SAMPLE MEDICAL EXPERT AFFIDAVIT ON HIV TRANSMISSION

STATE OF _____

COUNTY OF _____

_____ personally came and appeared before me, the undersigned Notary, the within named _____, who is a resident of _____ County, State of _____, and makes this his/her statement and Medical Expert Affidavit upon oath and affirmation of belief and personal knowledge that the following matters, facts and things set forth are true and correct to the best of his/her knowledge.

Affidavit of _____

1. HIV is spread by sexual contact with an infected person, by sharing needles and/or syringes (primarily for drug injection) with someone who is infected, or, less commonly (and now very rarely in countries where blood is screened for HIV antibodies), through transfusions of infected blood or blood clotting factors. Babies born to HIV-infected women may become infected before or during birth or through breast-feeding after birth.

2. The HIV virus is fragile and transmission is extremely difficult and occurs only through limited paths: through sexual intercourse, most typically male to female vaginal intercourse or through anal intercourse; through transmission from a woman with HIV to her fetus; or through intravenous drug use. A relatively small number of health care workers also have been infected in the workplace through significant exposure to the blood of HIV-positive patients, most typically through needlestick injuries.

3. Some people fear that HIV might be transmitted in other ways; however, no scientific evidence to support any of these fears has been found. If HIV were being transmitted through other routes (such as through simple touching, air, water, insects), the pattern of reported AIDS cases would be much different from what has been observed. For example, if mosquitoes could transmit HIV infection, or if parents and children could easily transmit HIV to other family members, many more young children and preadolescents would have been diagnosed with HIV. Instead, the number of young children with HIV has dramatically dropped in recent years as the use of drugs to prevent transmission during pregnancy and childbirth has become routine.

4. All reported cases suggesting new or potentially unknown routes of transmission are thoroughly investigated by state and local health departments with the assistance, guidance, and laboratory support from CDC. *No additional routes of*

transmission have been recorded, despite a national sentinel system designed to detect just such an occurrence.

5. The HIV virus cannot be transmitted through casual contact or day-to-day interactions at home, work, or school. One cannot contract HIV through touching, hugging, kissing, or sharing food, eating utensils, towels, bedding, swimming pools, telephones, or toilet seats.

6. A large number of families in the United States have been affected by the HIV epidemic. Many people living with HIV are raising minor children. Hundreds of thousands of children in the United States have at least one HIV-positive parent, and these families are found in all regions of the country.

7. HIV cannot be transmitted between family members in the normal household setting unless there is contact between an open wound or the mucous membranes of one person and the HIV-infected blood of another. Taking simple precautions in the home can eliminate even this extraordinarily low risk of transmission.

8. A parent with HIV poses no real risk of transmission to children in his or her care. HIV transmission simply is not associated with casual household contact. No one has ever transmitted HIV to a child by changing the child's diaper or clothes, feeding or caring for the child, kissing or hugging the child, or through any of the other typical interaction between a parent and a child.

9. There is no medical or public health need to separate otherwise healthy HIV-positive children from those who are not infected in the home, in schools, or in other activities.

10. Patients often ask their clinicians about the degree of HIV transmission risk associated with specific sexual activities. Numerous studies have examined the risk for HIV transmission associated with various sex acts. These studies indicate that HIV is not easily transmitted, and that even in unprotected anal sex, the per-act risk of transmission is 2% or less.

11. Oral sex has an even lower per-act risk of HIV transmission than penile-vaginal or penile to anal sexual activity. Oral sex is definitely not a primary means of HIV transmission. Engaging in lower-risk behavior such as oral sex reduces or eliminates the risk that HIV transmission will occur.

12. In the United States, the risk of HIV transmission from an HIV-positive woman to a man is much lower than the risk of transmission from an HIV-positive man to a woman. HIV transmission from women to men is not a major cause of the HIV epidemic in the United States.

13. The risk that a person with HIV will transmit the virus to another individual also is affected by numerous biological factors, such as the person's overall health and the amount of HIV virus in each person's system.

14. People with HIV who are taking antiretroviral medication reduce the likelihood of transmitting HIV to another person. The clinical goal of antiretroviral therapy is to reduce the amount of HIV virus in a person's system to levels approaching commercial laboratory undetectability. These undetectable HIV levels achieved by standard antiretroviral therapy further reduces the risk for HIV transmission to near-zero.

DATED this the _____day of _____, 20_____

_____
Signature of Affiant

SWORN to subscribe before me, this _____day of _____, 20____

_____
NOTARY PUBLIC

My Commission Expires:

_____

THE UNIVERSITY OF NORTH CAROLINA
AT
CHAPEL HILL

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September 26, 2017

[redacted]

Re: Review of opinion provided by [redacted]

Dear [redacted],

I have reviewed the opinion provided by [redacted] regarding the risk of future HIV transmission by [redacted] and [redacted] predicted adherence to HIV therapy following prison release.

My assessment of the abovementioned opinion is based on my experience and training as a board-certified infectious diseases physician with a career focus on the clinical management of HIV infection, my experience designing and conducting research to prevent and treat HIV infection, and my many years of experience as an HIV care provider in the community and in the [redacted] state prison system.

In [redacted] opinion, [redacted] offers conclusions based on [redacted] predictions of [redacted] future criminal behavior, substance use, and re-incarceration. [redacted] also provides predictions of [redacted] adherence to HIV therapy and [redacted] infectiousness following prison release. It is the latter portion of this opinion that I am qualified to assess and, therefore, focus my review.

The opinion states:

"Treatment requires high level compliance with the medical treatment plan for both diseases" where "both diseases" refers to HIV and HCV infections.

While greater than 90% adherence to daily medication was once required to achieve, and maintain suppression, of HIV replication in the blood, the opinion does not acknowledge that the available HIV medications are more 'forgiving' of lapses in adherence than older therapies. Studies that have longitudinally followed HIV-infected patients and monitored their adherence to HIV medications and their blood viral load have demonstrated that more modern regimens, that last longer in the body, require less adherence. Adherence levels as low as 75% (and even lower for some HIV therapies) have been found to yield rates of suppression of HIV levels that are not statistically different than those at higher adherence levels.[1, 2] Therefore, the opinion that high level compliance to HIV therapy needs to be qualified to sufficiently reflect the data.

The opinion states:

"… the inmate's unstable and at times elevated HIV viral counts are documented by medical providers…"

The characterization of [redacted] blood plasma HIV viral load levels as being "unstable" is not completely accurate. Below is a table of all HIV viral load determinations included in the reviewed medical records. A result of <20 indicates an undetectable level of virus present (i.e., the level of virus is too low to be counted by the test).

DATE	HIV VIRAL LOAD copies/mL
Nov 19, [redacted]	<20
Nov 5, [redacted]	447
Feb 11, [redacted]	<20
Aug 2, [redacted]	<20
Jan 2, [redacted]	110
Feb 7, [redacted]	668
Jun 1, [redacted]	<20

It is notable that overall [redacted] has maintained an HIV viral load that is considered low. The initial version of the test used to measure HIV levels in the blood had a cut-off of 400 copies/mL. Refinements to the test have led to a reduction in the limits of assay detection to 20 copies/mL. The upper range for these tests is 100,000 copies/ml and even greater. In addition, most of the results have been undetectable, including the most recent. Therefore, [redacted] has been demonstrated to have consistently low levels of HIV in his blood.

This last point is important. As the opinion states, transmission potential is related to HIV viral load level. However, the opinion fails to point out that the low level of virus that is consistently detected in [redacted] blood suggest that [redacted] has a very low risk of transmitting [redacted] virus to others - even if [redacted] engaged in risk behavior. In a landmark study conducted in Uganda, blood levels of HIV levels were measured in more than 15 000 study subjects, ultimately demonstrating that 415 HIV-infected subjects (228 infected men) were in a sexual partnership with an uninfected partner. HIV was not transmitted by infected subjects who had less than 1,500 copies/mL of HIV in their blood.[3] The viral load testing performed on [redacted] in November [redacted] is of particular interest in that notes at this time indicate he had been off of [redacted] HIV medication for 2 months. The low HIV viral load observed may be an indication that even off of HIV medication, [redacted] has a low viral load and therefore markedly reduced risk of transmitting HIV to others – a point that the opinion neglects. Therefore, the opinion that [redacted] HIV viral load is high and presents a high risk of transmission is not supported by the facts or the data.

The opinion also assigns blame to [redacted] for non-adherence to [redacted] HIV regimen, but ignores documentation of adverse effects of [redacted] HIV regimen as the stated cause. The following are statements included in the clinical notes contained in the medical records and document [redacted] complaints of intolerance to the selected HIV treatment regimens:

- Nov 30, [redacted] says [redacted] is not taking [redacted] medication because the "big brown" pill gives [redacted] indigestion. [redacted] never took them regularly [redacted] says. On investigation the "brown" pill is the orange one that is Epsicom. The Reyataz is red and blue capsule and does not bother [redacted] We will change [redacted] regimen which will still include the atazanavir. [Epzicom then entered as allergy on [redacted] allergy list due to nausea]

- March 8, [redacted] …confirmed that Epzicom (abacavir/lamivudine) was stopped due to GI intolerance.

- May 9, [redacted] Patient did admit to non adherence due to GI upset while taking on an upset stomach.

- Aug 22, [redacted] Patient acknowledged that [redacted] continues to have issues with GI intolerance that impair [redacted] medication adherence. Given the lack of resistance shown on archive genotype testing. Both the ID consultant and the author are convinced there is sufficient time to change the patient's ART regimen prior to release.

Adverse effects of medication are a leading cause of suboptimal adherence to any medication. Modification to the regimen, as is now being planned according to most recently reviewed clinical notes, would be an appropriate response.

The opinion states:

"As a result of the pattern of non-adherence, testing for resistance mutation analysis was done on [redacted] and "Resistance Associated Mutations" were observed; the most probable causative factor of HIV resistance is due to non-adherence as this precipitates a higher frequency of mutations in "individuals experiencing antiretroviral therapy failure."

The opinion does not make clear that the resistance testing dated March and April of [redacted] was performed using a new and novel technique to detect evidence of resistance in a patient's DNA. As stated in the results reports, this assay is validated for use on samples with at least 500 copies/mL of HIV. It is unclear what [redacted] viral load was at the time this testing was done as [redacted] February level was 668 copies/mL and his June level was <20 copies/mL.

Further, this testing revealed resistance mutations that may occur naturally or have been transmitted when [redacted] acquired HIV infection – none were associated with reduced susceptibility of any of HIV medications. The significance of these low-level mutations for clinical care is a subject of debate and it is far from conclusive that these potentially naturally-occurring and low level-minority mutations are evidence of treatment non-adherence. Therefore, the opinion's reliance on this novel test to indicate non-adherence to HIV therapy is not supported by the factual data.

More commonly, a genotype resistance test that sequences the actual HIV virus obtained from a patient is performed to assess for drug resistance. This was not performed – likely because the patient's viral load was too low and below the threshold for this test. However, the results of the previously described testing suggest that this, more standard, assay would reveal no mutations.

The opinion states:

"…sexual transmission is also a concern."

While HCV is potentially transmittable sexually, it is important to recognize that heterosexual transmission of this viral infection remains rare. The US Centers for Disease Control and Prevention (CDC) in its 2015 Sexually Transmitted Infections Guidelines states: "Because incident HCV has not been demonstrated to occur in heterosexual couples followed over time, condom use might not be necessary in such circumstances." [4] The guidelines do recommend condoms be used when the HCV-infected person is co-infected with HIV and/or has multiple partners. However, this recommendation is based on theoretical concerns as observational data demonstrate that heterosexual transmission of HCV to be very rare.

The opinion states:

"Co-infection with HIV and HCV" heightens risk of transmission.

As stated above, the major determinant of HIV transmission is the HIV viral load. The opinion suggests that at a specific HIV viral load, co-infection with HCV would increase transmission potential. There is no evidence that I am aware of supporting this assertion. Likewise, the very unlikely potential for [redacted] to transmit HCV to a female sexual partner is not known to be increased by [redacted] low-level HIV viral load.

The opinion states:

The [redacted] County HIV Acuity Assessment Tool is an indicator of [redacted] future behaviors.

The Acuity Assessment Tool appears to be designed to assess HIV-infected patient needs so that tailored interventions can be applied to support the patient and maintain their engagement in care. This tool is not designed to be an assessment of behaviors that risk transmission of HIV. To my knowledge, this tool has not been validated and a search of the literature failed to locate any publication describing its performance. Further, it is unlikely that this tool was developed for incarcerated persons and factors that predict care engagement are likely to be very different in correctional and community settings. As such, the application of this tool in this case is, in my opinion, unreliable and not based on sound methodology.

Overall, my review reveals several interpretations of the clinical data that are not supported by facts or data and the use of unreliable assessments of behavior to support predictions of future actions.

David Alain Wohl, MD

1. Bangsberg DR. Less than 95% adherence to nonnucleoside reverse-transcriptase inhibitor therapy can lead to viral suppression. Clin Infect Dis 2006; 43:939–941.

2. Genberg BL, Wilson IB, Bangsberg DR, et al.; MACH14 Investigators. Patterns of antiretroviral therapy adherence and impact on HIV RNA among patients in North America. AIDS. 2012 Jul 17;26(11):1415-23

3. Quinn TC, Wawer MJ, Sewankambo N, et al. Viral load and the risk of heterosexual transmission of human immunodefciency virus type 1. N Engl J Med 2000, 342:921±929.

4. https://www.cdc.gov/std/tg2015/emerging.htm#hepc

Guidance for a Legal Advocate Representing an HIV-Positive Client in a Criminal Exposure Case

The elements of criminal HIV exposure statutes vary by jurisdiction. Most penalize defendants when they do not disclose their HIV status before having specific kinds of contact with another person. What defines disclosure, and whether or not it took place, is often at the center of criminal cases.

The risk of actual harm is also at issue in some cases, especially when the defendant is on antiretroviral therapy and has an undetectable viral load. Although it is not impossible for someone with a low viral load to transmit HIV, experts agree that a low viral load significantly reduces the risk of HIV transmission. Use of a condom during sex also greatly reduces the transmission risk. Spitting or biting pose virtually zero risk of HIV transmission, and there has never been a single documented case of HIV transmission via saliva.

After identifying the elements of the offense with which the client is charged, and determining what the prosecution will need to prove, it may be helpful to have some or all of the following information about the client:

- ❑ When was s/he diagnosed as being HIV-positive?
- ❑ After diagnosis, was s/he counseled about the modes of HIV transmission and prevention methods?
- ❑ Is s/he on antiretroviral therapy?
- ❑ Was s/he on antiretroviral therapy at the time of the alleged contact?
- ❑ Did s/he tell the other person that s/he was HIV-positive?
- ❑ If not, why not?
- ❑ Would the other person have some other way of knowing about her/his HIV status?
- ❑ What type of contact was involved (sex, spitting, biting, etc.)?
- ❑ Did the other person consent to the contact?
- ❑ Did the other person consent to the contact after knowing that s/he was HIV-positive?
- ❑ If the contact involved sex, was a condom used?
- ❑ What kind of sex was involved (vaginal, anal, oral, sex toys)?
- ❑ If state law criminalizes exposing others to HIV in any way, did s/he know about the law?

It will also be helpful in most cases to prepare or obtain the following (in addition to relevant case law, statutes, and regulations):

- ❑ Information from a reliable source, such as a federal, state, or local health department, about the relative HIV transmission risks of various conduct.

- ❑ Testimony or affidavit from a medical expert about HIV transmission, including language indicating that HIV is not transmitted via casual contact, HIV is not transmitted via spitting or biting, and HIV is less likely to be transmitted when a condom is used or when a person's viral load is undetectable.

Questions for a Client in an HIV-Related Criminal Case
(As is often the case, some questions are appropriate for subsequent, not initial, interviews.)

1. Identifying and contact information

Parties to the Alleged Incident

2. Who is the complaining witness (CW)?

   A. Describe your relationship with CW: length of time, character of relationship, disputes (and witnesses or parties thereto), romantic or sexual involvement, etc. For what reasons might he be biased against you or motivated to harm you?

   B. How do you communicate with CW?

   C. *Preserve without delay* all communications with CW and any communications by CW to others that are in your possession or lawfully accessible by you (third party such as investigator should assist).

   D. Have you ever communicated anything to CW, in writing or otherwise, that could be construed as angry, threatening, or vengeful? Who could testify to these interactions?

   E. Do you know CW's HIV status? Under what circumstances, and when, did you come to know about it? Is there evidence of behavior on CW's part that may have put CW at risk for HIV infection and/or given rise to a fear of infection on CW's part?

   F. Has CW ever made similar allegations against others?

   G. What is known about CW's criminal history? Reputation for dishonesty?

   H. Have your interactions with CW ever been characterized by

threats, coercion, or manipulation on CW's part? Who could testify to these aspects of the relationship? What evidence corroborates them?

Factual Basis for the Charge

3. What is CW contending happened? Does CW claim to have been affirmatively misled about HIV status, or is this a mere failure-to-disclose case?

4. Who are possible witnesses to the incident or to your interactions with CW shortly before or after the incident?

5. Have you had any contact with these prospective witnesses? What is their contact information?

6. What conduct have you engaged in with CW in terms of sexual activity or IV drug use? Dates /frequency/duration? Other participants?

7. What evidence exists that you were involved in the specific actions or activities you have mentioned? What evidence exists that could be misconstrued as confirming certain actions or activities?

8. What if any measures did you and/or CW take to reduce the risk of transmission of HIV or other pathogens?

9. What does CW contend about your purported knowledge that you are HIV+?

Beginning of Investigation or Criminal Case

10. How did you learn that you had been charged or are under investigation?

11. Have you had any contact with any investigator or law enforcement personnel? Under what circumstances / conditions?

12. Have you given any statements? What did you say and to whom?

13. Have you consented to any search of your residence, vehicle, electronic devices, or belongings?

14. Have you received any directives / cautions against destruction or deletion of evidence / subpoenas / requests for meetings?

Client's History and Circumstances

15. Where do you access health care, if you do? (Obtain consent for each provider to release protected health information to counsel.)

16. Who has access to your medical records or other health information? What are the terms of the authorizations held by these persons in terms of time and scope?

17. If you are living with HIV, are you out about your status in any community or forum? Have you written or spoken about it? Are you publicly a member of any affinity, support, or advocacy group?

18. How have you learned about HIV? What do you know about modes and likelihoods of transmission? Does any evidence exist, written or audio/video or otherwise, that describes your beliefs about HIV transmissibility or prevention?

19. Client's testing and treatment history will likely be of paramount importance, but reliance on medical records rather than self-reporting is preferable, at least at outset: when and how diagnosed, opportunistic infections, viral load over time, CD4 counts, co-occurring conditions, regimens prescribed and history thereon]

20. How would you evaluate your mental health, now and at the time of the alleged incident? Is any aspect of this case causing or reenacting trauma for you?

Practice Questions and Issues Packet

Defending Criminal Cases That Involve HIV

I. First Principles

A. Courts and members of the public often base their judgments on outdated, inaccurate information about the infectiousness of HIV and the consequences of HIV disease. Successfully conveying the facts about transmission rates, treatment efficacy, life expectancy, and related factors can be more than half the battle when it comes to negotiating a favorable resolution of these cases.

B. Sensationalism and stigma surrounding HIV contribute to exceptionalism. Failures to disclose other health conditions virtually never lead to criminal charges. Prosecutions even for actual transmission of other STIs are virtually unheard of. The criminal law is a blunt instrument that is poorly suited to the protection of the public's health.

II. What's Your Statute?

A. Many states enforce statutes dating from the 1980s or 1990s that criminalize nondisclosure of one's HIV status whenever one engages in any of a list of enumerated acts such as oral sex, vaginal or anal intercourse, or the sharing of needles. These statutes apply regardless of whether the accused took measures to reduce the likelihood of infection, and even regardless of whether more than a minuscule chance of transmission from the specified conduct exists at all. The sensationalism mentioned above may have a tendency to fill in evidentiary gaps in the minds of judges and jurors: proving a negative such as a failure to disclose one=s status should, for example, be difficult for the prosecution, but outsized fears and dated assumptions about HIV may sway factfinders against the accused even on thin evidence.

B. Advocacy from members of affected communities is fueling criminalization reforms across the United States. Broadly speaking, these reforms don't take HIV cases entirely out of the criminal realm, but instead significantly narrow the conduct that can trigger criminal penalties. Prosecutions under these newer statutes can be defended in a variety of ways where they apply. In states where they do not apply directly, they can usefully identify the kinds of wrongdoing that, consistent with current science and sound public health principles, warrants criminal sanctions. They may, accordingly, guide discussions with prosecutors that could lead to dismissal, diversion, or mitigation of charges.

C. A notable example is a California statute enacted in October, 2017. *See* S.B. 239 (replacing former version of HEALTH & SAFETY CODE '120290). The statute is admirably clear in laying out the essential elements of the new misdemeanor offense, and each element suggests a point of defense or mitigation:

> (1) A defendant is guilty of intentional transmission of an infectious or communicable disease if all of the following apply:
>
> (A) The defendant knows that he or she or a third party is afflicted with an infectious or communicable disease.
>
> (B) The defendant acts with the specific intent to transmit or cause an afflicted third party to transmit that disease to another person.
>
> (C) The defendant or the afflicted third party engages in conduct that poses a substantial risk of transmission to that person.
>
> (D) The defendant or the third party transmits the infectious or communicable disease to the other person.
>
> (E) If exposure occurs through interaction with the defendant and not a third party, the person exposed to the disease during voluntary interaction with the defendant did not know that the defendant was afflicted with the disease. A person=s interaction with the defendant is not involuntary solely on the basis of his or her lack of knowledge that the defendant was afflicted with the disease.

D. Defense counsel should also look for prosecutors to deploy traditional criminal statutes in HIV-related cases. Allegations of aggravated assault and even attempted murder bring daunting sentencing exposure and reveal some officials' outdated understanding of the infectiousness and consequences of HIV disease. These offenses may seem to fit all too well with the notion that the client's body, blood, or semen is a deadly weapon or that alleged sex acts raised a risk of grievous, felony-making harm. Attempt charges may survive an impossibility defense, allowing a conviction when the accused specifically intended to, but could not possibly have, caused death by engaging in specified acts. *See, e.g., Scroggins v. State*, 401 S.E.2d 13, 18-19 (Ga. App. 1990) (affirming conviction for aggravated assault with intent to murder after HIV-positive accused bit officer while being arrested); *but see Smallwood v. State*, 680 A.2d 512 (Md. 1996) (rapist's knowledge of his HIV-positive status, by itself, was insufficient to support conviction for assault with intent to

murder). Where prosecutors or courts are sufficiently open-minded, however, you may achieve a retreat from sensationalism of this kind, by agreement, demurrer, or motion *in limine* limiting how the State can refer to your client or her health condition; and the panoply of defenses to attempt and other specific intent crimes, including voluntary intoxication in some states, may be in play.

E. Look for statutes outside your jurisdiction's criminal code that affect or are incorporated into the offense being charged. Several states' HIV crimes use health code definitions, many of which have likewise failed to keep up with developments in HIV prevention and treatment. As is true when defending against any novel or distinctive criminal charge, scrutinizing statutory language all the way to its roots may yield great benefits. *See, e.g., Rodriguez v. State*, __ S.E.2d __ (Ga. App. October 27, 2017) (No. A17A1301) (evidence of guilt under HIV-specific reckless conduct statute was legally insufficient; there was ample evidence in jury trial that defendant was HIV positive, but State presented nothing to establish that test by which he was determined to be seropositive was approved for that purpose by a particular state agency, as required by definitional provisions of health code).

F. An indispensable compendium of federal, state, and territorial criminal laws relating to HIV is Center for HIV Law and Policy, **HIV CRIMINALIZATION IN THE UNITED STATES: A SOURCEBOOK ON STATE AND FEDERAL HIV CRIMINAL LAW AND PRACTICE** (2017) (hereinafter "SOURCEBOOK").

III. From the Science to . . . the Science: Experts Are Critically Important

A. Outsize estimates of transmission risks, and of the effect on one's life in the event of HIV transmission, pervade decisions about both charging and sentencing. (In the latter context, HIV-positive defendants usually suffer when judges harshly exercise their broad sentencing discretion, not as a result of statutory penalty enhancements.) Misconceptions like "it's easy to catch" and "AIDS is a death sentence" still appear in some prosecutors' closing statements and sentencing memoranda.

B. The law has enacted these misconceptions in criminal law and other contexts, such that even when evidence has shown tiny risks arising from alleged sexual or other conduct, the "wrong done" has been considered grave because of the supposedly devastating effect of transmission when it does occur. *See, e.g., United States v. Lebowitz*, 676 F.3d 1000, 1016 (11th Cir.), (deeming consideration of HIV status in sex crime sentencing reasonable despite demonstrably minute transmission risk), *cert. denied*,

568 U.S. 1212 (2013); *see also* SOURCEBOOK, *passim* (collecting cases, with and without reported appellate decisions, in numerous US jurisdictions, to include instances of biting, spitting, and throwing bodily fluids).

C. In recent years, a number of courts have begun to take account of such factors as the low per-act risk of HIV transmission and the modern status of HIV disease as a chronic, manageable condition, as they weigh considerations of intent to harm, causation, and deterrence. *See, e.g., United States v. Gutierrez*, 74 M.J. 61 (Ct. App. Armed Forces 2015) (reversing military conviction for aggravated assault where HIV-positive defendant's sexual conduct was not "likely to cause death or bodily harm"); *United States v. Herrmann*, 76 M.J. 304 (Ct. App. Armed Forces 2017) (characterizing holding in *Gutierrez* "as a course correction where a minimalist approach regarding what constitutes 'likely' had crept into our jurisprudence in HIV cases); *Rhoades v. State*, 848 N.W.2d 22 (Iowa 2014) (granting postconviction relief from guilty plea to criminal transmission of HIV, where State improperly had court take judicial notice that accused could transmit regardless of viral load); *State v. Hogg*¸448 S.W.3d 877 (Tenn. App. 2014) (considering each alleged sex act with child victim to determine whether risk of transmission was significant or merely speculative); *People v. Giraud*, 980 N.E.2d 1107 (Ill. 2012) (defendant did not endanger life of child victim, so as to aggravate punishment for assault, merely by failing to use condom).

D. These favorable decisions highlight the importance of medical expertise to the defense of criminal HIV cases -- importance that will only increase now that a scientific consensus exists that persons with undetectable viral loads cannot transmit the virus to others. [Provide sample affidavit and/or opinion letter]

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17. If you are living with HIV, are you "out" about your status in any community or forum? Have you written or spoken about it? Are you publicly a member of any affinity, support, or advocacy group?

18. How have you learned about HIV? What do you know about modes and likelihoods of transmission? Does any evidence exist, written or audio/video or otherwise, that describes your beliefs about HIV transmissibility or prevention?

19. [Client's testing and treatment history will likely be of paramount importance, but reliance on medical records rather than self-reporting is preferable, at least at outset: when and how diagnosed, opportunistic infections, viral load over time, CD4 counts, co-occurring conditions, regimens prescribed and history thereon]

20. How would you evaluate your mental health, now and at the time of the alleged incident? Is any aspect of this case causing or reenacting trauma for you?

Legal Issues in an HIV-Related Criminal Case

1. Privacy of client's health information

   -- Does mere HIV-related charge trigger disclosure of health records?

   -- Should State make showing of need in chambers?

   -- Current knowledge about low/zero risk of harm informs analysis

2. Defenses to Nondisclosure of Status

   -- Scope and effect of complainant's consent to sex / charged conduct

   -- Admissibility of evidence of coercion/abuse/threats toward client

   -- Avoiding presumptions of wrongful intent based solely on status

3. Use of Medical Evidence

   -- Burden of proof with respect to likelihood of harm

   -- Funding for indigent defendants' expert witnesses

   -- Ex parte nature of requests for funds, interactions with experts

   -- Questions of law vs. fact re likelihood of transmission

4. Appellate and Postconviction Litigation

   -- Did trial counsel act based on now-discredited assumptions in preparing and litigating case? Plea negotiations, trial, sentencing

Motions to File in an HIV-Related Criminal Case

1. Suppress health-related information

   -- Federal and state constitutional privacy rights

   -- State statutory privacy schemes: challenges to blanket disclosure where HIV-related offense charged, or to court's balancing of interests as it grants disclosure

   -- Inadequacy of subpoena as means for acquiring PHI

2. Constitutional challenges

   -- In light of modern science does criminal statute have rational basis

   -- Given a legitimate interest in protecting public health, does statute fit and effectuate that interest?

   -- Reasons for making such motions include judicial education

3. Evidentiary Matters and Motions *in Limine*

   -- Preclude State from using inflammatory rhetoric, e.g., "death sentence," "deadly weapon," "slow-acting poison"

   -- Ensure that court permits evidence of measures taken to decrease or limit infectiousness; these bear on client's intent, complainant's responsibility for own health, etc, whether accounted for in statute or not.

   -- Protect rights to present a defense and vigorously to cross-examine complainant; do any rape shield or other evidentiary bars inhibit legitimate impeachment as to truthfulness, accusations against others, etc?

-- Preclude evidence of Defendant's post-arrest (or even pre-arrest, depending on jurisdiction) silence

-- Anticipate challenges to admissibility of communications by which HIV status disclosed, e.g., social media; text messages and other electronic communications, etc; foundations, authenticity, best ev.

-- Demanding rigorous adherence to testing norms and limitations where tests used to establish status

4. Sentencing issues

-- Eighth Amendment and state constitutional counterparts

-- Right to jury trial / *Apprendi* issues when enhancements apply

-- Again in light of current science, where purportedly aggravating factor may not exist, does rule of lenity require lesser punishment?

COURT OF [redacted], CRIMINAL DIVISION
[redacted], OHIO

STATE OF OHIO,	:	
	:	
Plaintiff,	:	
	:	
-against-	:	**Case No. [redacted]**
	:	
[redacted],	:	
	:	
Defendant.	:	

SENTENCING SUBMISSION OF DEFENDANT [redacted]

[redacted]
Attorney for Defendant
[redacted]

COURT OF [redacted], CRIMINAL DIVISION
[redacted] COUNTY, [redacted]

STATE OF [redacted],	:	
	:	
Plaintiff,	:	**SENTENCING SUBMISSION**
	:	**OF DEFENDANT**
-against-	:	**[redacted]**
	:	
[redacted],	:	
	:	**Case No. [redacted]**
Defendant.	:	

A. INTRODUCTION

This memorandum is respectfully submitted in connection with the upcoming sentencing of [redacted] in the above-referenced matter. [redacted] is deserving of the Court's compassion and understanding for three reasons: (1) her acceptance of responsibility and remorse for her actions; (2) her conduct was less serious than the typical HIV felonious assault offense according to the factors set forth §2929.12(C), Ohio Revised Code ("O.R.C."); and (3) she is highly unlikely, pursuant to §2929.12(E), O.R.C., to commit any future crimes. These factors offer strong support for imposition of a non-prison sentence.

B. THE INSTANT OFFENSE

An indictment was filed against [redacted] on [redacted], charging her with two counts of felonious assault in violation of §2903.11(A), O.R.C. [redacted] is [redacted], and at the time of the charges, was [redacted] years old. The charges were connected to alleged sexual activity between the defendant and the complainant. On [redacted], at a plea hearing, the defendant entered a guilty plea to Count One of the indictment, felonious assault in violation of §2903.11(B)(1)(D), O.R.C., felonious assault

in the second degree. As part of the plea agreement, the State of Ohio has agreed to "no recommendation" for her sentencing.

C. THE DEFENDANT'S PERSONAL HISTORY

1. Birth, Diagnosis and Medical Treatment

[redacted] was born on [redacted] in [redacted], [redacted], to [redacted]. Ms. [redacted] is the sister-in-law of [redacted]'s aunt and guardian, [redacted]. When [redacted] was born, [redacted] went to [redacted], [redacted], where her sister-in-law lived, to help her with the baby. [redacted] was impoverished, [redacted], and unable to properly care for the child. She lived in a one-room apartment with her three other young children. [redacted] father moved away from [redacted] when [redacted] was four weeks old; she has never met him.

When [redacted] first arrived, five weeks after [redacted] was born, she realized the baby was not well. [redacted] took the baby to a pediatrician who, after examining her and learning of her [redacted] background, had her take the baby to the local hospital, where she was examined and tested positive for HIV. See Letter of [redacted], attached as Exhibit "A." The baby was very sick, with a [redacted] count of [redacted], normal being between [redacted] gm/dL. [redacted] stayed with [redacted] for seventeen days at the hospital while she was being treated. During this period, family services investigated the baby's living situation and interviewed the [redacted] and [redacted] A determination was made that the mother was [redacted] for [redacted], and temporary custody was given to [redacted]. Id.

[redacted] knew that the best hope for proper treatment of [redacted] was for her to go the [redacted] Hospital in the United States, of which she had heard, id., and was close to [redacted], Ohio, where she had friends. [redacted] petitioned the court for

permanent custody of [redacted] and permission to take her to the United States for treatment. Id. The court granted her request and when [redacted] was well enough to travel, the family moved to [redacted], Ohio. While this was a momentous decision for the family, [redacted] knew this was necessary for [redacted] survival:

> [m]y husband's family was angry with me. Even my husband was not on my side. Six months ago we had our life in [redacted] with our [redacted], now we had a daughter with HIV and were moving to Ohio. It was never a decision for me. Taking care of [redacted] was the right thing to do.

Id. [redacted] mother, [redacted], died five years later.

Once the family had settled into their new home, [redacted] took [redacted] to the Children's Hospital. There she has been treated and well-cared for by a pediatric infectious disease specialist, [redacted], MD. Upon Dr. [redacted]'s recommendation, [redacted] was enrolled in a drug study, which was remarkably effective, lowering her viral load. [redacted] thrived. She stayed in the study for approximately eighteen months. Upon completion of the study, Dr. [redacted] continued her HIV treatment with a combination of medications, which continues to suppress her viral load. Reflecting on his long-term treatment of [redacted], Dr. [redacted] states:

> [[redacted]] regularly exhibits a positive and cooperative attitude during her clinic visits with me, despite the fact that these visits routinely require a long drive and a number of blood tests to maintain her health. Adolescence is often a time when individuals with HIV become very noncompliant. [redacted], however, has shown exceptional personal responsibility in taking her medications regularly and maintaining good health and an undetectable viral load.

Letter of [redacted], MD, dated [redacted], attached as Exhibit "B" (includes laboratory report and cited studies). [redacted] is also being treated by Dr. [redacted] at the

[redacted] Care Center in [redacted]; she also notes that [redacted] is compliant with her medications and has thus suppressed her viral load to less than [redacted] copies of the virus per milliliter of blood. [1] See Letter of [redacted], MD, dated [redacted], attached as Exhibit "C."

When [redacted] was [redacted] years old, she was told more specifically about her [redacted] death, and everything about HIV and her HIV status. Her medications were explained to her, and the effect they had on her viral load. As she has achieved an undetectable viral load in the last two years, [2] she understood that it would make transmitting the virus as an HIV positive female to an HIV negative male through [redacted] essentially impossible, as long as she took her medications every day as prescribed. Dr. [redacted] reports:

> [a]s a Pediatric Infectious Disease specialist, I have cared for [redacted] since [redacted] . . . . [w]ith respect to [redacted] undetectable viral load, as a specialist in Infectious Diseases, I am able to offer context to its relevance regarding the risk of transmitting HIV. In two recent studies examining the rate of HIV infection involving a positive partner with a viral load <200, one study (Loutfy et al, 2013) showed the risk of transmission involving a heterosexual vaginal encounter to be 0 per 100 patient years, while the second study (Rodger et al, 2014), showed that even among condomless heterosexual vaginal sex the risk was 0.

Exhibit "B." The Co-Director of the [redacted], who knows [redacted] very well, has a similar observation:

[1] Less than 20 copies of virus per milliliter of blood is significantly less than the amount of virus that meets the definition of "undetectable," which is less than 40 to 75 copies. *See* AIDS.gov, *"Viral Load"* (September 3, 2015), available at https://www.aids.gov/hiv-aids-basics/just-diagnosed-with-hiv-aids/understand-your-test-results/viral-load/. An "undetectable" viral load means that a laboratory test cannot detect HIV in a person's blood, although it still may be present in a very small amount. Id.

[2] See laboratory reports in Exhibits "B" and "C."

> [redacted] is undetectable. You'll hear from others that to be undetectable after having HIV for as long as she has had it means she takes her medications with at least 95% consistency. I couldn't manage that. She's done what it takes to ensure that she will not transmit her HIV, *that she will not do to someone else what was done to her*. She of all people, understands the weight of this.

Letter of [redacted], Co-Director, [redacted], attached as Exhibit "D."

2. Education, Childhood and Adolescence

When [redacted] was several years old, she was enrolled in a [redacted] program in [redacted]. At that time, it was determined that she had a [redacted], due to an [redacted] of [redacted]. [redacted] was then enrolled in preschool at Potential Development Program in [redacted]. [redacted] did well in the Potential Development Program and was subsequently admitted to public school. As the court is aware, at that time, the public schools in [redacted] were in the process of being reorganized, and [redacted], like many other children, was switched between various schools. Despite her own personal challenges and a having to attend different schools, [redacted] loved going to her classes and learning. Although quiet and reserved, she had friends, loved to dance and sing, and worked at her studies diligently.

[redacted] is very close to her three cousins: [redacted], [redacted], and [redacted]. The [redacted] children were raised as "siblings." The cousins are now [redacted], [redacted] and [redacted] years old, respectively. [redacted] is especially protective of [redacted]. All four children attended the [redacted] Program at the [redacted] in [redacted]. This is an after school program for children [redacted]. Co-Director [redacted] recalls:

> I have known [redacted] since she was [redacted] years old, when her adoptive parents (her biological uncle and his wife) and their family came/moved to [redacted] and found our program. She used to tag along with her parents and older brothers when they helped us clean and renovate our newest program site, and even at that age, tried to help with jobs twice her size.

Exhibit "D." One of the volunteer tutors at the program states:

> [p]erhaps the best testament to [redacted] character can be seen in her interaction with others, particularly her younger brother, [redacted]. [redacted] has [redacted] and can become uncomfortable in social situations and settings. [redacted] has provided [redacted] with encouragement, patience, and a calming presence so that he was able to attend the children's program. Knowing that his older [redacted] was there to protect him has given him this ability.

Letter of [redacted], dated [redacted], attached as Exhibit "E."

[redacted] aunt, [redacted], who at one point was employed at the [redacted] Community Health District as an [redacted] educator, has always encouraged [redacted] to know the facts about her medical condition. Exhibit "A." As a result: "the family was open about [redacted] status, despite the ugliness that [redacted] often experienced as a result, so [redacted] was too. A lot of her online and offline friends knew she was positive. She didn't make a big deal about it or use it, but she didn't hide it either." Letter of [redacted], Exhibit "D." [redacted], the volunteer tutor recalls:

> [redacted] has been honest and forthcoming about her status with her peers, even when she has faced ostracism or ridicule for doing so. For example, I recall a conversation I had with [redacted] when she was in high school and when she disclosed her status to a friend. The friend betrayed her trust and shared this information on social media with his classmates. Despite this, [redacted] continued to go to school and continued to pursue her education, exhibiting traits of courage, determination, and perseverance. [redacted] even wrote an essay at school about being HIV-positive and what this has meant for her in life.

Exhibit "E." About [redacted] essay, [redacted] recalls: "[f]or Prom, [redacted] won [a prize for] an essay in which she wrote about the role HIV has played in her life – from the loss of her mother at a young age to moving to [redacted], to her medication, to talking to her peers about HIV." Letter of [redacted], Exhibit "A."

Several of the adults in the program who have worked with [redacted] for years and know her extremely well and attest to her desire and determination to get her high school diploma, despite her many challenges. [redacted], Director of [redacted] for the last 6 years, discusses [redacted] successful efforts to get her diploma:

> . . . [redacted] attended our after school tutoring program 3 evenings per week and summer camp until she graduated in May of [redacted] . . . [redacted] never complained about the amount of work she needed to do (a full class schedule plus the independent work of the credit recovery classes). She also never procrastinated. She promptly began work and worked diligently the entire tutoring time. I frequently brought the evening snack to her desk and drove her home so that she could finish an assignment. While it was apparent that she needed additional help in [redacted], she was not tested nor did she receive an IEP [Individualized Educational Plan] until her senior year after she was 18. Several times, in an effort to protect [redacted] from stigma, physical harm, and the associated danger high school and the teenage years can present to an HIV positive teen, [redacted] family urged her to drop out and get her GED. I felt that [redacted] certainly could graduate and deserved to walk across that stage with her peers if she so desired. She always maintained her determination to graduate, so our [redacted] worked with her- and for her –to do so.

Letter of [redacted], Director of [redacted], [redacted], dated March 21, [redacted], attached as Exhibit "F." Having earned her high school diploma, [redacted] is looking for appropriate employment through the Bureau of [redacted]. Id.

[redacted] is pregnant with her first child. The birth is expected on July 2, [redacted]. Both [redacted] and her family are thrilled that there will be a beloved addition[3] to the family. She is greatly looking forward to raising the baby, in a way that her own mother was unable to care for and raise her. As [redacted] states: "I just focus on being responsible and getting ready for my baby." Letter of [redacted], dated [redacted], attached as Exhibit "G."

D. CURRENT SCIENCE REGARDING HIV TRANSMISSION AND THE DEFENDANT'S MEDICAL REPORTS

The most current medical and scientific facts about HIV, and what [redacted] was told by her medical providers about her medical status, bear directly upon [redacted] actions, and establish that she very reasonably did not believe her sexual interaction with the complainant would result in any possibility of harm, an important factor for the Court to consider under §2929.12(C)(3), O.R.C. ("the defendant did not expect to cause physical harm to any person"). There is clear consensus among medical, scientific, and public health professionals that HIV is not easily transmitted.[4] HIV is one of the least transmissible of all sexually transmitted infections.[5] The only established transmission

[3] *See* Exhibit "B," Letter of [redacted], MD. Dr. [redacted] states that the risk of transmission to [redacted] baby is as low as 1% where the mother is adherent to her medical therapy. *See also* CDC, *HIV Among Pregnant Women, Infants, and Children*, available at http://www.cdc.gov/hiv/group/gender/pregnantwomen/ (if a woman takes HIV medicines exactly as prescribed throughout pregnancy, labor, and delivery, and provides HIV medicines to her baby for 4-6 weeks, the risk of transmitting HIV can be 1% or less).

[4] The low transmission rates of HIV are illustrated by the sharp contrast with the prevalence in the U.S. of HPV, which the CDC states is present in nearly 79 million Americans, to the extent that most, if not all, sexually active citizens will have HPV during their lifetimes. *CDC, Genital HPV Infection – Fact Sheet (February 2015) available at* http://www.cdc.gov/std/hpv/stdfact-hpv.htm. HPV is the main cause of cervical cancer. *See CDC, Basic Information about Cervical Cancer (October 2014), available at* http://www.cdc.gov/cancer/cervical/basic_info/index.htm. Approximately 11,000 women develop cervical cancer each year. *Id.*

[5] The Center for HIV Law and Policy, *HIV, STIs & Relative Risks in the United States* (finding "that other sexually transmitted infections can pose similar, and sometimes equally great or greater, risks than HIV"), *available at*

routes are: anal or vaginal intercourse; sharing infected needles or syringes; mother to child before or during birth (as [redacted] was infected) or through breast-feeding after birth; and significant exposure to HIV-infected blood/ blood products, or organ transplantation in very rare circumstances.[6] The likelihood of transmission depends on various biological factors, such as a person's overall health, use of protective barriers such as condoms, and viral load (the amount of HIV in the person's bodily fluids).[7] Only certain bodily fluids, for example blood, semen, vaginal secretions, or breast milk, containing sufficient viral load, can cause transmission.[8] *See, e.g.*, *Henderson v. Thomas*, 913 F.Supp.2d 1267 (M.D. Alabama 2012).

Effective medical care and treatment can reduce the already low per-act risk of HIV transmission.[9] [redacted], as noted by her doctors and in her medical records, has been

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www.hivlawandpolicy.org/sites/www.hivlawandpolicy.org/files/HIV%20Infectious%20Disease%20Comparative%20Risk%20Table%20-%20U.pdf.

[6] "HIV can be transmitted via the exchange of a variety of body fluids from infected individuals, such as blood, breast milk, semen and vaginal secretions." WHO, *HIV/AIDS Factsheet* (July 2014), *available at* www.who.int/mediacentre/factsheets/fs360/en/; *see also* CDC, *HIV Transmission* (Sept. 2014), *available at* www.cdc.gov/hiv/basics/transmission.html (describing HIV transmission).

[7] Julia Fox, *et al.*, *Quantifying Sexual Exposure to HIV Within an HIV-Serodiscordant Relationship: Development of an Algorithm*, 25(8) AIDS 1066 (2011) [hereinafter, Fox, *Sexual Exposure*], *available at* www.ncbi.nlm.nih.gov/pubmed/21537113 ("The risk of HIV transmission reflects two distinct entities, the relative risk of HIV acquisition amongst HIV-uninfected individuals, which represents a composite of genetic factors, immunological factors, nature and frequency of sexual exposure, and presence of concurrent sexually transmitted infections (STIs) and the onward transmission risk posed by HIV infected individuals which is determined by HIV plasma and genital tract viral load, concomitant STIs, viral characteristics.") (citations omitted); *see also* Pragna Patel, *et al.*, *Estimating per-act HIV transmission risk: a systematic review*, 28 AIDS 1509-1519 (2014) (greatest sexual risk of HIV transmission is for receptive anal sex, at 138 infections per 10,000 exposures; this and other estimated risks of sexual HIV infection reduced by 99.2% with use of both condoms and antiretroviral therapy of person with HIV.) www.niaid.nih.gov/topics/HIVAIDS/Understanding/Pages/riskFactors.aspx (describing factors that increase risk of HIV transmission).

[8] CDC, *HIV Transmission (December 14, 2015), available at* http://www.cdc.gov/hiv/basics/transmission.html. See also *CDC, HIV and Its Transmission* (July 1999), *available at* www.hivlawandpolicy.org/sites/www.hivlawandpolicy.org/files/CDC%2C%20HIV%20and%20its%20transmission.pdf (noting that "contact with saliva, tears, or sweat has never been shown to result in transmission of HIV.").

[9] David Wilson, *et al.*, *Relation Between HIV Viral Load and Infectiousness: A Model-Based Analysis*, 372 (9635) LANCET 314, 317 (2008), *available at* www.who.int/hiv/events/artprevention/wilson_relation.pdf

on antiretroviral medications for years and her viral load is *undetectable*. Exhibit "B." This means that the chances of her transmitting HIV on that basis alone were negligible or "extremely low."[10] In one recent study that followed 767 couples where one partner was infected but on therapy with an undetectable viral load, there were no transmissions despite condomless sex and an estimated 44,400 anal or vaginal sexual acts.[11] Dr. [redacted] cites to and includes a copy of the PARTNER Study, which reports identical results. Exhibit "B."

However, even without having an undetectable viral load, unprotected [redacted] between a HIV negative male and an HIV positive female - the alleged sexual activity here - poses a per-act risk of 1 in 2,380, or roughly 0.04%, chance of infection.[12] Between [redacted] adherence to her medications, which caused her viral load to be undetectable, and the type of sex she allegedly had with the complainant, the chances that she could transmit the virus were almost impossible.[13]

(finding that "[a]lthough the primary purpose of antiretroviral therapy is to slow disease progression in people with HIV infection, it is likely to have the secondary benefit of reducing the risk of new transmission to HIV-negative sexual partners").

[10] Letter of Dr. [redacted], Exhibit "C," discussing the risk of transmission solely based on an undetectable viral load, without considering the specific type of sexual activity underlying the conviction.

[11] A Roger, T. Bruun, V. Cambiano, J. Lundgren, et al., HIV Transmission Risk Through Condomless Sex if HIV+ Partner On Suppressive ART: PARTNER Study, Abstract 153LB , Conference on Retroviruses and Opportunistic Infections (CROI March 2014); see also http://www.hivandhepatitis.com/hiv-prevention/hiv-test-treat/4553-croi-2014-no-one-with-undetectable-viral-load-transmits-hiv-in-partner-study.

[12] CDC, HIV Transmission Risk: Estimated Per Act Probability of Acquiring HIV from an Infected Source, by Exposure At (July 2014), available at www.cdc.gov/hiv/policies/law/risk.html.

[13] As the court is aware, due to medical advances, particularly the development and vastly increased availability of highly-effective antiretroviral therapies, HIV disease has evolved from a difficult, often fatal condition to a manageable, if chronic, one which does not have a significant impact on life expectancy for those in care. While no one would deny that HIV remains incurable, or that it is a life-long condition requiring regular care and daily medication, it is hardly what was formerly considered a "death sentence":

> HIV medications and treatments have significantly changed the course of HIV infection since the early days of the epidemic. With daily medication, regular laboratory monitoring, and lifestyle changes (e.g., exercise, adequate sleep, smoking cessation), HIV can be manageable as a chronic disease. People living with HIV can enjoy healthy lives.

Additionally, it is well established that most HIV transmission occurs during the period of acute infection, which is the one to four-week period following the time when an individual becomes infected and prior to the time when current-day antibody tests would produce a positive result.[14] Far fewer infections occur at the stage that [redacted] was when the underlying activity occurred, the period after acute infection (as noted, [redacted] has been HIV positive since birth). [redacted] had absolutely no reason to believe that there was any chance that she would transmit HIV to a sexual partner; this understanding should be considered by the Court in determining her sentence under §2929.12(C)(3), O.R.C. (no expectation of causing physical harm), more fully discussed below.

E. SENTENCING CONSIDERATIONS

1. [redacted] Conduct is Less Serious Than Conduct Normally Constituting This Offense

[redacted] has accepted full responsibility for her actions as is noted in her statement to the Court: ". . . I feel very terrible about breaking this law and for all the fear and pain I have caused [redacted]." Letter of [redacted], Exhibit "G." She understands she is responsible for her behavior and will never engage in such activity again. Further, she has

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HIV AIDS Basics at http://www.aids.gov/hiv-aids-basics/just-diagnosed-with-aids/overview/chronic-manageable-disease. Remarkable refinement of HIV drug treatments now makes it possible to manage HIV with a single daily pill; newly diagnosed individuals with access to medical care can anticipate a near-normal life expectancy. Pilcher CD, Tien HC, Enron JJ et al., Brief but Efficient: Acute HIV Infection and the Sexual Transmission of HIV, Quest Study and DukeUNCEmory Acute HIV Consortium, 189 J INFECT DIS 1785-92 (2004), available at http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3130067/. In fact, "[a]s of 2013, a 20-year old with the HIV virus who is on ART and is living in the United States or Canada has a life expectancy into their early 70's, a life expectancy that approaches that of an HIV-negative 20-year old in the general population." Id. To nonetheless punish [redacted] based on the severely outdated belief that HIV transmission risks probable suffering and death would be disproportionate and fundamentally unfair.

[14] Bluma G. Bremmer, *et al.*, *High Rates of Forward Transmission Events after Acute/Early HIV-1 Infection*, 195(7) J. OF INFECTIOUS DISEASES 951 (2005), *available at*, http://jid.oxfordjournals.org/content/195/7/951.full; *see also* Myron S. Cohen & Christopher D. Pilcher, *Amplified HIV Transmission and New Approaches to HIV Prevention*, 191(9) J. INFECT. DIS. 1391 (2005), *available at* http://www.who.int/hiv/events/artprevention/cohen_amplified.pdf.

learned that Ohio law prohibits her from having sexual contact without first disclosing her positive HIV status.

[redacted] conduct, however, in light of the factors set forth in §2929.12(C), O.R.C., indicates that her behavior was "less serious than conduct normally constituting the offense." As the court is aware, these factors are:

> (1) The victim induced or facilitated the offense.
> (2) In committing the offense, the offender acted under strong provocation.
> (3) In committing the offense, the offender did not cause or expect to cause physical harm to any person or property.
> (4) There are substantial grounds to mitigate the offender's conduct, although the grounds are not enough to constitute a defense.

§2929.12(C)(1)-(4), O.R.C. Three of these factors offer support for a non-prison sentence.

a. The Complainant Facilitated the Offense

[redacted] met and began dating the complainant, another teenager, in the summer of [redacted]. [redacted] is a sheltered young woman; her family is extremely protective of her, given her medical and [redacted] condition. She does not have a driver's license, and when not at school or at her after hours program or volunteer work at the [redacted], typically is at home. The factual basis for the charges in the indictment are based on activity that occurred when the complainant came to [redacted] home at [redacted] when her family was asleep. So as not to wake her aunt and uncle, the complainant, with [redacted] assistance, snuck into the house. While [redacted] was responsible for her part in this story, the complainant facilitated the activity by sneaking into a young woman's home when he knew the adults would be asleep and unaware of what was occurring. This was not a situation where a young man was pressured into having sex by

a young woman; the complainant came to [redacted] residence in the middle of the night. Since the young woman was kept under close supervision by her guardians, the complainant helped create the situation that allowed the activity to occur. This factor, that the victim facilitated the offense, §2929.12(C)(1), O.R.C., should be considered by the Court in determining [redacted] sentence.

b. [redacted] Did Not Cause or Expect to Cause Physical Harm to the Complainant

Factor §2929.12(C)(3), O.R.C., also shows that [redacted] conduct was less serious than the typical offense. In committing the underlying activity, [redacted] did not cause or expect to cause physical harm to the young man. She was entirely reasonable in believing this, as her understanding comports with the most current and comprehensive science about HIV. See Sections "C" and "D" above. As discussed, [redacted] has been HIV positive since her birth and has been on medication since she was less than six months old. She has always been adherent to her medications and as a result, her HIV viral load is undetectable. See Exhibit "B." While in no way excusing her behavior, these factors are extremely important in understanding her actions.

The type of sexual activity that [redacted] and the complainant allegedly had, [redacted], has an extremely low transmission rate. This transmission rate, however, was even more greatly reduced from that extremely low rate for several reasons, including the facts that [redacted] was not newly infected, had no sexually transmitted infections such as genital ulcers, chlamydia or gonorrhea, and most importantly, is adherent to her medication regimen, which has reduced her viral load to undetectable status.

As [redacted] has been told by her medical providers, being undetectable means that the possibility of transmitting the virus is virtually non-existent. [redacted] has been

counseled repeatedly about her condition, by her medical providers, her aunt and uncle, and the teachers at [redacted]. All these authorities explained to her what is well known in the most up-to-date medical science; she was not able to "do to someone else what was done to her." Exhibit "D."

c. There are Substantial Grounds to Mitigate [redacted] Conduct

Finally, while not a defense to the charge under §2903.11(B), O.R.C., that an individual must inform his or her partner of their HIV positive status before engaging in sex, [redacted] reasonably thought the complainant knew of her HIV status. [redacted] family was very open about her condition and her aunt was an [redacted] educator. [redacted] told most of her friends online and offline about her HIV status, her positive HIV status was circulated in social media, and she wrote a school essay about what it means to live with HIV. This undoubtedly caused her to expect that all of her peers knew she was HIV positive and that a fellow teenager from her community, with whom she shared mutual friends, was aware of her condition before having sex. See pages 6-7, *supra*. While not an excuse, and one that will not be repeated, under §2929.12(C)(4), O.R.C., it is a factor that mitigates her conduct.

2. Consideration of the Relevant Factors Under §2929.12(E), O.R.C., Suggest that [redacted] Will Not Commit Any Future Crimes

Analysis of all factors under §2929.12(E), O.R.C., indicates that [redacted] is not likely to commit future crimes. This is [redacted] first offense. She has not been adjudicated a "delinquent child," §2929.12(E)(1); she has "not been convicted of or pleaded guilty to a criminal offense," §2929.12(E)(2); and she has led a law-abiding life for her entire life, §2929.12(E)(3). Her imprisonment for approximately a month impressed upon her the gravity of her offense: "[b]eing in jail for one month and house arrest made me feel like I

learned something." Exhibit "G." Most importantly, she has shown genuine remorse for her activity as she states to Your Honor:

> . . . I want to apologize . . . I think I know what [redacted] was going through. If my daughter was in a situation where I thought she might be hurt I would be panicked or scared and would not know what to do. I am sorry for letting the situation occur, for letting him come to my house . . . I now know that it was a mistake for me not to tell [redacted] everything I know about my HIV . . . I feel terrible about breaking this law and for all of the fear and pain I have caused [redacted]. I want to do good things with my life and not to hurt anyone, so I feel very sorry for the trouble I have caused [redacted], his family, my family, and the court.

Exhibit "G." Her remorse for violating the law is profound and she has learned that she cannot ever again engage in the behavior for which she was convicted. It is clear that she will not commit such an offense ever again: ". . . I know that I would never be in that situation again." Id.

a. There are "other relevant factors . . . indicating that [redacted] is not likely to commit future crimes."

As the Court will understand from the letters submitted from [redacted] family, friends, teachers and religious advisers, [redacted] is a remarkable young woman who has made one serious mistake. The staff at [redacted] all attest to her determination, despite her [redacted] and medical challenges, to become the "best she can be" by applying herself to her studies and obtaining her high school diploma. Exhibits "D" – "F" and "H." They also note that she is a sensitive young woman who watches out for her younger brother who is [redacted], and has volunteered at [redacted] to help make the lives of other young people affected by, or living with HIV better. Id. The [redacted] states:

> During the time that I have known [redacted], she has always represented herself as a very respectful, caring and helpful young woman. [redacted] would often mention her desire to one day, begin a career working with children and she made sure to take every opportunity to gain experience in that area here at [redacted]. While attending [redacted] after graduation, [redacted] often times would volunteer to work with the younger children in our program. She worked one on one with our kindergarten age students, giving them the additional individual support that they needed to benefit as fully as possible while participating in our program. I feel that these experiences made extremely positive impacts on both [redacted] and the younger children with whom she worked. [redacted] is a great young woman who consistently displays a positive and upbeat attitude and I have been very fortunate to get to know her over the last year.

Letter of [redacted], Child Advocate, [redacted], dated March 22, [redacted], attached as Exhibit "H." *See also* Exhibit "F" ("as an adult volunteer . . . [s]he read to our younger kids and helped them with their homework. She knows how important tutoring, a safe relationship, and love and support can be and she wanted to make sure the younger kids had all that she had as a student. Many of the kids in our program miss her and look forward to her return.")

Her aunt, despite having [redacted] children of her own, deeply loves [redacted], and will continue to do everything she can to provide her with guidance and opportunities: "I am excited to be there for [redacted] when she has her little girl. I want to be there for her and she knows that I will always be there for her, I will always advocate for her because she is my daughter." Exhibit "A." With such strong community and familial support, [redacted] will not be allowed to violate the law a second time.

C. CONCLUSION

For the foregoing reasons, and as the State has made no recommendation for a sentence in this case, we respectfully request that the Court impose a non-prison sentence on [redacted].

Respectfully submitted,

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[redacted]

TO: [redacted], Esq., Assistant County Prosecutor