

Rights, Duties, HIV/AIDS and Corrections

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In formulating policy on HIV/AIDS in prisons, concepts of rights and duties arise as considerations in a number of contexts. Relevant duties which have at least a minimal basis in law include:

- duty of care for the health and well-being of prisoners;
- duty to comply with human rights obligations and non-discrimination requirements; and
- duty to provide a safe system of work for employees.

The interpretation of these duties by prison administrators and consideration of these duties by legislators in framing new laws and regulations are significant to decisions regarding HIV testing programs, segregation and isolation practices, and the provision of health and welfare services for prisoners.

These should not be viewed as necessarily conflicting duties. Nor should it be assumed that to recognise prisoners' rights is at odds with the duty to minimise the HIV epidemic in the community at large. It is not a question of balancing prisoners' rights against the public health imperative of HIV prevention, but rather of recognising that the achievement of individual behaviour change necessary for HIV prevention requires recognition of individual prisoners' rights.

Practice and policy in relation to HIV/AIDS in Australian prisons over the last six years has demonstrated a lack of appreciation of the public health implications of failing to guarantee prisoners' rights. Simply put, failure to assess the impact of testing and segregation programs adequately, failure to acknowledge the duty to comply with human rights obligations, and failure to take seriously the occupational health and safety issues result directly in an increase in the spread of the HIV/AIDS epidemic.

Duty of Care to Prisoners

This duty is the one which, to date, has figured most prominently in discussions of the relevance of legal liability to policy development on HIV/AIDS. It is stated as a rationale for testing of prisoners upon entry and at regular intervals in the National HIV/AIDS Strategy. The National Strategy document explains that 'this duty includes taking precautions to prevent transmission of HIV by rape or consenting sexual activity, or needle sharing with infected prisoners, or protecting infected prisoners from assault by other prisoners or prison staff' (Commonwealth of Australia 1989, p. 50).

The legal basis of this duty is twofold. Firstly, prisoners retain some common law rights. I suspect that the precise position differs between each jurisdiction (for example, *Felons (Civil Proceedings) Act 1981* (NSW), *Treasons and Felonies Act 1981* (NT)). It is a well established principle of tort law that correctional authorities owe a duty of care to persons under their care or control, and that breach of this duty gives rise to liability in negligence (*Ellis v. Home Office* [1953] 2 All ER 149 at 154; *D'Arcy v. Prison Commissioners* (1955) *The Times* 17 November; *Anderson v. Home Office* (1965) *The Times* 8 October; *Egerton v. Home Office* [1978] Crim LR 494; *Howard v. Jarvis* (1958) 98 CLR 177; *L v. Commonwealth* (1976) 10 ALR 269). The duty extends to the taking of reasonable precautions to prevent one prisoner harming another.

Thus, Western Australian prison authorities have been found to be liable in negligence for failing to prevent one prisoner assaulting another prisoner where the assailant had a history of mental instability and violent behaviour. In this case the prison authorities failed to isolate the prisoner from other inmates or deny him access to potential weapons (*Dixon v. the State of Western Australia* [1974] WAR 69). Similarly, Northern Territory authorities have been found liable for failing to prevent a sexual assault where a prisoner was placed in a cell with two other prisoners who were prone to violence (*L v. Commonwealth* (1976) 10 ALR 269).

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

The second basis of the duty of care is prisons legislation. The various Acts and Regulations governing prisoners impose or imply certain minimal duties of care owed to prisoners. In NSW, s. 16(1) of the *Prisons Act 1952* provides that every prisoner must be supplied at public expense with such medical attendance, treatment and medicine as in the opinion of the medical officer is necessary for the preservation of the health of the prisoner, other prisoners and prison officers. Regulation 154 of the NSW Prisons (General) Regulations 1989 provides that a prisoner shall not be subjected to cruel, inhuman or degrading treatment or be subjected to any other punishment or treatment that may reasonably be expected to affect adversely the prisoner's physical or mental health. In Victoria, s. 47 of the *Corrections Act 1986* provides that prisoners have a right to 'reasonable medical care'. In the ACT, r. 13 of the Remand Centre Regulations provides that prison medical officers are under a duty to do such things as are necessary to safeguard the mental and physical health of detainees.

There are major limitations on the enforcement of duties of care arising from prisons legislation or under common law principles. There are very few cases in which prisoners have litigated on the basis of rights derived from prisons legislation in order to secure more favourable conditions. The courts are reluctant to interpret such duties as enforceable duties. Statements of duties found in prison legislation or regulations have been described in

one New South Wales case as 'mere directions' bearing on prison administration which do not give rise to a right of civil action (*Smith v. Commissioner of Corrective Services* [1978] 1 NSWLR 317 at 328 per Hutley J).

Further, prison legislation generally protects prison authorities from liability. For example, in New South Wales, s. 46 of the *Prison Acts 1952* has the effect that no action or claim for damages lies against prison authorities unless it is proved that the act was done maliciously and without reasonable or probable cause. The section will be extended when the legislation facilitating compulsory HIV testing commences operation (*Prisons (Medical Tests) Amendment Act 1990*) with the effect that liability in relation to the taking of blood tests and disclosure of results is to be limited. Under Queensland legislation, prison authorities are not liable for acts done bona fide and without negligence (*Corrective Services Administration Act 1988* (Qld) s. 62).

Added to these legal barriers to enforcement of rights are the obvious practical barriers. Prisoners access to legal services is notoriously inadequate. In the context of HIV/AIDS, prisoners affected by HIV/AIDS have obvious incentives not to involve themselves in court battles with prison administrators. Fear of victimisation and the need to avoid stress for health reasons are major considerations. Cases where prisoners do gain access to the courts are most exceptional. The conditions imposed on NSW prisoners after an incident in which it is alleged that a prison officer was infected with HIV after a syringe attack has given rise to such an exceptional case. The recent ban on personal property held by NSW prisoners and the locking up of prisoners who resisted the ban has led to Supreme Court proceedings to challenge the measures adopted by Department of Corrective Services (*Newcastle Herald* 8 Oct. 1990, p. 9). It will be instructive to learn whether these most draconian measures are given the sanction of the courts.

Although the duty of care derived from common law and statutory or regulatory provisions is not subject to frequent enforcement or court review, and although the content of the duty tends to be diluted in judicial interpretation, the duty is a concept to which administrators and legislators do turn when developing policy options. It is vital that the concept of a duty of care owed to prisoners is developed in order to give meaning to HIV/AIDS prevention and care strategies. A brief examination of NSW's experience in introducing compulsory HIV testing demonstrates this point.

The *Prisons (Medical Tests) Amendment Act 1990* was passed by the NSW Parliament in June 1990 to provide a legal basis for compulsory HIV testing of the NSW prison population. The Ministers for Corrective Services and Health both spoke in the parliamentary debates of the Government's duty to pass the legislation (NSW Legislative Assembly, *Prisons (Medical Tests) Amendment Bill, Second Reading Speech*, 10.5.90, 21.5.90). They acknowledged that prison administrators have a duty of care at common law and under statute to protect the health of prisoners. The Minister for Corrective Services argued that compulsory testing would assist prison authorities to carry out their duty of care to both the infected and the uninfected.

The Minister for Corrective Services sought the advice of the Crown Solicitor as to what the duty of care means legally in the context of HIV/AIDS. The Crown Solicitor advised that the duty extends to:

- detection of the incidence of HIV infection;
- prevention of the spread of HIV; and

- provision of appropriate medical treatment to prisoners with HIV (NSW Legislative Assembly, Prisons (Medical Tests) Amendment Bill 1990, Second Reading Speech, 10.5.90, p. 2996.)

The politicians were duty bound to act, or so the argument ran. No one would doubt that law-makers must do something about HIV/AIDS in prisons. It is the NSW experience to date, that politicians' words mask grave failings in deeds. By passing a law to test all prisoners for HIV, the Government was seen to be grasping the nettle, making the hard choices, 'not shirking responsibility' in the words of the Minister for Corrective Services (NSW Legislative Assembly Prisons (Medical Tests) Amendment Bill 1990, Second Reading Speed, 10.5.90, p. 2995).

It is a commonly held misconception that HIV testing is a public health measure. With no other measures in place, it is not. Testing alone achieves nothing. It just satisfies some that something is being done. It goes nowhere in addressing the real issues of prevention and care. When made compulsory and without measures which enable prisoners to prevent the spread of HIV (that is, distribution of condoms and needle cleaning solutions and access to drug use rehabilitation programs), it is likely to be a counterproductive measure. At the same time as the NSW Government passed legislation making it compulsory for the prison population to be tested, it reaffirmed its decision not to distribute condoms in prisons (*Sydney Morning Herald* 14 June 1990, p. 4). Without comprehensive education and counselling programs, testing may encourage those who test negative to continue with high-risk activities.

In NSW, there is much evidence that prison authorities are not taking their duty of care seriously. Although the practical and legal barriers to enforcement of the duty to which I have referred mean that they are not held strictly accountable for failure to meet an appropriate standard of care, the duty still remains. Given the indisputably high number of drug users in prisons and in the context of the crucial epidemiological role of the drug using population in the spread of HIV in the general community, public health considerations place an additional onus on prison authorities to develop meaningful preventive policies and practices.

In the USA, there has been a great deal of litigation surrounding the discharge by prison authorities of their duties in relation to HIV/AIDS care and prevention. Uninfected prisoners have sued the authorities for failing to test and segregate. In a recently reported case, *Cameron v. Metcuz* 705 F. Supp 454 (N.D. Ind 1989), an uninfected plaintiff prisoner sued prison authorities for failing to segregate a known infected prisoner with a violent history who had bitten the plaintiff. In that case, the court found that the authorities' failure to segregate a known infected prisoner with a violent history did not amount to gross negligence or reckless indifference to the prisoner who was bitten. Infected prisoners have challenged segregation policies as unconstitutional, discriminatory or contrary to statutory obligations of care. The failed challenge to Alabama's testing and segregation policies in the class action *Harris v. Thigpen* 727 F.Supp 1564 (M.D.Ala. 1990) is the most prominent recent case of this nature. The prospect of looming court challenges has encouraged United States legislators to consider seriously the impact of new prison procedures introduced to deal with HIV/AIDS.

In 1987 the Government of Oregon sought to establish how best to discharge its duty of care. Central to its concerns was the impact of compulsory testing programs on HIV prevention. A study was conducted by the State Department of Corrections (Andrus et al. 1989). Nine hundred and seventy-seven prisoners entering the prison system were offered voluntary confidential HIV testing and counselling. Two-thirds of the prisoners accepted this offer. Those declining the offer were asked whether they would consider anonymous testing. Twenty-seven per cent of prisoners who had declined voluntary testing stated that they would have considered anonymous testing, had it been available. Those who declined voluntary testing were tested in any event at a later date. Blood specimens which had been drawn from all prisoners for the detection of syphilis were tested for HIV in a blinded

fashion. Of the total 977 prisoners, twelve were HIV antibody positive. Six of the twelve were from the group which had agreed to voluntary testing. Six were not. Fifty-six per cent of those who declined testing were considered to be high-risk for HIV due to their status as hepatitis B core antibody positive, IV drug users, and/or gay. The study found, however, that of the prisoners considered to be at risk of HIV by these criteria, only one in fifty-three was infected.

'The problem then', the study found, 'is not that there are a lot of infected inmates that need to be identified. Rather, there are a lot of at-risk, as yet, unidentified inmates that need to be convinced to change their behaviour (Andrus et al. 1989, p. 841).

The study concluded that, given that there was no evidence that mandatory testing has an affect on behaviour change, but that there is mounting evidence that voluntary testing and counselling does change behaviour, and given that two-thirds of at risk prisoners had availed themselves of voluntary testing, a voluntary testing program was the preferred policy option. The study was careful to confine its findings to the local context. In particular, low prevalence of HIV (about 1.2 per cent) in the prison population was considered significant. 'When most persons at risk are not yet infected, voluntary HIV prevention programs that emphasise counselling may be more effective than mandatory programs that emphasise testing' (Andrus et al. 1989, p. 842). The Government of Oregon acted on this study. Funding was provided for a comprehensive voluntary testing and counselling program. The legislature decided against compulsory testing.

More recently, a similar study which evaluated the rate of voluntary testing as against admitted HIV risk status and HIV seroprevalence assessed through blinded surveys, was conducted by the Wisconsin Department of Health and Social Services (Wisconsin Department of Health and Social Services 1989). This study found that the rate of acceptance of voluntary HIV testing by individuals at increased risk of HIV was greater than those denying high-risk behaviours, and that HIV antibody positive prisoners did not systematically defer from voluntary testing where counselling and education were provided. The study noted that some of the infected inmates who declined voluntary testing may have been tested prior to incarceration or in previous incarcerations. The study concluded that voluntary testing facilitates the acceptance of risk reduction counselling more effectively than mandatory testing because it enables the counsellor and the inmate to establish a relationship based upon consent. Voluntary counselling and testing were recommended for prison systems with low HIV prevalence prison populations.

The observations made in these United States studies apply to our own situation. HIV seroprevalence in Australian prisons is estimated to be at a similar level to that in Oregon and Wisconsin when those studies were conducted. Further, the level of at risk behaviour is estimated to be high in Australian prisons. The lesson then is that Australian policies must be aimed at behaviour change rather than at artificial attempts to confine the problem by identification and isolation of the infected. The NSW Crown Solicitor's advice that the duty of care of prison authorities extends to ascertainment of the incidence of HIV infection must be read in context with the other elements of the duty: prevention of spread and care for the infected. I submit that the only way in which these elements are reconcilable is through a voluntary testing program emphasising the crucial role of behavioural change.

Duty to Comply with Human Rights Obligations and Non-Discrimination Requirements

Over the last decade corrective service administrators have begun to acknowledge that international human rights obligations which bind Australia have a bearing on the duties of prison authorities (Birtles 1989). Standard Guidelines for Corrections in Australia have been agreed upon by corrective services Ministers in Australia and were published in 1989 (Conference of Correctional Administrators). They are based on international obligations contained in the UN Standard Minimum Rules for the Treatment of Prisoners drafted by the United Nations and endorsed by its Economic and Social Council in 1957 (UN Department of Public Information 1984).

Whilst not intended to have legal force, the Standard Guidelines are intended to 'provide a base for protecting human rights in Corrections in Australia'. The Guidelines state the following guiding principles:

1.2 Correctional programs are by the deprivation of liberty to varying degrees, a punishment in themselves. Therefore correctional programs must not, except as incidental to the maintenance of discipline or justifiable segregation, aggravate the suffering inherent in such a situation.

1.8 There must be no discrimination in any aspect of correctional programs on the grounds of ... physical or mental impairment ... except as it is necessary in properly meeting the needs of a disadvantaged individual or group.

Amongst the guidelines relevant to prisoner management are the following statements:

5.33 Prolonged solitary confinement, corporal punishment, punishment by placement in a dark cell, reduction of diet, sensory deprivation and all cruel, inhumane or degrading punishments must not be used.

5.70 Prisoners isolated for health reasons should be afforded all rights and privileges which are accorded to other prisoners so long as such rights and privileges do not jeopardise the health of others.

In addition to the existence of these non-legal guidelines, prison authorities must develop an awareness of human rights obligations as a result of the introduction of human rights and equal opportunity legislation in Australia at State and federal level over the last fifteen years.

Legislation currently in force in NSW, Western Australia, Victoria and South Australia makes it unlawful to discriminate on the grounds of physical impairment in the provision of a service. In South Australia and NSW it is also unlawful to discriminate on the grounds of homosexuality (*Equal Opportunity Act 1984 (SA)*, *Equal Opportunity Act 1984 (WA)*, *Equal Opportunity Act 1984 (Vic)*, *Anti-Discrimination Act 1977 (NSW)*). Complaints in relation to HIV/AIDS are received by the agencies which administer this legislation. The legislation binds public authorities. I am not familiar with the use of the legislation in jurisdictions outside NSW, but I am aware that it has been used to review discriminatory treatment of prisoners by corrective service employees in NSW and South Australia (Mead 1990).

The Commonwealth's Human Rights and Equal Opportunity Commission is empowered to inquire into acts or practices which are inconsistent with, or contrary to, human rights recognised by human rights instruments to which Australia is a party. Special procedural provisions are made in the legislation for the taking of complaints from prisoners (*Human Rights and Equal Opportunity Commission Act 1986 (Cwlth)*, s. 20(6)). The Commission is currently considering a complaint lodged by a NSW prisoner regarding conditions of confinement subsequent to the crackdown on prison property (*Sydney Morning Herald* 10 Sept. 1990, p. 5.). Although the Commission's powers to deal with complaints from individual prisoners are limited to federal prisoners, the Commission has a wider jurisdiction to conduct general inquiries where human rights abuses are suspected. There are many human rights obligations which are relevant to HIV/AIDS prevention and treatment in prisons. In particular, reference should be made to Article 7 of the International Covenant on Civil and Political Rights which provides that 'no one shall be subjected to cruel, inhuman or degrading treatment. In particular, no one shall be subjected without their free consent to medical or scientific experimentation'.

Many prisoners with HIV experience discrimination in the conditions of their confinement (Godwin & Lake 1990, p. 46; WA Legislative Assembly 1990, p. 56). There is much evidence that inadequate care is provided for the health and safety of prisoners with HIV/AIDS.

The West Australian Parliamentary Select Committee on HIV/AIDS has reported that the conditions for prisoners with HIV at Fremantle prison are 'inadequate and completely inappropriate'. Unwarranted procedures were found in the serving of food and the laundering of clothing. Books which are used by prisoners with HIV/AIDS are destroyed and not circulated. The Committee called for 'urgent revision' of the double punishment which occurs where men who test positive for HIV and who would normally be incarcerated in a minimum or medium security prison must be confined, often twenty hours a day, to a maximum security prison (WA Legislative Assembly 1990, p. 57). The Western Australian experience does not stand alone.

Prisoners have seldom been able to lodge complaints for human rights abuses or discriminatory treatment. There are many practical reasons why this is so. Access to legal services, is in any event, limited. The powers of the new anti-discrimination and human rights agencies in the prisons context are largely untested. Nevertheless, it is important in the context of HIV/AIDS, that significance is accorded to the existence of prison authorities' duties to comply with international human rights obligations.

This is particularly so given the importance of anti-discrimination measures in the context of HIV/AIDS prevention in the general community. There is an important public health dimension to the duty of non-discrimination. Just as in the general community discrimination alienates people at risk from voluntary education, treatment and counselling programs (the only programs known to have an impact on HIV/AIDS prevention), discrimination in the prison context distances both uninfected and infected prisoners from programs which may have an impact on behavioural change. An essential additional point is, of course, that most infected and uninfected prisoners enter the general community upon release. Governments have just as much responsibility, for the sake of HIV/AIDS prevention, to educate infected and at risk prison populations about behaviour change, testing and treatment options as they do other sectors of the community. Failure to prevent discrimination both inside and outside prisons indicates a failure by the authorities to recognise this responsibility.

Duty to Provide a Safe System of Work

Since the recent incident in which it is alleged that a prison officer was infected with HIV after a syringe attack in a NSW prison, attention has been focused on HIV/AIDS as an occupational safety issue. Occupational health and safety legislation in all Australian jurisdictions imposes a strict duty on all employers, including corrective services departments, to provide a safe workplace.

HIV/AIDS as an occupational issue has only been addressed in Australia in any detail in the health care context. Since 1986 Infection Control Guidelines have been made available by the Commonwealth Government to guide health care employers on appropriate measures to minimise the risk of HIV transmission in the workplace (AIDS Task Force 1986; Australian National Council on AIDS 1990). The concept of universal infection control procedures (treating all people as if they are infected) has been adopted from United States. In that country, the application of infection control procedures is now mandatory in many States, and health care providers face penalties for failure to implement them.

In the USA, the current infection control guidelines issued by the Centers for Disease Control extend not only to health care workers but also to corrective service personnel (Centers for Disease Control 1989). These guidelines have been approved and adopted by the American Correctional Association, the affiliated American Correctional Health Services Association and the US National Commission on Correctional Health Care. The guidelines provide the following rationale for the extension of the principle of general infection control to emergency and public safety workers (including law enforcement and correctional facilities):

Use of general infection control measures . . . is important to protect both workers and individuals with whom they work from a variety of infectious agents, not just HIV and HBV (Hepatitis B). Because emergency and public safety workers work in environments that provide inherently unpredictable risks of exposures, general infection control procedures should be adapted to these work situations. Exposures are unpredictable, and protective measures may often be used in situations that do not appear to present risk. Emergency and public safety workers perform their duties in the community under extremely variable conditions; thus control measures that are simple and uniform across all situations have the greatest likelihood of worker compliance. Administrative procedures to ensure compliance can also be more readily developed than when procedures are complex and highly variable (Centers for Disease Control 1989, p. 9).

It is important to understand the logic behind universal or general infection control in addressing HIV/AIDS in the workplace. Treating all prisoners as potentially infectious obviates the need to identify those who are infected. Implementation of guidelines should be accompanied by education of staff as to the nature of risks associated with different medical conditions and situations. The use of general infection control procedures defeats the argument that there is a need to segregate infected prisoners for the safety of prison staff. Thus, the duty to provide a safe system of work can be reconciled with the duty of non-discrimination. It is the most appropriate response given the legal parameters. It is also the only response which provides for the general safety of all staff, not just those thought to be specially at risk. In particular, it avoids overreaction by staff when they do work with prisoners with HIV.

The Commonwealth should, along the United States model, extend the application of its published infection control guidelines to correctional facilities.

Other Legal Duties

There are a number of other legal duties which are relevant to the formulation of prisons policy on HIV/AIDS. They will be mentioned briefly to flag their potential importance.

A controversial area relates to the duty of prison medical authorities where a person is tested prior to, or upon exit from, the prison system. What is the legal duty to the ex-prisoner to follow up the test with a result, be it a negative or positive one, and to provide post-test counselling? It would seem reasonable, in respect of a matter so important as HIV diagnosis, that the legal responsibilities of prison authorities may continue in certain circumstances even where the person is no longer a prisoner. Moreover, it is at least arguable that liability may arise as a result of a breach of duty in this regard.

Further, what duty is there to notify third parties at risk of infection, for example, the wife of an infected prisoner? The dilemma may arise where a prisoner is allowed visits from or visits to a sexual partner. There is no clear answer to these questions. Analogous situations have been considered in the non-prison context, particularly in relation to balancing the duty of a medical practitioner to keep patient information confidential with the possible duty of care to third parties at risk (Neave 1987). Authorities in these areas suggest that, except in cases where there is a clear and imminent risk to a third party, the duty is to maintain confidentiality rather than to warn third parties.

Significant developments have occurred in recent years in relation to legal rights to confidentiality and privacy. The sensitivity of HIV/AIDS related information is such that it is a likely candidate for legal protection. Prison authorities should be aware that breach of confidence is now a recognised action by which people may claim compensation or other remedies.

Conclusion

The duty of care for prisoners' health, the duty to comply with human rights and non-discrimination obligations, and the duty to provide a safe system of work each will have a slightly different legal appearance in each Australian jurisdiction. Each State and Territory must assess how best to reconcile these duties with local conditions.

I have sought to offer some directions as to priority concerns in formulating local strategies. Given the experience of voluntary educational programs in achieving behaviour change, voluntary testing programs combined with comprehensive education and counselling, availability of condoms and needle cleaning equipment, and access to drug rehabilitation programs would best fulfil the duty to prevent the spread of HIV/AIDS. Given the discrimination experienced by people in some segregated HIV/AIDS prison units, a policy of general integration rather than segregation would best fulfil the duty to provide non-discriminatory services. In the area of occupational safety, a policy of universal infection control procedures would best fulfil the duty to all prison staff.

Consideration of rights and duties should not be an exercise in merely avoiding the threat of court proceedings. In practice, prisoners seldom are able to enforce what legal rights they have. But this is not to say that the duties which correlate to these rights should not be taken seriously by authorities. Further, given the immensity of the impact of HIV/AIDS on the whole community, the duties of prison authorities must be interpreted in the context of a general HIV/AIDS prevention strategy which emphasises the voluntary compliance of affected communities with those strategies.

There is a clear case for urgent reform of the law as it relates to prisoners' rights to ensure meaningful HIV/AIDS prevention and care strategies for both the prison and general populations. Rights to health care and access to condoms and needle cleansing agents should be enshrined in legislation as enforceable rights. Human rights and anti-discrimination legislation should be reviewed to ensure that incarcerated populations have equal access to anti-discrimination remedies and equal rights to freedom from discrimination as the general population. For corrective services employees, the right to a safe workplace should be given meaning through the promulgation of universal infection control guidelines. Every decision made in respect of the administration of prisons must be assessed in terms of its eventual impact on society as a whole.

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