compliance, and whether this would only be a fine, or also potential imprisonment. A further consideration would be community perception of such an offence/penalty relative to other offences. Comparison to other NSW offence and penalty levels would need to be undertaken.

In Western Australia for example, the maximum penalty for failure to comply with a disease test order is a fine of up to \$12,000 and/or imprisonment for up to 12 months.

5.5.3 Can a person be arrested or detained for the purpose of testing?

If the aim of a mandatory disease testing scheme is an outcome where a sample is taken, arrest and detention of a person who does not comply with a test order could be necessary, for the purpose of taking a sample.

However, arrest and detention would need to be very carefully considered as it is a serious infringement of an individual's rights and should always be a last resort.

An exception to this would be where the source person is a prisoner, who is already detained.

Arrest and detention of a person for the purpose of taking a sample is possible in other jurisdictions. In Western Australia, following the making of an order, police may apprehend and detain a person without warrant for the purpose of taking a sample. In South Australia, if a person does not comply with a testing order, police may apply to a court for a warrant for the person's arrest for the purposes of testing. It should be remembered that in those jurisdictions, an order can only be made where the person has committed a relevant offence.

Consideration may also be given to whether a person may be detained for the purpose of determining/making a testing order, such as occurs in Western Australia.

5.5.4 Can reasonable force be used to ensure a sample is taken?

It is possible that a person subject of a mandatory disease testing order may resist testing. An issue to consider is whether reasonable force should be able to be used to ensure the person is tested. Like arrest and detention, use of force is a very serious measure that should always be a last resort, and its possibility would need to be carefully considered.

Use of reasonable force to enable a sample to be taken is possible in all other jurisdictions, but may not be utilised in practice. It is likely a health care professional would refuse to take a sample in a situation where the source person does not consent and reasonable force is to be used.

Given the inability of any test to provide definitive evidence of risk, and the importance of the other aspects of risk assessment including counselling, forcibly taking a sample may not be justifiable.

5.6 What safeguards should be included in any scheme?

5.6.1 Restrict testing orders via risk assessment

See discussion under section 5.3.

5.6.2 Consider special arrangements for children and other vulnerable people

A different procedure may be appropriate in the case of children and other incapable persons, such as those with an intellectual disability, in recognition of their lack of legal capacity and need for additional assistance and safeguards.

In Western Australia and Queensland for example, alternative procedures apply in the case of children or incapable persons. In NSW, too, legislation often provides alternative procedures or additional safeguards, such as witnesses and support people, for children and vulnerable persons.

5.6.3 Consider appeal processes

Depending on the testing model, consideration should be given to whether an order made by a court or police officer may be appealable. Appeal provisions would most likely apply where a court has determined an application for an order.

Some other jurisdictions include an appeal mechanism, including Queensland and Western Australia, while other jurisdictions provide no avenues of appeal.

Any appeal mechanism should be time limited such as to a period of 48 hours, so that the process is not drawn out, impacting the anxiety of the emergency services worker (although noting that the window period does not allow definitive results).

5.6.4 Limit analysis of samples only to HIV, hepatitis B and hepatitis C

Legislation should limit samples collected to analysis only for HIV, hepatitis B and hepatitis C.

5.6.5 Restrict disclosure of test results

Test results following analysis should only be disclosed to the extent necessary to facilitate the rapid diagnosis and clinical management of the person/s affected.

Test results should only be disclosed to:

- the relevant health care professional/s
- the source person (via their health care professional)
- the relevant emergency services worker (via their health care professional).

The relevant emergency services worker should be prohibited from disclosing, communicating, or making a record of anything in relation to the results that might identify the source person.

Test results should be prohibited from being recorded in any police database or records, or anywhere else outside a health care setting.

Disclosure of test results should be strictly prescribed by legislation and significant penalties should apply for unauthorised disclosure of results. Jurisdictions with mandatory disease testing all incorporate this safeguard.

5.6.6 Restrict admissibility of test results

Test results should be inadmissible as evidence for other purposes or legal proceedings. This should be prescribed by legislation. Jurisdictions with mandatory disease testing all incorporate this safeguard.

5.6.7 Safeguards for health care professionals required to take samples

There is an ethical dilemma for health care professionals who may carry out testing at the direction of another authority such as a court or senior police officer.

The health care professional needs to ensure that informed consent is provided for the test, and has a duty of care to ensure test results are communicated to that person, and that appropriate management is provided to that person.

Accordingly, there may need to be some legal protection for health care professionals so that no civil or criminal liability attaches to their carrying out any function under a mandatory disease testing scheme.

5.6.8 Provide for destruction of the sample

The sample should be destroyed following analysis.

5.7 Sample collection and analysis

There are some further practical considerations as to how a scheme might work in NSW.

Some of these could be dealt with by legislation while others may be a matter of policy and agreements. Most jurisdictions do not prescribe a detailed sampling or analysis procedure in their legislation.

- **What sample/s can be taken** – a blood sample would be required to be taken.
- **Who can take a sample** – a health care professional, pathologist or other qualified person would take a sample.
- **Where does the sample get collected** – further consideration would be required, for example whether the source person is directed to a hospital or other prescribed place. A prescribed place may, for example, be within a correctional facility, so inmates do not have to leave for testing.
- **Where is the sample analysed** – further consideration would be required, including who pays for sample collection and analysis.

6. Do benefits of mandatory disease testing outweigh impacts?

6.1 *Efficacy of testing in supporting the welfare of workers*

The Parliamentary Committee heard a clear message from the Police Association that mandatory disease testing would be of benefit to the welfare of police officers, providing greater certainty and peace of mind about the possibility of infection.

However, the medical utility of testing the source of bodily fluids has been questioned by health care professionals, because medical evidence shows results are not conclusive, could be misleading, and may not alter the course of clinical management.

Additionally, even where the source person tests positive, there are varying degrees of risk that the disease will transmit to the emergency services worker. A further consideration is that a positive test result from a source person could have an opposite effect than intended by adding to a worker's stress, rather than ameliorating it.

While testing would not be conclusive, it may still be of comfort to a worker during the window period, and may assist in reducing the level of anxiety for the affected worker and their family. A testing mechanism would also assist in providing as much information as possible to the worker and their health care professional to guide their medical management and counselling.

However, experience in health care settings shows that prompt expert assessment and counselling can be effective in managing the concerns of exposed workers, without necessarily requiring testing.

Additional steps that could be taken by emergency service agencies, to review policy and procedures and provide more early intervention counselling to support a worker, are worth considering regardless of whether mandatory testing is implemented. Enhancements to policy and process to ensure emergency services personnel have access to best practice care following an exposure may include:

- prompt assessment, counselling and management by a health care professional after exposure to bodily fluids.
- policies that would allow the source person to be counselled and the opportunity to consent to testing (for exposures that are not deliberately perpetrated, experience in NSW Health indicates the majority of patients consent to testing for blood borne viruses following appropriate counselling).

6.2 *Impact on source person required to be tested*

The efficacy of testing and the benefits to emergency services personnel exposed to bodily fluids need to be carefully weighed against the imposition on the right of others within the community to best practice health care, bodily autonomy, privacy of their health information and consenting to medical procedures on them.

Blood sample collection is common, routine and minimally invasive, but is nonetheless a medical procedure. Disclosure of medical results to others, while being restricted under any scheme, would still be of concern to some individuals from a privacy and health information perspective.

Community health professionals and stakeholders have also expressed concern that mandatory disease testing could increase the stigma and discrimination experienced by those living with a blood

borne virus, and risks damaging significant social and medical progress in preventing and treating these diseases within the community.

The extent of the state's ability to impose on these rights depend on the design of the scheme and what powers may be given to the state to compel persons to have samples taken.

Some key ethical and social questions that have emerged in considering a mandatory disease testing scheme are whether it is:

- acceptable that any person could be penalised for failing or refusing to undergo disease testing;
- acceptable that any person could be compelled to undergo disease testing if they refuse to provide consent, or against their will;
- acceptable for an individual to possibly create further distress to a victim by refusing to undergo disease testing within certain parameters.

In considering these questions further issues arise including:

- whether a different, more enforceable testing regime should apply to persons who have committed an offence, such as assaulting an emergency services worker.
- whether it is acceptable that persons who have committed no offence (and who may be victims themselves) should be compelled to undergo testing, or should be penalised if they do not.

6.3 Economic and financial impacts

There are costs incurred by emergency service agencies in managing the health and wellbeing of emergency services personnel who have been impacted by an exposure incident, such as:

- emergency services personnel taking extended sick leave;
- emergency services personnel lodging a claim for physical and/or psychological injury (e.g. a police officer could potentially receive 7 years of income protection payments on top of workers compensation payments under current insurance arrangements);
- emergency service agency costs in managing workers' physical and/or psychological injury claims and return to work program; and
- loss of productivity for emergency service agencies.

There will be cost impacts of the suggested reforms in this paper, including:

- enhancing work health and safety mechanisms to ensure skilled and prompt support for exposed workers, which may require an investment in personnel, training and support materials.
- administering a mandatory disease testing scheme, including the cost of:
 - health care professionals and officials making risk assessments;
 - health care professionals, officials, or courts authorising testing;

- ensuring the source person complies with testing, such as applying to court for a warrant or for police officers to detain the source person for the purpose of testing;
- health care professionals taking samples;
- laboratory analysis of samples; and
- health care professionals receiving and disclosing test results.

Costs associated with implementing suggested reforms may be offset against reduced costs associated with exposure incidents. For example, more effective management and counselling may reduce injury claims and workers compensation costs. The extent to which this could occur would require further consideration.

Appendix

A. Jurisdictional Analysis - mandatory disease testing schemes

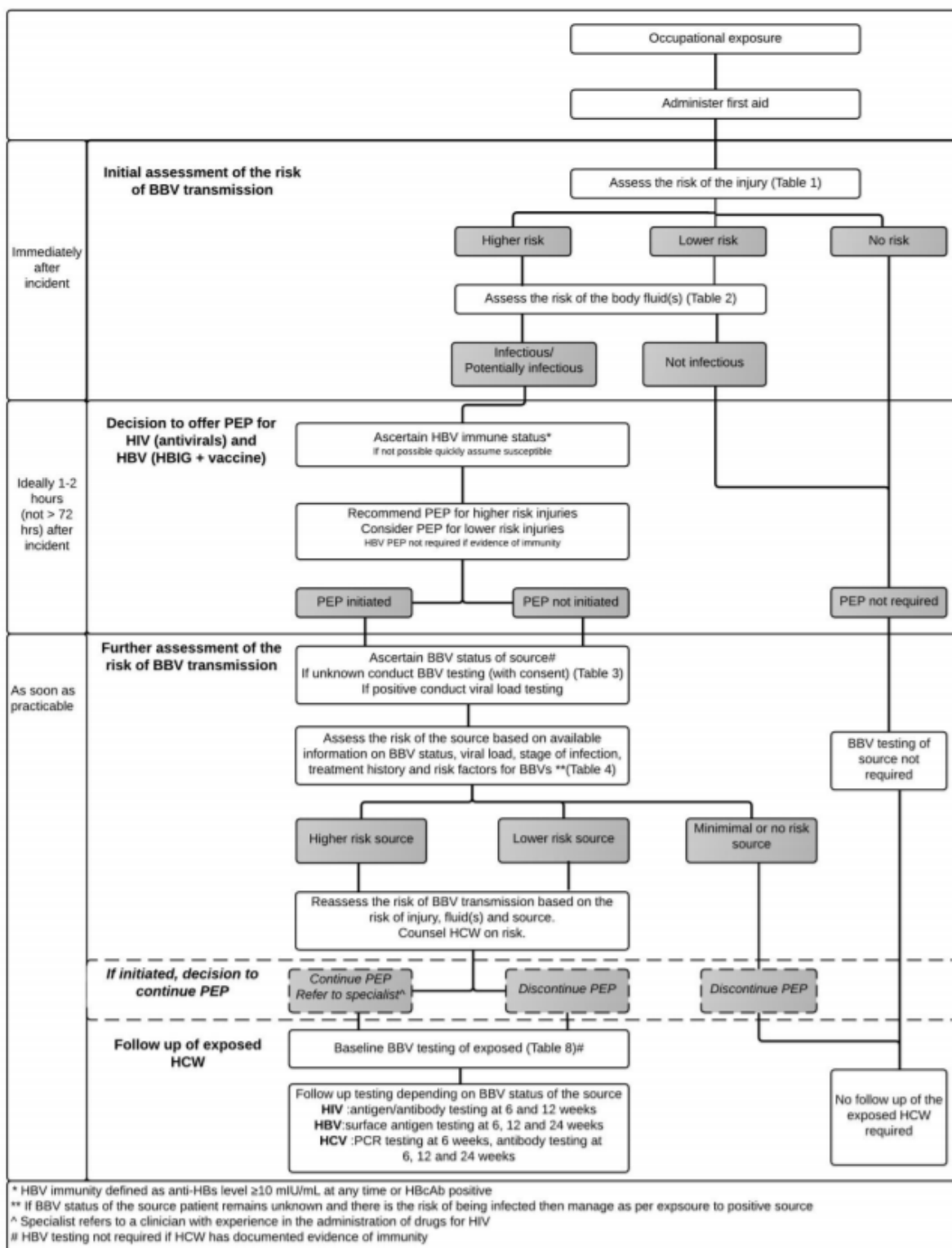
B. Flowchart – NSW Health care workers

C. Proposed disease testing options – on a page

D. Case studies – Blood and Body Fluid Phonenumber

Jurisdiction	What is the threshold for making an order?	Who is covered by the order?	Who makes the order and how is it made?	Compulsion to comply with order / undergo testing	Safeguards	Sampling and analysis procedure
<p>Victoria Part 8, Division 5, <i>Public Health and Wellbeing Act 2008</i></p>	<p>The Chief Health Officer may make an order if they believe that:</p> <ul style="list-style-type: none"> An incident has occurred involving a caregiver or custodian and a person infected with a specified infectious disease (HIV, hepatitis B, C or other relevant forms of hepatitis) could have transmitted that disease to any of the other persons involved, and The person to whom the disease could have been transmitted has been counselled about the risk of being infected by this disease and consented to be tested, and The person who could have transmitted the disease has been offered counselling and has refused to be tested, and The making of the order is necessary in the interest of rapid diagnosis and clinical management and, where appropriate, treatment for anyone involved in the incident. 	<p>Police officers, paramedics, medical practitioners, caregivers</p>	<p>The Chief Health Officer makes an order for post-incident testing. This power may be delegated to a senior medical officer (s 137).</p> <p>Formal requirements are set out in s 34(2) and a form is included in the Guidelines for post-incident testing orders and authorisations.</p> <p>The order must be in writing and only takes effect once it has been served on the person named in the order.</p> <p>The Chief medical officer may examine any relevant health information held by the Department about a person who they consider may be the subject of a post-incident test.</p>	<p>The Chief Health Officer may seek an order from the Magistrate's Court to authorise a police officer to use reasonable force to:</p> <ul style="list-style-type: none"> take the person to a specified place, and/or restrain the person to enable a registered medical practitioner to take a sample of blood or urine. <p>The Magistrate's Court will only make an order in exceptional circumstances and may make the order subject to conditions.</p>	<p>Results of the testing are inadmissible.</p> <p>Under s134(11), if alternative measures are available which are equally effective in ensuring the rapid diagnosis and clinical management for any person affected, the measure which is the least restrictive of the rights of the person should be chosen.</p> <p>The person who makes the testing order must ensure the relevant person is counselled after the test has been conducted.</p> <p>No avenues for appeal are provided for in the Act.</p> <p>Persons who lack capacity to consent may be subject to an order for testing.</p> <p>The results of the test must only be disclosed to the extent necessary to facilitate the rapid diagnosis and clinical management/ treatment of the person affected (s 136).</p> <p>Information that could identify the person tested must not be disclosed when the results of the test are communicated to the person at risk of infection.</p> <p>Failure to comply is an offence with a fine of \$9,514.20.</p>	<p>Sampling of blood and or urine must be conducted by a pathologist or medical practitioner.</p> <p>The analysis procedure is not specified in the Act.</p>
<p>Western Australia <i>Mandatory Testing (Infectious Diseases) Act 2014</i></p>	<p>A public officer may apply to a senior police officer for a disease test approval under s 8(1) if:</p> <ul style="list-style-type: none"> there are reasonable grounds for disease testing, which means that there are reasonable grounds for suspecting a transfer of bodily fluid from a suspected transferor to a public officer as a result of: <ul style="list-style-type: none"> a) an assault by them against the officer b) their lawful apprehension or detention c) any other prescribed circumstance and the suspected transferor is not a protected person, and the senior police officer is not involved in the investigation of the suspected transferor. 	<p>Police officers, police-related officers or police service employees</p>	<p>A public officer may apply to a senior police officer.</p> <p>Formal requirements are set out in s 8(3). The application need not be in writing.</p> <p>A disease test approval must be in approved form (s 10). The disease test approval must be served on the suspected transferor (s 11).</p>	<p>A police officer may detain a suspected transferor for as long as is reasonably necessary to enable the determination of the application (s 9).</p> <p>A police officer may apprehend the suspected transferor and detain them for as long as is reasonably necessary to enable the taking of a sample of their blood, including entering a premises and taking the suspected transferor to a suitable facility (s 10).</p> <p>Failure to comply with a disease test approval or disease test order carries a \$12,000 fine and imprisonment for 12 months.</p>	<p>A disease test order must be sought from a court if it concerns a child or someone who lacks legal capacity.</p> <p>The Court may make a disease test order, which must be in approved form. The court may make the order subject to conditions and explain the order to the person to be tested or their representative and serve them with a copy of the order.</p> <p>A person may appeal a disease test order to the District Court.</p> <p>Test results are inadmissible. Samples are prohibited for use for other purposes (\$9,000 fine and 9 months imprisonment).</p> <p>Disclosure of the results of the analysis is strictly prescribed under s 29. A breach of this section carries a \$9,000 fine and imprisonment for 9 months.</p>	<p>The process for taking a blood sample is outlined in s 26. A doctor, nurse or qualified person takes a blood sample.</p> <p>A sample is analysed at a pathology laboratory with appropriate facilities for testing it for infectious diseases.</p> <p>An officer of a pathology laboratory may destroy the blood sample.</p> <p>The suspected transferor is not allowed to pay for the taking of the blood sample.</p>

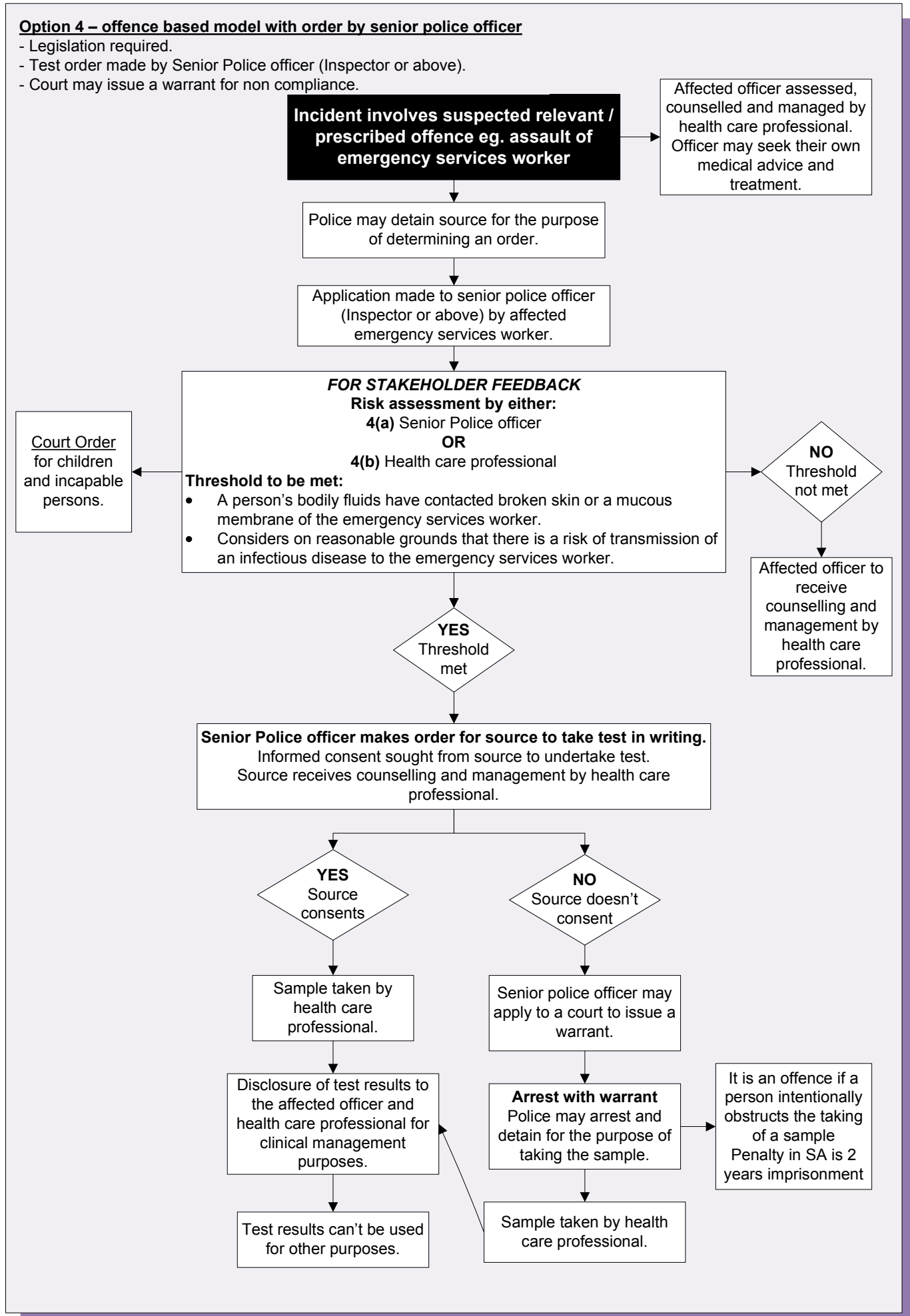
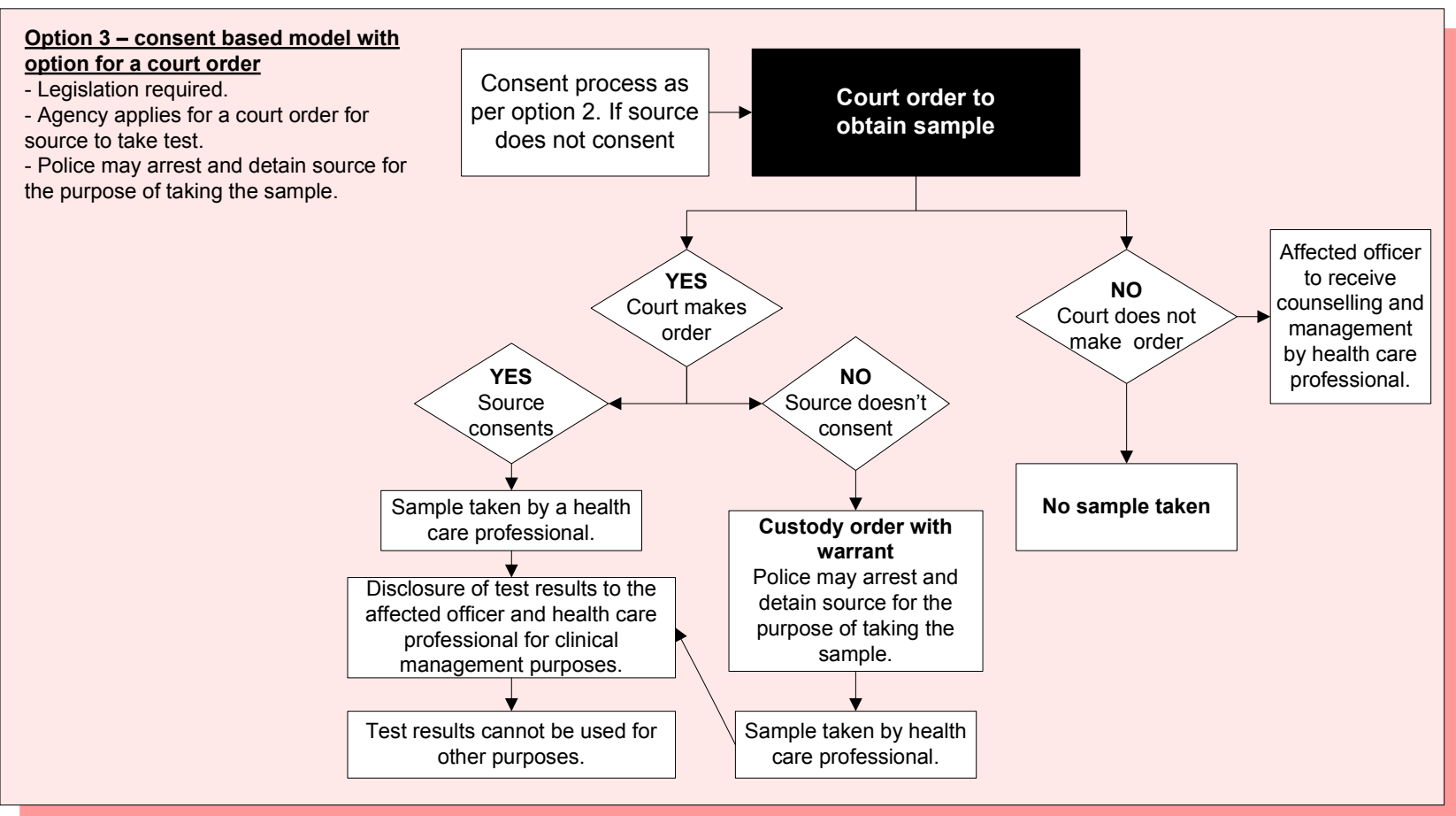
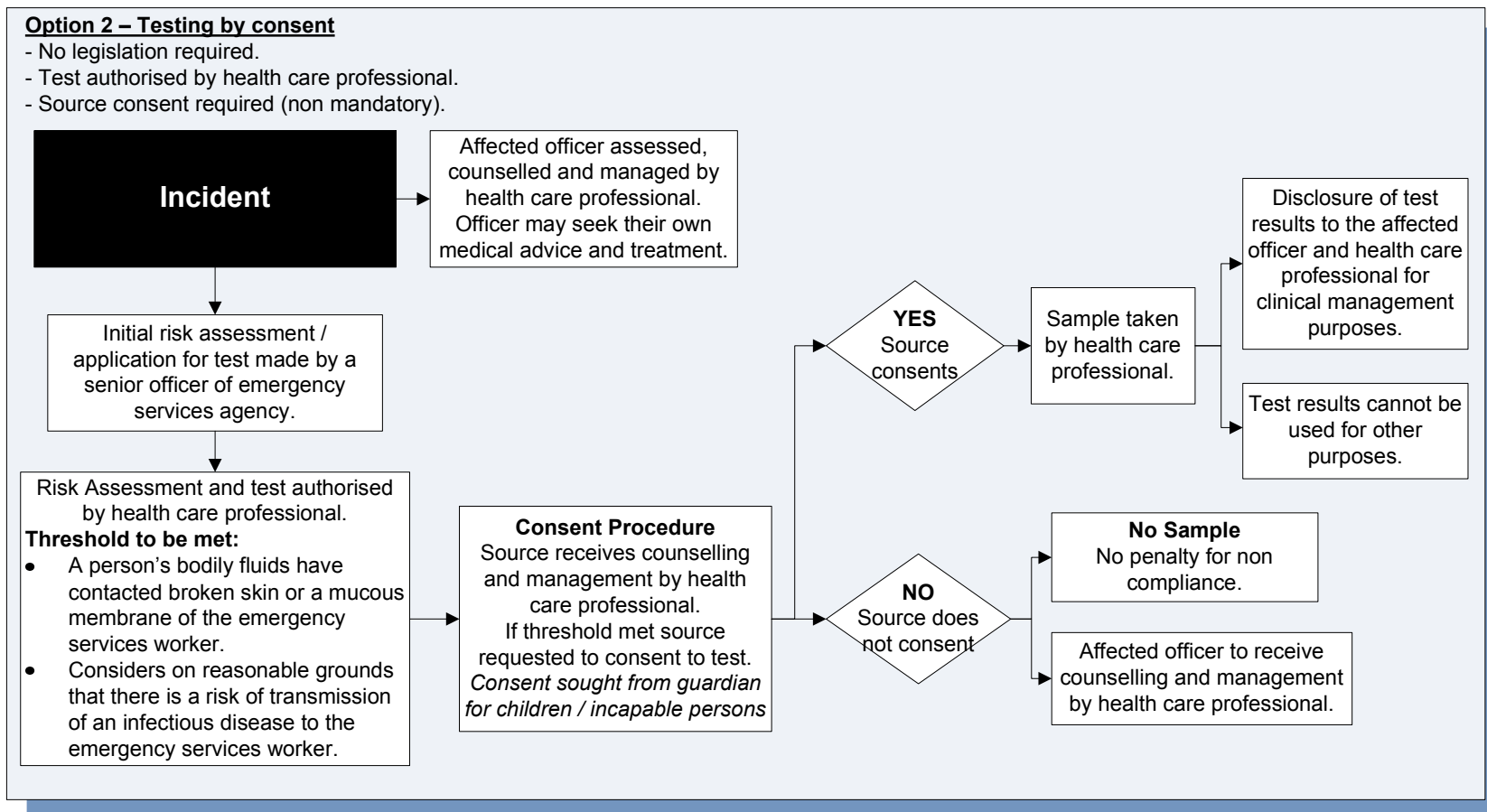
Jurisdiction	What is the threshold for making an order?	Who is covered by the order?	Who makes the order and how is it made?	Compulsion to comply with order / undergo testing	Safeguards	Sampling and analysis procedure
<p>Queensland Chapter 18, <i>Police Powers and Responsibilities Act 2000</i></p>	<p>The purpose of Chapter 18 is to ensure victims of particular sexual offences and serious assaults receive appropriate treatment by authorising the taking of blood and urine samples from a person a police officer reasonably suspects has committed the relevant offence, and the analysis of those samples.</p>	<p>Victims of particular sexual offences and serious assaults. A serious assault occurs if bodily fluid has penetrated, or may have penetrated, the victim's skin.</p>	<p>A police officer may apply for a blood and urine test to a magistrate or the Children's Court for a disease test order (s 540). The application must be in writing and include the grounds on which it is made. The disease test order, if made, must be in writing and include the matters in s 543.</p>	<p>Reasonable force may be used by the doctor or nurse to take the sample.</p>	<p>Notice must be given if a police officer applies for a disease test order for a child. A person may appeal a disease test order to the District Court. Disclosure restrictions are set out in s 547. Breach of this section carries a \$5,046 fine and 6 months imprisonment.</p>	<p>A police officer may ask a doctor or prescribed nurse to take blood and urine samples from the relevant person. A sample must be sent to a health agency with appropriate facilities for testing the sample for relevant diseases.</p>
<p>South Australia Part 2, Division 4, <i>Criminal Law (Forensic Procedures) Act 2007</i></p>	<p>A sample of blood may be taken from someone if a senior police officer is satisfied that the person is suspected of committing a prescribed serious offence (including assault) against a person in prescribed employment in the course of their duties and it is likely that they were exposed to biological material of the person as a result.</p>	<p>Police officers, nurses, doctors, paramedics, emergency services workers.</p>	<p>A written record must be made when a senior police officer requires a person to provide a blood sample.</p>	<p>A police officer may issue directions about the time, place and custody of the person from whom the sample is to be taken. If they fail to comply with these directions, a police officer may apply to the Magistrate's Court to issue a warrant for the person's arrest to be brought to a police station for the carrying out of the procedure. Reasonable force may be used to take the sample. A person who intentionally obstructs the taking of a sample is liable for imprisonment for 2 years.</p>	<p>There are a range of safeguards that apply generally to the taking of forensic samples, including having a witness present. The Commissioner of Police must ensure that part of the blood sample is provided to the person for the purposes of independent analysis. Detailed disclosure restrictions apply generally to the taking of forensic samples.</p>	<p>The sample must be taken humanely, by a doctor or person qualified to take a blood sample. The sample must only be analysed for communicable diseases.</p>



Proposed Disease Testing Models

Incident Threshold: A person's bodily fluids have contacted broken skin or a mucous membrane of the relevant emergency services officer. Sample testing will be for prescribed diseases of HIV, Hep B and Hep C

Option 1 - Review Agency Policy and Practices
 Improvements to agency policy and practice to ensure that emergency personnel are promptly assessed, counselled and managed by a trained health care worker with access to specialist advice immediately following an exposure to potentially infectious body fluids.



Blood and Body Fluid Line Case Studies**Case Study 1:**

Sam, a police officer, is bitten on the hand while arresting a suspect on a domestic violence call-out. The suspect is known to be an injecting drug user.

Sam calls the Blood and Body Fluid Line because she is concerned that she may have been exposed to HIV or hepatitis C as a result of this incident.

The nurse then asks how large and deep Sam's wound is. If wound is large and/or deep, Sam is referred to the emergency department of the nearest hospital for management of the wound. However, Sam reports that her wound is superficial.

The nurse advises Sam that her injury is very low risk for transmission of HIV, hepatitis B and hepatitis C. The nurse also advises Sam that human bites are high risk for bacterial infection and recommends visiting her GP or staff health service if the wound becomes infected.

The nurse asks Sam if she has been vaccinated for hepatitis B and if she has good surface antibodies. Sam reports that she has been vaccinated for hepatitis B, but has no idea if her surface antibodies are good. The nurse says that Sam's GP or her staff health service will be able to check her hepatitis B surface antibodies through a blood test.

Sam asks if she should get tested for HIV and hepatitis B and C. The nurse advises Sam that the blood and body fluid line would not recommend blood borne virus testing for low risk injuries like hers.

Sam thanks the nurse for the information and reassuring her that her injury is very low risk.

Case Study 2:

Dave suffers a needle stick injury to his finger while responding to a drug overdose. He suffers the injury while removing a needle from the overdose victim's arm, and the needle was visibly bloodstained. This had occurred two hours ago, and the wound had been washed with saline and a dressing applied.

Dave calls the Blood and Body Fluid Line because he is very worried that he may have been exposed to HIV or hepatitis C as a result of this incident.

The nurse then asks if Dave has been vaccinated for hepatitis B and if he has good surface antibodies, and Dave reports that he is vaccinated and his surface antibodies are good. Dave then asks about how much of a risk his injury may have exposed him to.

The nurse informs Dave that his injury poses no risk of hepatitis B transmission as he is immune to it, but the injury is moderate risk for HIV and higher risk for hepatitis C. The nurse recommends that Dave begin post-exposure prophylaxis (PEP) as soon as possible, advising him that to be effective PEP needs to be started within 72 hours of exposure to HIV. The nurse advises Dave that he can access PEP free of charge from a hospital emergency or sexual health clinic, and that that PEP is a 4 week course of tablets that need to be taken daily. The nurse also advises Dave that if PEP is started

within 72 of exposure to HIV and taken as directed, it is over 99% effective in preventing the transmission of HIV.

Dave asks if he should be tested and what for. The nurse recommends the following tests:

- At baseline: HIV serology, hepatitis C antibodies
- 3 months from baseline: – HIV serology, hepatitis C antibodies
- 6 months from baseline: hepatitis C antibodies

The nurse advises Dave to go to staff health at the hospital he is based in for testing. Dave asks if PEP is available for hepatitis C because he is very worried that he may have contracted hepatitis C through his injury. The nurse says that there is no PEP for hepatitis C, but that if he does test positive for hepatitis C that there is now a cure in over 95% of cases. The nurse tells Dave that the new treatments for hepatitis C are one tablet a day for 8 weeks, GPs can provide it, and they have very few side effects. Dave thanks the nurse for their help and says he is going straight to emergency to start PEP. Following the receipt of a PEP starter pack from the emergency department, Dave is seen by an infectious disease specialist who provides Dave with further reassurance about his risk of infection and that he does not need to take any special precautions to protect his family.