Joint Submission to the Review of the Mandatory Disease Testing Act 2021

14 November 2025

Acknowledgement Statement

This joint submission has been prepared by a coalition of community-based organisations with deep expertise in HIV, viral hepatitis, sexual health, harm reduction, and human rights. Together, ACON, the HIV/AIDS Legal Centre (HALC), the Bobby Goldsmith Foundation (BGF), the Sex Workers Outreach Project NSW (SWOP NSW), the National Association of People with HIV Australia (NAPWHA), Positive Life NSW, the NSW Users and AIDS Association (NUAA),the Australasian Society for HIV, Hepatitis and Sexual Health Medicine (ASHM), and Hepatitis NSW bring decades of collective experience working alongside affected communities to advance health, dignity, and inclusion. We thank the review for the opportunity to contribute our shared insights and hope that the outcomes of this process will support evidence-based policy, safer workplaces, and a more just and inclusive approach to public health in New South Wales.

ACON is NSW's leading health organisation specialising in community health, inclusion, and HIV responses for people of diverse sexualities and genders.

The HIV/AIDS Legal Centre (HALC) is the only not-for-profit, specialist community legal centre of its kind in Australia. HALC provides free and comprehensive legal assistance to people in NSW with HIV or hepatitis-related legal matters and undertakes community legal education and law reform activity in areas relating to HIV and hepatitis.

The Bobby Goldsmith Foundation (BGF) is Australia's longest-running HIV charity, and provides practical, emotional and financial support to people living with HIV in New South Wales and South Australia.

The Sex Workers Outreach Project New South Wales (SWOP NSW), a member of Scarlet Alliance, has delivered peer-led services to the sex industry in NSW for over 35 years to provide NSW sex workers with the same access to health, safety, human rights, and workplace protections as all other Australian workers.

The National Association of People with HIV Australia (NAPWHA) is the national peak, non-government organisation representing community-based groups of people living with HIV across Australia. NAPWHA's membership of national networks and state-based organisations reflects the diverse make-up of the HIV- positive community and enables NAPWHA to confidently represent the positive voice in Australia.

Positive Life NSW (Positive Life) is the lead peer-based agency in NSW representing people living with and affected by HIV in NSW. Positive Life provides leadership and advocacy in advancing the human rights and quality of life of all people living with HIV, and to change systems and practices that discriminate against people living with HIV, our friends, family, and carers in NSW.

NSW Users and AIDS Association (NUAA) is a community-led organisation representing people with lived or living experience of illicit drug use. NUAA operates across NSW delivering a range of harm reduction services and is a key voice in NSW policy and research. Our mission is to advance the health, human rights and dignity of people who use or have used illicit drugs in NSW.

The Australasian Society for HIV, Hepatitis and Sexual Health Medicine (ASHM) is the national peak body representing healthcare professionals in HIV, viral hepatitis and sexual and reproductive health. ASHM delivers training to build workforce capacity and strengthen health systems to ensure high-quality HIV, viral hepatitis and sexual and reproductive health services, including prevention, testing, treatment and care.

Hepatitis NSW is a state-wide, not-for-profit charity started by members of the hepatitis community in 1991, funded by the NSW Ministry of Health. We provide information, support, referral and advocacy for people affected by viral hepatitis in NSW. We also provide workforce development and education services both to prevent the transmission of viral hepatitis and to improve services for those affected by it. The Hepatitis NSW vision is '*A world free of viral hepatitis*'. We are committed to supporting the NSW Government to achieve the elimination of hepatitis B and hepatitis C by 2028.

Policy objectives and context

Frontline workers across NSW deserve the utmost care for their health and wellbeing, particularly when they face health risks in the workplace. The policy objective of the *Mandatory Disease Testing Act* 2021 (NSW) ('the Act') is to protect these workers in the event of exposure to a BBV.

This objective is vital, and the health and safety of frontline workers are paramount. However, the Ombudsman report demonstrates that the Act's objectives are not being met. In fact, the Act is working against workers' wellbeing and infringing on the human rights of community members.

The Ombudsman's primary recommendation was that the government consider repealing the Act. The Ombudsman's view, that 61 amendments must be implemented to address the issues with the Act, raises serious questions about whether there are systemic issues inherent in legislation of this nature.

Across all work environments in NSW, effective and safe policies are already in place that address the risk of BBV exposure in the workplace, such as the SafeWork NSW draft policy, '*How to manage BBV exposure risks in the workplace – hepatitis B virus, hepatitis C virus and HIV Code of Practice'*. These policies effectively maintained the safety of workers, including frontline health workers, prior to the commencement of the Act in July 2022. There had not been a transmission of a BBV in NSW in a healthcare setting since 1994 and no recorded transmission within the NSW Police Force (NSWPF).

We encourage robust policy to address BBV exposure; however, the current Act is not fulfilling this role. Instead, the Ombudsman's findings highlight that the Act promotes false, defunct and misleading information regarding BBV exposure risks, increases worker stress, and has led to the mismanagement of sensitive health data of both frontline workers and community members.

Stigma, discrimination, and over-policing are known to be major drivers of BBV transmissions, as well as being barriers to care and support for people living with those viruses, contravening the goals of the NSW *HIV Strategy 2021-2025* ('HIV Strategy'), the *Hepatitis C Strategy 2022-2025* ('Hepatitis C Strategy') and *Hepatitis B Strategy 2023-2026* ('Hepatitis B Strategy')

The *Mandatory Disease Testing Act 2021* (NSW) must be repealed. Repeal of this legislation would continue to work towards the NSW Government's commitment to ending HIV stigma, as it is in the NSW HIV strategy. Similarly, NSW has committed to the elimination of Hepatitis C and B as public health issues, as set forth in the Hepatitis C Strategy and Hepatitis B Strategy. The Act undermines the tireless work and bipartisan response of the NSW Government and partner organisations have put into reaching State, National and indeed, International, HIV and Hepatitis B and C targets.

While we strongly recommend repeal, if the Act is to remain, we have provided recommendations in line with the Ombudsman's report for reform to ensure the Act better fulfils its primary purpose - safeguarding both workers and the community - in a safe, ethical, and evidence-based manner.

Primary Recommendation:

- That the *Mandatory Disease Testing Act 2021* (NSW) ('the Act') be repealed in its entirety

Recommendations should the Act not be repealed:

In order of appearance in the below submission, in response to the questions provided in the consultation paper.

- Invest in evidence-based workplace policies with a strong focus on mental health and BBV education.
- Exclude saliva from the scope of the Act.
- Designate the NSW Chief Health Officer (CHO)as the sole decision-maker and authority on MTO applications and allow for review of CHO decisions by NCAT
- Promote access to BBV specialist advice for workers.
- For an MTO to be issued, a relevant medical practitioner must determine that there is a real risk that a worker has contracted a BBV from the contact incident.
- Update and expand the definition of 'vulnerable party' with increased protections.
- Include all Aboriginal and Torres Strait Islander people in the definition of vulnerability.
- Strengthen mental health support for affected workers, including BBV education.
- Prohibit blood testing of third parties before the completion of a review.
- Require that in MTO applications to the CHO, applicants are asked to consider and disclose whether the third party involved may be vulnerable.
- Prohibit seeking informed consent from vulnerable third parties.
- Establish clear regulations on the information required for valid informed consent.
- Introduce stronger privacy protections for all parties involved in an MTO.
- Regulate who can provide, receive, and access testing results.
- Prohibit senior officers from accessing workers' medical records or contacting their medical practitioner.
- Mandate that only the worker may engage with their medical practitioner.
- Strengthen procedural safeguards to prevent misuse of the Act.
- Require annual public reporting on the use of the Act.

Appropriateness of the Act's terms for securing the policy objectives

The Act is failing to achieve the policy objectives outlined in section 3(a). The Ombudsman Report indicates the Act was frequently applied in circumstances where there is no genuine risk of BBV transmission. Most notably, two-thirds of applications involved exposure to saliva, which does not pose a risk of transmission. This undermines the intent of the legislation and contributes to misinformation about BBV exposure.

The legislation was introduced with the stated objective of alleviating the stress and anxiety of frontline workers following an exposure event. The Ombudsman's survey of workers who had submitted an MTO application found:

- No respondents indicated their treatment had changed following a third-party test.
- Respondents largely felt that the scheme had not promoted their wellbeing; and
- Some workers felt the process of applying for an order instead contributed to their stress and anxiety.

The process following MTO applications or reviews needs to be updated to prioritise the health and wellbeing of the worker, with a focus on mental health. This must include access to appropriate support services, timely medical services (including PEP), and comprehensive education on the transmission of BBV and the stigma associated with it.

Testing of a third party after exposure to bodily fluids does not provide conclusive answers as to their BBV status, and transmission cannot be proven, even based on a positive result. Many resources are available that offer guidance in this regard, such as ASHM's resource 'Emergency Service Providers and Bloodborne Viruses 2024', which outlines the risk of transmission in different scenarios and explains prevention and treatment options in simple terms.[1]

Recommendations:

1. Full repeal of the Mandatory Disease Testing Act 2021.
2. Invest in evidence-based workplace policies with a strong focus on mental health and BBV education.

[1] Australasian Society for HIV, Viral Hepatitis and Sexual Health Medicine (ASHM) (2024) 'Emergency Service Providers and Bloodborne Viruses', available at: https://ashm.org.au/wp-content/uploads/2025/03/Emergency-Service-Providers-and-Blood-Borne-Virsues-2024.pdf.

Criteria to apply for and make MTOs

Since the onset of the HIV epidemic, there has been widespread societal fear surrounding HIV and HIV transmission, and it is often this fear that fuels negative attitudes and discriminatory behaviours.[2] By making orders possible in circumstances where there is negligible or no risk of BBV transmission, the scheme reinforces long held myths about the transmission of BBVs like HIV, hepatitis B and hepatitis C, perpetuating stigma surrounding them. This is known to worsen public health outcomes and community wellbeing.

Spitting and saliva do not carry any risk of transmission of BBVs.[3] Saliva alone must be omitted from the definition of 'bodily fluid' under the Act, with any risk of transmission due to potential blood content assessed solely by the CHO. The ability for other senior officers or the NSW Minister for Health to prescribe additional bodily fluids should be removed.

While the Act requires a worker to consult a 'relevant medical practitioner' before applying for an order, it does not require the practitioner to determine that a real risk of transmission exists for the order to be granted, nor does the senior officer have to take account of the practitioner's opinion when deciding whether to approve the MTO.

Given the large number of orders that proceeded despite no risk of transmission being identified, it is clear medical advice was not always followed, or that it was incorrect. It is therefore essential that a different and effective approach be adopted to deliver information about BBV transmission, one that does not unnecessarily violate the bodily autonomy of third parties.

The primary evidence-based intervention to prevent HIV transmission is post-exposure prophylaxis (PEP). This can, and should be, provided as a fully effective treatment in response to an exposure to a bodily fluid that carries the risk of BBV. MTOs should only be able to be issued in circumstances where a worker has been offered PEP.

Testing the potential 'source' alone does not prevent HIV transmission, and in fact, increases the likelihood of transmission because it encourages workers to wait for test results instead of taking PEP when such biomedical intervention would be effective. MTOs should not be relied upon as the sole response to an exposure incident.

[2] Broady, T. et al. (2020) *Stigma Indicators Monitoring Report* (UNSW Centre for Social Research in Health, Report). https://unsworks.unsw.edu.au/entities/publication/0eaa7812-eef1-488d-a859-eed05d96df26

[3] Cresswell, F. V., Ellis, J., Hartley, J., Sabin, C. A., Orkin, C., & Churchill, D. R. (2018). A systematic review of risk of HIV transmission through biting or spitting: implications for policy. *HIV medicine*, *19*(8), 532–540. Advance online publication. https://doi.org/10.1111/hiv.12625

We recommend that there should therefore be a legislative requirement for a relevant medical practitioner to determine that there was a real risk of BBV transmission before an MTO is issued, and the CHO to be satisfied of this determination on reasonable grounds. Victoria's legislative approach to mandatory testing , contained in the *Public Health and Wellbeing Act 2008* (Vic) offers a better model for NSW as it requires the CHO to believe an incident has occurred in which HIV or hepatitis posed a real risk of BBV transmission for an MTO to be issued.

Victoria's approach more effectively balances the rights of workers with those of third parties.[4] This is similar to the approach to WA's *Mandatory Testing (Infectious Diseases) Act 2014* (WA), where there must be reasonable grounds for suspecting a transfer of certain bodily fluids into another person's anus, vagina, mucous membrane, or broken skin[5]. NSW's current requirement for merely 'deliberate exposure' is far too low a threshold, which can lead to MTO being issued as a punitive measure rather than out of genuine concerns for the worker's health. Exposure without the transfer of bodily fluids to another person's anus, vagina, broken skin or mucous membrane poses no risk of BBV transmission. [6]

Recommendations:

3. Exclude saliva from the scope of the Act.
4. Require all MTO applications to be reviewed by the Chief Health Officer.
5. Promote access to Blood Borne Virus specialist advice for workers.
6. For an MTO to be issued, a relevant medical practitioner must determine that there is a real risk that a worker has contracted a blood-borne disease from the contact incident.

Vulnerable Third Parties

The Ombudsman Report made clear that protections for vulnerable third parties in the Act are not working. We consider the current definition of a vulnerable third party under the Act to be inadequate. Stronger safeguards must be implemented to ensure vulnerable individuals are identified and protected, and that their rights are not overlooked by those seeking an MTO. This is especially true for cohorts at higher risk of criminalisation, such as Aboriginal and Torres Strait Islander people and people with mental health challenges and cognitive impairments.

[4] *Public Health and Wellbeing Act 2008* (Vic) s 134 (1)(a).
[5] *Mandatory Testing (Infectious Diseases) Act 2014* (WA) ss 4, 8.
[6] Barré-Sinoussi F, Abdool Karim SS, Albert J, Bekker LG, Beyrer C, Cahn P, Calmy A, Grinsztejn B, Grulich A, Kamarulzaman A, Kumarasamy N, Loutfy MR, El Filali KM, Mboup S, Montaner JS, Munderi P, Pokrovsky V, Vandamme AM, Young B, Godfrey-Faussett P, 'Expert consensus statement on the science of HIV in the context of criminal law', *Journal of the International AIDS Society* (2018) 21(7):e25161. doi: 10.1002/jia2.25161. PMID: 30044059; PMCID: PMC6058263.

While Aboriginal and Torres Strait Islander people are already overrepresented in the NSW justice system, there is a higher proportion still of Aboriginal and Torres Strait Islander people subject to MTOs.

Aboriginal and Torres Strait Islander people comprised 28% of all applications in the Ombudsman review period, despite representing only 3.4% of the general population. 50% of the applications made by Corrective Services NSW were related to Aboriginal and Torres Strait Islander people. In this way, MTOs exacerbate the existing and growing overrepresentation of Aboriginal and Torres Strait Islander people within NSW justice system. In March 2025, there were 4,244 Aboriginal adults in custody, which is 32.4% of the adult custody population in NSW.[7] From March 2020 to March 2025, the number of Aboriginal inmates increased by 18.9% while non-Aboriginal prisoners decreased by 12.5%.[8]

Aboriginal and Torres Strait Islander people were less likely to be assessed as a vulnerable third party, despite higher rates of mental and cognitive impairment in this cohort. On this point, we refer the Reviewers to the submissions of the Aboriginal Legal Service NSW/ACT (ALS), which identify a general trend of police failing to recognise mental health and cognitive impairments in Aboriginal people in custody. We endorse the ALS's recommendation that all Aboriginal and Torres Strait Islander people should be deemed vulnerable under the Act. We also recommend that the definition of vulnerability be expanded to explicitly include all Aboriginal and Torres Strait Islander peoples.

Also of significant concern, the NSW Ombudsman's Report highlighted that 17 individuals detained under the *Mental Health Act 2007* (NSW) were not recognised as vulnerable, despite their mental illness forming the legal basis for their detention. [9] This reflects the broader failure in the criminal justice system to effectively engage with and protect vulnerable individuals. In only 12 (13%) of NSWPF MTO applications during the period investigated by the Ombudsman was a third party identified as vulnerable, which is likely an underestimation. The report also found that procedural fairness mechanisms for vulnerable third parties were largely ineffective, with timeframes making it unfeasible for these individuals to seek legal or health advice.

Furthermore, we refer the Reviewers to the submissions made by the ALS regarding the need to consider excluding children from the scope of the Act. We support the recommendation that people in custody settings should be recognised as vulnerable third parties or deemed not able to consent to an order, given that their circumstances impact their ability to give free and informed consent.

Recommendations:

7. Update and expand the definition of 'vulnerable party' with increased protections.
8. Include all Aboriginal and Torres Strait Islander people in the definition of vulnerability.

[7] https://bocsar.nsw.gov.au/media/2025/mr-custody-mar2025.html
[8] https://bocsar.nsw.gov.au/media/2025/mr-custody-mar2025.html
[9] *Mental Health Act 2007* (NSW) s 12.

Decision-Making and Reviews

To better protect and promote workers' health and wellbeing, the authority to issue MTOs should rest solely with the CHO. This would ensure that applications are medically justified and that affected workers receive appropriate guidance and support.

This approach aligns with the model of mandatory testing in Victoria,[10] and is consistent with existing public health frameworks in NSW, which vest powers related to mandatory treatment and prevention of BBV transmission in health authorities.[11] While the Act continues, community, health and person-led efforts to prevent HIV transmissions are undermined.

Responsibility and additional powers in this area should rest with health agencies, who have the expertise, experience and accountability to apply such powers appropriately and safeguard both public health and individual rights.

With the CHO as the sole decision-maker for all MTO applications, a pathway for review should be available to the NSW Civil and Administrative Tribunal (NCAT) if a third party or worker wishes to appeal a decision of the CHO. This is comparable to the approach adopted in Victoria.[12] It avoids applying a criminal justice approach to what is fundamentally a health and wellbeing issue, preventing further strain on NSW's already overburdened court system and legal assistance sector, as could happen if courts make all determinations.

The current process, which allows senior officers to be decision-makers, lacks the clinical foundation and procedural fairness required for effective MTO decisions. The review process is also unclear and inaccessible to those most affected by the Act. The Ombudsman's Report found that in 139 applications, there was only one that was subject to review. This does not indicate the Act's effectiveness, but rather, that there is a lack of awareness of third-party rights under the Act.

Health authorities have relevant expertise and existing experience issuing and overseeing public health orders under the *Public Health Act 2010 (*NSW). Whilst we acknowledge the concerns identified in the NSW Ombudsman Report and by the CHO regarding the limitations in their ability to undertake a comprehensive merits review, if required, we maintain that the CHO is better positioned than the courts (and senior officers) to determine whether a 'real risk of transmission' exists, our proposed threshold for testing and to determine whether a third party is vulnerable.

To address the CHO's concerns, we suggest granting the CHO the power to refer a determination to NCAT if another limb of the test, such as whether there has been a deliberate transmission, is in dispute. That is, any aspect of the test other than whether there is a 'real risk of transmission'. Thereby, legal expertise can be applied where necessary, ensuring procedural fairness is maintained whilst retaining a role for the CHO's expertise and role in managing public health risks.

[10] *Public Health and Wellbeing Act 2008* (Vic) Div 2.
[11] See especially *Public Health Act 2010* (NSW) Div 4
[12] *Public Health and Wellbeing Act 2008* (Vic) s 134.

This model would be less burdensome than the current role of the CHO in these decisions – hearing applications for review under section 23 of the Act, which requires the CHO to adopt a quasi-judicial role, considering submissions of involved parties. NCAT is more suitable for hearing review applications.

The requirement under the Act that blood testing takes place before the outcome of a review is a serious breach of bodily autonomy and is contrary to the most basic principles underpinning Australian administrative law and international human rights law.

As we have previously recommended, and as the Ombudsman proposed (Recommendation 15), testing should not proceed if there is a review underway. [13]

The application process must be updated to be CHO-led, with clearer guidance provided to all parties involved in an MTO to uphold the rights of all involved.

Recommendations:

9. Designate the Chief Health Officer as the sole decision-maker on MTO applications and allow for review of CHO decisions to NCAT.
10. Strengthen mental health support for affected workers, including BBV education.
11. Prohibit blood testing of third parties before the completion of a review.
12. Require that in applications to the Chief Health Officer, applicants are asked to consider and disclose whether the third party involved may be vulnerable.

Testing by consent

We are particularly concerned by the number of applications that proceed with testing with the consent of third parties. One-third of all applications in the first 18 months of the Act's operation resulted in the third party consenting to testing, even in circumstances where there was no transmission risk, or there may not have been a basis for an MTO under the application criteria.

It is unclear what information was provided to third parties to obtain this consent, which raises a concerning gap in oversight and accountability. The Act requires consent to be sought by the senior officer, and so consent is being obtained in a non-clinical context, without the opportunity for medical or legal advice.

[13] Australasian Society for HIV, Viral Hepatitis and Sexual Health Medicine (ASHM) (2024) 'Emergency Service Providers and Bloodborne Viruses', available at: https://ashm.org.au/wp-content/uploads/2025/03/Emergency-Service-Providers-and-Blood-Borne-Virsues-2024.pdf.

We are concerned that third parties are consenting to a test in situations where there is no risk of transmission, simply to avoid or limit extra contact with the justice system, or due to other pressures exerted on them or their support people.

The report observes police applying pressure to third parties to consent to a test and notes the inherent power imbalance between police and third parties. This includes instances where third parties have consented to a test on the understanding that it will result in their release from custody sooner. While seeking informed consent is best practice, the Ombudsman report contains evidence that police are obtaining consent from individuals who are not well-informed about their rights. A relevant case study to this issue in the Ombudsman report recounted that a woman who was sedated and known to have schizophrenia 'consented' to a test, despite being a vulnerable person.

Under the Act, if a third-party consents to a test, then an application for an order must be refused. In these circumstances, the Act provides no safeguards for the person consenting. For example, there is no requirement for the consent to be in a particular form, or for information to be provided to better inform that consent. There is also no guidance in the Act on whether, or how, the results should be disclosed if testing is done by consent, either to the third party themselves or emergency service workers involved.

We believe that seeking consent from vulnerable third parties is inappropriate and should not occur. Those classified as vulnerable, such as those with mental health or cognitive impairments, are not in a position to provide informed consent, and therefore, this should not be possible under the Act.

There must be clearer regulations regarding what information is required for someone to consent to a test. This insufficient regulation allows MTOs to proceed under the guise of consent, even when that consent is not valid or informed. If the Act is not repealed, it must be amended to reflect the need for informed consent to be gained from individuals who can provide it, and that clear, standardised information is provided to support truly informed decision-making.

Recommendations:

13. Prohibit seeking informed consent from vulnerable third parties.
14. Establish clear regulation on the information required for valid informed consent.

Third party protections (including blood samples and test results)

Currently, the Act does not contain sufficient privacy protections regarding the disclosure of blood test results of third parties. The Ombudsman's report revealed serious cases of confidentiality breaches, including reports that blood tests had been uploaded to police systems.

As a general standard, police should not have access to anyone's medical records, especially those of vulnerable people and from often marginalised communities. Having easy access to these records perpetuates the false narrative that third parties are a serious threat to public safety, consequently worsening stigma.

One case study reported that a doctor, unknown to the patient, had been sent blood test results and subsequently received a call in which they were pressured to hand over the results. This case study highlights the importance of robust regulation regarding testing, including who is authorised to conduct it, who can receive and report results, and how these processes are managed.

The Act also has no explicit protection prohibiting workers from disclosing the blood test results of the third party to other workers or individuals uninvolved with the MTO process, further violating the right to privacy of the third party. To address these issues, we reiterate our recommendation that the CHO should be the sole authority responsible for approving MTOs. Ensuring that, in each case, proper medical oversight is provided, privacy is respected, and that the MTO occurs only in the case of genuine risk of transmission.

Recommendations:

15. Introduce stronger privacy protections for all parties involved in an MTO.
16. Regulate who can provide, receive, and access testing results.

Other issues (Senior officers' access to workers' medical records and medical practitioners, enforcement, Ombudsman monitoring and reporting)

Senior officers should have no access to workers' medical records or to their medical professional on their behalf, as this is a clear breach of privacy. Instead, workers should be supported to engage with their relevant medical practitioner, including consulting with a BBV specialist, should there be a risk of transmission.

The Ombudsman's report has revealed ongoing misuse of the Act, including concerns about inappropriate access to sensitive health information and a lack of procedural safeguards. If the Act is to continue, it should do so only with significant amendments as per the recommendations in our submission and those of our partners.

Annual reports on the use of the Act should be mandated for provision to the public, ensuring accountability for its use. The Ombudsman currently reports every three years, but given the severity of the concerns raised, more frequent reporting is warranted. It is critical these reports are detailed, collecting details like:

- The number of MTO applications made.
- The number of MTOs issued.
- The demographic information of third parties involved, especially whether they are Aboriginal and Torres Strait Islander, or have a disability.
- High-level data regarding the circumstances surrounding the incidents involved.

Regarding enforcement, we support the Ombudsman's recommendation that the section 21 power to use reasonable force should not apply if the detained third-party is detained solely in connection with an offence under the Act (Recommendation 36).

The use of force to detain or restrain a person for the purposes of obtaining a blood sample is a significant intrusion on bodily autonomy. If the Act is to continue, we believe that the section 21 power to use reasonable force to detain or restrain someone to obtain a sample should be removed. In circumstances where someone is already guilty of an offence and fails to abide by an MTO, this measure is disproportionate.

At the very least, the exercise of the power should be subject to more robust oversight.

In Victoria, reasonable force can only be used to detain or restrain someone to enable a sample to be taken on application by the CHO to the local court. The court can only issue such an order if the circumstances are 'so exceptional that the making of the order is justified'.[14]

[14] *Public Health and Wellbeing Act 2008* (Vic) s 134(3)-(4).

A comparable approach should be adopted in NSW, incorporating a clear definition of exceptional circumstances that includes situations where there is a moderate to high risk of bloodborne virus transmission. It may be that NCAT is the most suitable forum for hearing these applications for the use of force, if the government adopts our recommendation that the CHO determine applications and any appeals be determined at NCAT.

Ultimately, while we continue to support the full repeal of the Act, we focus on developing effective and evidence-based policies in all workplaces that support frontline workers who may be exposed to BBVs while at work.

Recommendations:

17. Prohibit senior officers from accessing workers' medical records or contacting their medical practitioner.
18. Mandate that only the worker may engage with their medical practitioner.
19. Strengthen procedural safeguards to prevent misuse of the Act.
20. Require annual public reporting on the use of the Act.