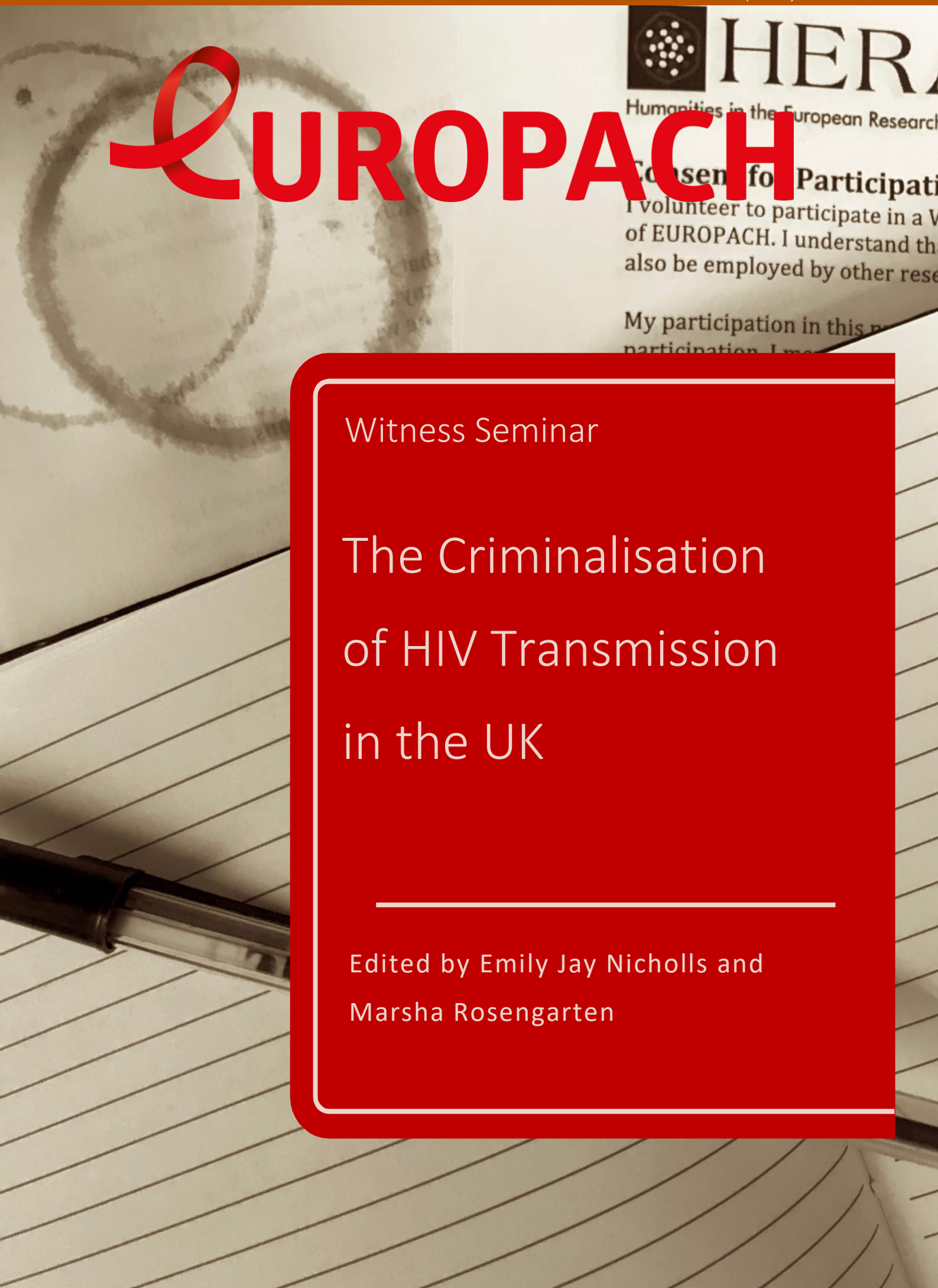

Witness Seminar

The Criminalisation of HIV Transmission in the UK

Edited by Emily Jay Nicholls and Marsha Rosengarten

The witness seminar is part of a series convened by Emily Jay Nicholls and Marsha Rosengarten, Centre for Invention and Social Process (CISP), Goldsmiths, University of London.

The series forms a component of research within "Disentangling European HIV/AIDS Policies: Activism, Citizenship and Health" (EUROPACH), a collaboration between four European universities – Humboldt-Universität zu Berlin (Institute for European Ethnology), Goldsmiths, University of London (Department of Sociology), University of Basel (Department of History) and Jagiellonian University (Institute of Sociology).

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ABBREVIATIONS

ASBO	Antisocial Behaviour Order
NAT	National AIDS Trust
THT	Terrence Higgins Trust
ACPO	Association of Chief Police Officers
GLA	Greater London Authority
CPS	Crown Prosecution Service
BHIVA	British HIV Association
BASHH	British Association for Sexual Health and HIV
GBH	Grievous Bodily Harm
MESMAC	A sexual health organisation (previously Men Who Have Sex With Men – Action in the Community)
SOPO	Sexual Offences Prevention Order

BACKGROUND TO THE WITNESS SEMINAR SERIES

As convenors of the seminar and editors of this text, we would like to offer some background to our decision to conduct witness seminars aimed at enhancing historical understandings of the HIV/AIDS epidemic in the UK. Included in this background is an account of how they were organised and who we approached to participate.

This witness seminar, 'The Criminalisation of HIV Transmission in the UK' was the first in the series for the UK component of 'Disentangling European HIV/AIDS Policies: Activism, Citizenship and Health' (EUROPACH), funded by the Humanities in the European Research Area (HERA).

Our decision to employ the mode of a 'witness seminar' was inspired, in part, by a meeting with the Advisory Committee that we assembled for the UK research. We had intended to use this meeting as an opportunity to present the project and our work so far to advisory committee members and to ask for advice and feedback. However, what emerged was not a simple two-way dialogue where we asked for advice and they gave it, but instead a space in which all of the members of our advisory committee drew on their experiences and expertise, bounced off one another, and told us far more than we might ever have thought to ask them.

One of us had already consulted some of the witness seminar transcripts produced by the History of Modern Biomedicine Research Group based at Queen Mary, University of London and available through the Wellcome Library. What was immediately apparent in these transcripts was their ability to capture both technical and specialist knowledge about particular health issues, but also that the issues were made readable and comprehendible to someone with little knowledge of the topic at hand. Although our witness seminars take a different format, we hope similarly that the resulting texts will shed light on some of the complexities of the history of HIV/AIDS.

Having already considered the possibility of using the method ourselves and then being part of the lively space that emerged in our advisory committee meeting, we decided to hold the witness seminars in order to provide a history or, rather, histories of the UK HIV/AIDS epidemic, reflective of different perspectives, tensions and personal experiences. The resulting text from this seminar sits alongside oral history interviews undertaken as part of the EUROPACH project and other witness seminars undertaken during the course of our research. By contrast with the personal narratives provided by our one-to-one interviews, we have sought to create a space in

which people from different backgrounds and with different experiences of the epidemic could come together and tell their stories in conversation with others. As such, the personal narrative is still present within the witness seminar transcripts, but this is in conversation with others' experiences and has thus resulted in a mode of collective retelling.

Although we were inspired by the witness seminar transcripts we had already consulted, we decided to undertake this work in a manner attuned to our prior familiarity with the HIV epidemic and the manner in which many of those invited were well-versed in discussion about historical dimensions of the epidemic. The more conventional witness seminar design often asks participants to prepare presentations in advance. Bearing in mind our participants experience in collaborative discussions and conscious that those we had invited would be better placed to decide on what was relevant, we did not specify any prior preparation. Nor did we ask for any style of presentation. In sum, we prioritised cultivating an open forum where a dialogue would emerge between participants who in same cases were already familiar with each other and in other cases not. Nevertheless, it was necessary to provide a starting point and for this reason we circulated a list of topics for possible discussion a couple of weeks before the meeting (see Appendix).

SEMINAR INFORMATION

Some of the participants in this witness seminar were already known to us through our own engagements in HIV and our knowledge of their contribution, while others were invited on the recommendation of those we had already approached. As mentioned above, we circulated a list of proposed topics for discussion a couple of weeks before the seminar, but made clear that we would welcome diversions from this list.

The seminar *The Criminalisation of HIV Transmission in the UK* was held in the home of one of the convenors in London on 17th February 2018 and was scheduled to run for two hours. During the seminar, audio recordings were made, which were then transcribed and edited in order to enable a clear reading of the text. Footnotes were then added and the text was circulated to participants with an invitation to further edit, redact or expand on their contributions. All participants signed consent forms agreeing to make the final transcript available for public viewing once they had been given the opportunity to edit or redact their contributions.

THE CRIMINALISATION OF HIV TRANSMISSION IN THE UK

This witness seminar brought together key actors who have been involved in the response to the criminalisation of HIV transmission in the UK. Just as in other witness seminars in this series, participants did not only discuss what happened, but gave great depth to this history by describing what they felt and observed from their active involvement in the early phase of the epidemic. In reflecting on the first English transmission case, for example, one participant described a feeling of having been taken unawares, despite warnings of this possibility following a successful prosecution in Scotland having occurred only recently. Discussion regarding disagreements within and between HIV organisations on the issue of criminalisation at this time; and the difficulty of constructing a coherent argument against criminalisation to those outside of the sector, revealed some of the challenges which came with mobilising a response. On the other hand, the drawing up of prosecutorial guidelines with the Crown Prosecution Service (CPS), are reflective of a strategic approach to managing the issue by those in the HIV sector, as well as the importance of 'luck,' both in terms of things happening at the right time, but also in being paired with the right representative.

Participants elaborated on some of the arguments that have been made against the criminalisation of the reckless transmission of HIV, but also proffered a more in-depth discussion of the ways civil society organisations navigated this issue in the early response to criminal cases, while not neglecting the broader issues wherein HIV and the criminal law meet. This brought into view other issues, such as that of access to treatment for migrants, recent trials by police forces in the use of 'spit hoods' and employment and disability legislation. As a result of the coming together of these issues, while this text focuses on the specifics of the response, it also situates the criminalisation of HIV transmission within its broader policy and legal context.

The seminar began with a brief description of the project and the purpose and process of the witness seminar. Participants were then invited to introduce themselves and describe their first engagements with HIV and criminalisation.

Emily Jay Nicholls: I'm the postdoctoral researcher on this project. I was awarded my PhD quite recently, and my thesis followed the construction an archive of the HIV/AIDS epidemic in the UK. In the thesis, I thought about the place of personal histories within the process of the archive. Now I'm here working on the EUROPACH project.

Robert James: I'm here in a personal capacity, I've been involved with the voluntary sector for umpteen years including with Ceri (Hutton) at various points, and I'm not representing Sussex University where I have a new job.

Catherine Dodds: I started thinking and talking with Matthew (Weait) about issues of criminalisation in 1998. This morning I reviewed the section of my PhD thesis which was about this topic. I guess a fair amount of the social science research that I undertook on the topic was when I worked with Sigma Research which was part of Portsmouth university at the time. We also did a further project with service providers while we were affiliated with London School of Hygiene and Tropical Medicine. Now I work with the University of Glasgow, I guess it's just best to say that this is about my own body of research across institutions, and certainly doesn't represent any one of those.

Ceri Hutton: I worked in HIV/AIDS from 1988 to '98, first at National AIDS Trust and then at Immunity Legal Centre. I think the reason why I was contacted for this seminar is because I chaired the UK forum on HIV and human rights for five years, which was the group that produced the UK Declaration of Rights for People with HIV and AIDS. Part of the motivation for the UK Declaration was precisely to provide a robust defence against criminalisation which at the time was very much around in the ether and discussed in the media - not only relating to sexual transmission. So that's where my knowledge for this comes from. Since 1998 I've been mainly working in the human rights and migration fields rather than in HIV, so I'm trying to dredge back into memory from a long time ago for this discussion.

Matthew Weait: I've been working in this field since early 1990s, early to mid-1990s, before treatment anyway, so from about '93. It took over my academic life for a very long time, well it still does in so far as I've got time, being a Dean and all of that stuff, and I have written quite a lot about HIV criminalisation and criminal justice, and been involved in a number of initiatives with NAT with Yusef (Azad) and with THT. I worked on the legal services group as a volunteer before that got abolished at THT.

I worked on the Global Commission for HIV and the Law, I've done stuff with UNAIDS, various international initiatives, and I think that's why I am here. I have worked with Catherine (Dodds) at SIGMA on quite a lot of the reports on this subject, had the pleasure of being Robert (James)'s PhD supervisor, and I suppose that's my connection. I've known Lisa (Power) since the late '80s at Switchboard, and Yusef since we started working on the Birkbeck event on Dica possibly, I imagine.

Yusef: I'm director of strategy at the National AIDS Trust, I have been there since 2004, that was my first job and my only job to date in the HIV sector, and I guess I am speaking in both a professional and personal capacity and I'm very happy for it to be cited as coming from an employee of NAT. Almost the very first thing I did in terms of a project in joining NAT was organise the Greater London Authority (GLA) seminar with Lisa (Power) on criminalisation, and really I've worked with everybody around this table on the issue and continue to do so to this day. I was very involved with the Crown Prosecution Service (CPS) and Association of Chief Police Officers (ACPO) and also initiatives led by UNAIDS and WHO Europe on the issue as well.

Marsha Rosengarten: I'm a Professor of Sociology at Goldsmiths, University of London. I'm the principle investigator on the UK part of this project of putting together an archive of the history of the epidemic. Most of my experience actually has been as a researcher in Australia. I started working on HIV when I was doing my PhD in the mid-80s, and then had a research position in Sydney before moving to London, and working on how antiretroviral drugs which had come into being in the early 2000's, how they were affecting the experience of the clinic and also sexual practices. Since then most of my interest has been on how biomedicine understands the epidemic and – in its best intentions – sometimes has a rather exclusionary focus on how to think about the complexities of the epidemic. I will add that I don't know anything about the legal aspects of HIV, so I am really here to learn.

Lisa Power: I'm currently the chair of the HIV Justice Network, but I'm not here representing them. At the time of most of what we're likely to talk about I was the policy director of Terrence Higgins Trust, in which capacity I have worked with pretty much everyone who is involved here. We were in an interesting position – and one which NAT came to take up after it became known around HIV work as well – of dealing with both the policy and campaigning aspects and also the individual casework, which made for some interesting clashes of conscience occasionally, and because we had the national helpline we got calls from people on all sides of

the issue which also made for interesting perspectives, and some difficult conversations within THT from staff with different perspectives too. So, it was an interesting hot seat at the time.

Emily: Although our focus today is on the criminalisation of HIV transmission, I wonder if it might be worth beginning by thinking about some of the broader legal issues for people living with HIV, in terms of thinking about the legal context?

Yusef: Well there are criminal law issues, broader than the issue either of endangerment or transmission. They have actually come to the fore a bit more recently, and one of these issues is whether deception as to HIV status vitiates consent to sex. So, could you be accused of rape or sexual assault if you either don't declare or lie about your HIV status? What we're also finding in the criminal law is that HIV is often being brought up in normal assault cases as an aggravating factor in sentencing, even though the person is almost certainly undetectable and therefore non-infectious and there was no risk of transmission from the fracas that the person was in, but it's used in some way to taint the identity of the person and results in heavier sentences. So, it's good you raise this because I guess there are broader issues about how the criminal law deals with the person living with HIV, how that person is viewed in a whole nexus of stigma and discrimination, and we are battling on. Matthew and I went to a meeting quite recently on the rape issue, so we're battling on a number of other fronts, and I think historically of course there was also the issue around stigma and discrimination until the Disability Discrimination Act which made that unlawful.

Matthew: That's a very good summary that Yusef has provided. I think one of the things that's very interesting if we're going to focus on criminalisation but contextualise it is that because criminalisation depends – for a successful prosecution though not for an investigation or an arrest – on people being diagnosed and knowing their status. There are a lot of ways in which criminalisation is implicated very importantly in public health, so that any legal constraint on people being able to access testing, being able to access treatment so that they can reduce their infectiousness, means that they are more intensively implicated in potential criminal liability. And so the wonderful work that was done by NAT and others in getting undocumented migrants access to treatment was really important because that's a legal issue which wouldn't be seen as a criminalisation issue. But given that the intensity, certainly in some of the early cases on black African migrants meant that if those people had been undocumented or unable to access treatment because of their status they would be more likely to be successfully prosecuted because their status.

And issues around disability discrimination law and all of the conflicts that happened around – I defer to other people on this point – but the debate that happened about HIV being, as it were, treated as a disability for the purposes of the equalities legislation and the Disability Discrimination Act – which were very contentious in lots of ways – were very important in enabling people to have the accommodation made at work. If they were changing treatment or needed to go to an appointment, were concerned about their health otherwise and have that recognised in the workplace, and any legal constraint on preventing people doing that also impacts on general health, wellbeing, mental health, stress at work, and all of those other stresses which are associated with, indirectly, mental health issues around risk taking behaviour. And there is quite a lot of research on that of course, about esteem and people feeling able to be empowered in their sexual relationships to disclose in intimate relationships.

So I think it's very important to understand criminalisation as being an entry point to a much broader and much more, for many people, important set of debates about the way in which public health law, public health and political identity and HIV intersect, and I am increasingly of the view and have had conversations with people about this recently, about the merits as it were of focusing on criminalisation as the endpoint, because it's an extremely difficult argument to win with those who are antipathetic, whereas human rights and health arguments have a more receptive audience I think.

Lisa: But I think it was interesting that throughout the debates from a very early stage there was the tension between public health needs and criminal law attitudes, and I think we naively assumed that public health arguments would hold more traction than they proved to with quite a lot of the criminal justice system, and that was quite problematical at times. They also frequently turned it on its head, because I remember us arguing about how criminalisation would deter people from testing, and one of the responses to that was, "Well, we should criminalise people who don't bother to take a test, we should be able to prosecute people who haven't taken a test," which of course would have been disastrously in the wrong direction.

Catherine: Another point that I wanted to make, that doesn't follow on from Lisa's points, but follows on a little bit more from Matthew's. Going back to the question about other forms of law, not that I think we necessarily have the time to get into it, but it's also very clear in the way that people with HIV often discuss how they feel about the impact of criminalisation that in many cases they're subject to the criminal law for other reasons, so being a sex worker, being an injecting drug user, the fact that the first UK prosecution was against a heroin injector in

prison in Scotland, that was Stephen Kelly[1]. And also in discussions that I certainly had on a project that was happening at the time of the Dica case[2], but wasn't about criminalisation, where people with HIV were saying at the time that they felt that their sense of equal citizenship was under threat and I think that's about being a part of the package of feeling like you're part of a criminalised community anyway. The extent to which that was the case amongst gay men to me didn't really enter in to the conversation as much in terms of gay men's history of being criminalised, that was a more distant past. But the real threat of feeling like you might be removed and lose your immigration status, it meant that people felt that the punitive impact of this had far reaching implications because they did not already feel equal before the law.

Robert: I think also that worked, I'm going to talk about haemophiliacs because I'm a haemophiliac, and I can remember that the first time I really heard of criminalisation as an issue was Roy Cornes[3] who was a haemophiliac. It never went to court, there was never… well there was a sort of investigation but it was just a huge media episode, and I remember I was living in Berlin at the time, and I was so glad I was not in the country, because I thought even though I'm a haemophiliac, I've got HIV, there's huge amounts of sympathy for the haemophiliacs, there certainly was at that point, now people have just forgotten us. But I thought, "I'm so glad I'm not in Britain when this is going mad," and it really was going mad for about a month I think, and I just wouldn't want to be in that society when those awful things were happening. That wasn't legal so much as a feeling that I might get thumped, I might get spat at… again. So the issue, even if it never went to court, the impact it had on people who… I have no qualms, no problems with law around my status, but that had such a big psychological impact at the time.

Lisa: I also think that we were quite naïve in that we did have the warning of a case in Scotland, we had the warning of what happened with Cornes, we also had the warning of a case from Cyprus which involved an English woman, and yet when the Dica case hit and then several others in fairly quick succession afterwards, I feel that none of us had actually worked out our

[1] Stephen Kelly was convicted of "culpable and reckless conduct" under Scots law in 2001. Kelly had contracted HIV in Glenochil Prison, Scotland in 1993, where he was one of at least 14 people serving a custodial sentence to become HIV positive.

[2] Mohammed Dica was convicted of two counts of reckless transmission in 2003, which was the first conviction in an English court. An appeal was launched and won in 2004, then subsequently retrialled three times before being convicted on one count of recklessly inflicting grievous bodily harm in 2005.

[3] Roy Cornes was accused of deliberately infecting four women with HIV in 1992 but following R v Clarence, it was thought that no law applied.

position sufficiently to be able to counter the prejudicial arguments that were being made in the media. It was extremely difficult in the early days to get a good case across in the media about what was going wrong, and I think that's actually something that I look back on and think why did we not… why had we not scenario-planned for that? Because we should have seen it coming.

Catherine: That ambiguity was picked up on by people at the time, and in the research I was doing at the time, people felt confused because they weren't hearing a clear message from even within an organisation that they were dealing with. They might talk to different individuals who might have different perspectives, and it was a tricky time, and you were talking about that at the beginning Lisa, that there was a lot of settling of issues to be done within HIV organisations before an organisation could decide if they wanted to say something, what they were going to say, and then between HIV organisations as well.

Yusef: I think certainly it did develop over time, but I think it was quite striking that within a short time there was a strong consensus of opposition amongst HIV organisations to prosecutions for reckless transmission. But you're right Lisa, I think what we were not good at was explaining why we were opposed to it, and so in a sense our opposition was a cultural kickback and refusal to have a criminal justice system about which many of us had lots of suspicions anyway intruding on the lives of people living with HIV. And criminalisation also went totally against a culture in the HIV sector of community and solidarity, instead you had one person with HIV taking another person with HIV to court, so all those discourses of blame.

Lisa: I remember one of the guys from the first gay case that came to court, the guy who was being prosecuted turning to me and saying, "He's prosecuting me, what am I supposed to do, am I supposed to go out and prosecute the guy I know gave it to me? I don't want to do that." But there was this feeling that somehow people ought to be doing those kinds of things.

Matthew: But I think the other thing that is really important to remember is that there was never any strategic decision to criminalise disease transmission. Rather, as a consequence of case law in the late 1990's about nuisance phone calls, which effectively allowed lawyers to construct cases where you didn't need to prove assault which made Section 20 cases possible in the English criminal law[4] – of course it was different in Scotland at the time – was the reason

[4] This comment refers to cases in which the accused did not directly inflict physical assault but, rather, their actions were argued to have indirectly caused physical or psychological harm (such as fear and anxiety as a result of nuisance phone calls). (See Weait 2007, pg. 89-96 for detailed discussion).

why these cases became possible. And in the late 1990's when Lisa and others were working with THT legal service group with the Home Office around the reform of the Offences Against the Person Act, it was extremely clear in that White Paper[5] that there was no political will to criminalise reckless transmission of disease, it was going to be limited to the intentional transmission of serious disease. And the problem was that the Labour government which came in '97, obviously which is always the case with criminal law, it went to the bottom of the legislative reform agenda, and is still not something which has ever adequately been addressed.

In the 20 years since that's happened, the last Law Commission report[6] was in fact slightly retrograde in that respect and actually was more conservative than it was when access to treatment and those issues were more problematic, even though it was after the introduction of antiretrovirals. So, I think Lisa and Catherine are absolutely right about those and there was a recognition among HIV organisations that the prosecution of reckless transmission was something that we didn't want to encourage or allow. Even though the reasons for it were complex, the rationale for it, I think was on public health grounds. But I think there was a very strong recognition even if it was implicit, even then when there hadn't been quite so much research of the impact on HIV related stigma, that debate was much nascent at that time, and it wasn't nearly as mature as it is now. And the very fact that your serostatus could render you potentially into a criminal, simply by the decision of a lover to go to the police rather than to accept what had happened, and treat it as a health issue was actually quite strong at the time, and the government themselves *at that time* were on the side of those organisations arguing against it, it just never crystallised into any kind of legislative reform agenda. I think that moment has passed as well, I don't think that's ever going to happen.

Ceri: I was just thinking about when we launched the UK Declaration of Rights for People with HIV and AIDS. I don't know if people remember, but the Conservative Family Campaign launched a 'charter of responsibilities'[7] as a way of trying to counter our arguments. It was

[5] HMSO (1998) Violence: Reforming the Offences against the Person Act 1861 (consultation paper and draft bill) which suggested that there should be legislation making only the intentional transmission of disease an offence (i.e. this did not include reckless transmission). This followed proposals by the Law Commission (1993) which had, in contrast, suggested that the Offences against the Person Act should be reformed in such a way that both the intentional and reckless transmission of a disease was a criminal offence.

[6] Law Commission (2015)

[7] To coincide with the launch of the UK Declaration of Rights for People with HIV and AIDS, the Conservative Family Campaign launched their own declaration in response, 'HIV Infected Citizens: Charter of Human Responsibility'. The result was that the launch of the UK Declaration became a series of 'debates'

interesting how the UK Declaration, which had taken an awful lot of work and involved trawling through all the major human rights conventions and covenants in order to synthesise the rights which were relevant to people with HIV/AIDS was instantly met with a piece of work which bore no relation to any existing right frameworks but was merely an assertion of opinion. For example, they asserted that 'people with HIV should not prepare food to be consumed by others' – clearly this was based on no scientific evidence, and certainly not on any rights frameworks. It was a classic case of false equivalence: one a well-researched, well thought through and referenced document and the other literally a series of thoughts which seemed to have been drawn up overnight virtually on the back of a fag packet. Of course, the media picked up on that juxtaposition above all and the media was full of various members of the UK Forum on HIV and Human Rights arguing with Stephen Green from the Conservative Family Campaign – it was mainly him. I was just thinking when Lisa was talking there, can you remember the Moral Maze[8] incident, which was when the Moral Maze decided to wade in on this…

Lisa: Oh God, yes.

Ceri: It was a debate about criminalisation, prompted by the launch of the Declaration. The UK Declaration had sparked interest in the media and criminalisation was also being talked about at that time for various other reasons – so the programme went straight in on 'should people with HIV be criminalised', and the thing I remember about that debate particularly was that those of us 'defending', as it were, got a huge grilling: there were apparently more complaints about that programme and how it treated its 'witnesses,' including myself, than they had ever received before. I remember Janet Daley was on the panel and David Starkey I think too. I remember them saying to me, "Well, are you saying that people with HIV shouldn't declare their status?" And they were focussing on transmission in a work context, because that was the gist and gravamen of the Conservative Family Campaign's point, which was that people with HIV should declare their status if they're serving food and that sort of thing and essentially not endanger 'normal folk' in any way, as they saw it.

I remember for instance one of them asking me why people with HIV, who might suffer sight impairment, should be allowed to drive buses or trains, and answering that if somebody had

with the Conservative Family Campaign about rights vs responsibilities on all the major news outlets at the time, both TV and radio.

[8] A BBC Radio 4 discussion programme.

eyesight problems clearly they would not be a very good driver but that any job suitability – or lack of it – was based on individual assessments not on the 'fact' of HIV diagnosis. So the Moral Maze elided, really, the issues around disclosure and criminalisation sexually, with the other issues of disclosure in a wide range of other circumstances. That's what was going on at the time, and I do remember getting back to the ranch at the National AIDS Trust, and thinking that actually we need to get our arguments lined up on this one in order to be easily able to respond to this line of attack. Because at that time which was 1992 I guess, perhaps earlier, we just hadn't got those arguments easily lined up. So, all that public debate happened, and at the time you mentioned rights and somebody else would mention responsibilities.

Lisa: But it's easy to… we're remembering now but at the time the attitudes within HIV organisations it was pretty much like the Wild West. If you approached a local HIV organisation you couldn't tell whether they were going to be like MESMAC… you had people like MESMAC who were so anti-prosecutions that they would not speak to complainants, which I thought was dreadful because actually we found in speaking to complainants at THT that quite often you could talk them off the ledge, and also they were not being warned by the police as to what they would go through, and that you might be given the right to anonymity but if you were prosecuting someone who had been your boyfriend for a year, your friends would all know who you were. So, we found it really important to do that.

But at the other end of the scale, you had people like Sahir House in Liverpool who had a prosecution going on and the guy who was being prosecuted, his photo was on page one of the Sun and I rang them up to try and talk to them about the case and they refused to talk to me about the case because they said it was confidential, and I said, "Well, it's on page one of the Sun so it's not that confidential anymore." So, we had these really wide-ranging attitudes from different HIV organisations, and actually they were played out very much within THT as a big organisation, and I can remember policy forums within THT where I had a small number of staff who were perfectly happy with people being nicked and a large number of staff who thought that nobody should ever be prosecuted for absolutely anything ever, even intentional transmission. Trying to bring that together was very interesting and I'm sure we weren't the only organisation that faced that.

Catherine: I think the other contrast as well, we don't have any clinicians around the table, is that bringing in the question of HIV nurse specialists, HIV consultants, again there was a diverse range of views held, there were many clinicians who were working very closely with everybody here on trying to diminish the harm of criminalisation. But at the same time it was

becoming clear that often they… Lisa and Yusef, at your end when you were hearing about cases first emerging you were hearing that either public health specialists or nurses or consultants were actually sometimes instigators at the point of complaint. And so there was a fair amount of work to be done across the breadth of the HIV sector to find out what was happening there, and to again try and get more people on the same page.

Matthew: On that point, it's off out of the jurisdiction but it's worth remembering that the Ryan White Care Act[9] was one where, as far as I recall, states were eligible for the money for endpoint care for people with AIDS diagnosis only if the state had criminalisation statutes.

Lisa: Yes, that's right.

Matthew: In other words, there was a direct elision between an articulation of a certain kind of responsibility and penal accountability, and eligibility for funding to support care. That was something which I think impacted on a whole slew of doctors of course, because what they wanted to do was get access to money to support and care for their patients, the people they were looking after, and it was a very high price to pay. But it became enmeshed in that sense of… in that I think the point Ceri was making about the Moral Maze, the responsibility point, the health point, all became mashed up. And what Catherine says about the clinicians, I remember the first time I met Jan Albert which was at a conference in Vienna on infectious diseases, it wasn't an HIV conference, and we had an, insofar as one can have an incredibly impassioned conversation with Jan because he's a very measured man, from the Karolinska Institute, that at that time he was very sceptical about not criminalising. Because I think he felt that it was a disincentive at the very least to people to take risks with their own and other people's health, and he changed his mind absolutely over the period of about ten years and that was also because phylogenetic analysis became an increasingly important part of cases. Legal advocates, activists and others became much more aware of what the limitations of that science, that analysis, that forensics was, and it enabled some of the more egregious prosecutions to be challenged or ones where there were miscarriages of justice or there could be a significant risk of that.

But I think one of the most impressive things was that translation of a, I won't say predominantly because I've got no empirical evidence for it, but certain scepticism about decriminalisation among high level clinicians and public health doctors to, when I go to

[9] Ryan White Comprehensive AIDS Resources Emergency (CARE) Act (1990).

conferences now and you only need to look at the Canadian consensus statement[10], the Australian consensus statement[11], the Scandinavian statement, to see that there are a lot of people now who are unwilling to at the very least accept the legal logic or the legal way of framing responsibility even if all they're prepared to do, which is a significant thing for us, is to say that the probability of transmission is so small as to not constitute what a lawyer might think of as reckless behaviour. And that's been a really important thing, and I think that relationship between clinical… they have been quiet advocates in many ways, but certainly some of the more… can I just tell one story which is wonderful? I did some research on activism in the Nordic countries, and I was speaking to a very good, very well-informed Danish activist and he said, "Look, if I go in my Converse All Stars and my t-shirt to the Ministry of Justice and I say that there is no evidence that criminalisation has any positive impact on public health, and may have a deleterious one and impact negatively on stigma and discrimination I get one look. But if the consultant HIV clinician from the main state hospital, city hospital, goes and says exactly the same thing he will be listened to or she will be listened to by the Minster." And so that bringing in of professionals as one of the segments of activists and recognising who you speak to, at what point in the policy cycle, and who does the speaking, became incredibly important, and you saw this wonderful segmentation which you've seen ACT UP anyway in the '80s and stuff in New York. But I think that was one of the things that I began to notice over that period a lot actually, recognition of expertise and allowing the people who had the access and the voice to do the work. I think we've had this conversation, Yusef and I, about NAT being the lead in conversations because the status that it has in these debates means that it carries with it under the signature allies but sometimes that voice is the one that should go forward because it's the more credible one, I suppose.

Lisa: But also clinicians were incredibly important in sorting out their own house. I remember a number of early BHIVA and BASHH conferences where there were fairly… I talked about the slightly chaotic attitude in the HIV voluntary sector where people took very different

[10] Loutfy et al (2014). The consensus statement was put together by six Canadian medical experts and, in relatively simple terms, assesses factors associated with HIV transmission. It argues that HIV is much more difficult to transmit than is commonly assumed and that it is important that this is understood in order to prevent potential miscarriages of justice with regards to HIV and the criminal law.

[11] Boyd (2016). This consensus statement, written by leading clinicians and scientists, discusses current scientific evidence regarding transmission risk. It argues that, as the risk of sexual transmission of HIV between two partners with different HIV status' can be considered to be either 'low,' 'negligible,' or 'too low to quantify,' great care should be taken in deciding whether to move forward with a prosecution.

viewpoints, but the doctors were just an extreme range of viewpoints, and as you say some of them were actually dobbing their patients in which was utterly unacceptable.

Yusef: But I think it's important to, with the benefit in hindsight, or even now to realise that the… it's quite unusual within the world of HIV policy this particular issue because it's one where general liberal thinking and gay community thinking don't necessarily come with us. Catherine, I know, has done research on this, and if you did a survey of gay men even now, I think, and put the scenario within which someone would be prosecuted, most of them would say absolutely go for it. So, the position we found ourselves in which doesn't detract from Matthew's really good point that you can move people along the pathway, is that this is an issue where we were out on a limb, even within the constituencies that historically had supported us, and for, I believe, very good reasons we scrambled to a position over time rather messily, where there we at least managed to forge a consensus around reckless transmission and what we thought. But we didn't have our arguments as to why we disagreed with it really in order, I think I kind of probably have got them in order in the last year or so. But it was… and we're still in that situation, really, I think to a large degree. So, I was struck by what Lisa said about how we were on the back foot, because the ground had already been lost as to whether this was an issue that came within the ambit of the criminal law. And as soon as criminal lawyers start talking about criminalisation they come to one conclusion, or seem to.

Matthew: Some of them.

Yusef: Some of them do, yeah exactly. So, it was a great shame that the government didn't pass that draft bill and make it impossible for reckless transmission to be prosecuted[12]. Public health arguments didn't really have any purchase with the Crown Prosecution Service, and there is a public interest test that the prosecutors apply, but we found out very quickly that public interest tests do not encompass public health, and when we tried, as Lisa said, to make a public health argument around deterrents from testing – albeit, it was completely un-evidenced – their response was to allow, in certain circumstances, prosecutions even when someone didn't have a diagnosis.

Lisa: The public interest and the public duty argument I found was regularly used by the police to excuse behaviour like taking someone accused's phone away from them and calling

[12] HMSO (1998) Violence: Reforming the Offences against the Person Act 1861 (consultation paper and draft bill)

everybody in the phone and telling them that person had HIV, just in case they had slept with them. We forget some of these appalling behaviours that happened in the early days. I remember talking some British transport policeman down from going through somebody's phone that had over 1,000 contacts, because they had been doing a lot of online dating I think.

Marsha: I'm wondering does this follow on from this tradition of contact tracing for sexually transmitted infections generally?

Catherine: I think that's much more prevalent in lots of other health systems. But what I find really interesting about talking about our circumstance in the UK compared to someone in Canada or to colleagues in America is that, yes, their contact tracing mechanisms and the tying in between the public health role of the public health nurse who is keeping on top of somebody with a recent diagnosis, who might be in a bit of a chaotic situation, and the role of that public health nurse to potentially report if that person isn't following the behaviours that might be expected of them or a requirement that's been made in some way, they can be very quickly swept up and criminalised because of the nature of that system. And Matthew will know a lot more about this than I, but I think in Scandinavia again there's similar tying in. Whereas I think we have been quite lucky in the UK, we've got contact tracing, but to my knowledge it doesn't tie in quite…

Matthew: On that very point, which I think is very important about political culture more broadly and tradition, which is that in Canada, in Australia to some extent, and certainly in the Nordic and Scandinavian countries there is a much more public health orientation which sees criminal law as being a component of a wide array of powers which are framed in terms of public health. It might be a limit point but it's definitely within that domain, and one of the reasons why we have been fortunate in this country compared with some is the odd consequence of our criminal law being informed by an *incredibly* liberal political set of principles which treats sex and consequently HIV that might be transmitted during sex as a matter of contract. This means that if you disclose to your partner the risk to which they may be put and the person accepts the risk it's exactly the same as saying, "Will you pay me ten pence for this?" And somebody agreeing, and you can't then go back and say it was too expensive. That liberal framing of the relationship at an intimate level finds its way through contract, through criminal law and in all sorts of… I was just going to say going back to that, the contact tracing issue was always I think something that was slightly separate from the criminal law, and seen in a different domain of logic. I think that's right, and whereas in public health oriented systems that you find in countries such as the ones that Catherine mentioned, that's not the case.

Yusef: I think there was a bit of a debate, going back to Lisa's point about police officers, but police officers do have this concept of duty of care, and so they did use that as a reason in the early cases to claim a sanction to go and tell Uncle Tom Cobley and all, "That ex had HIV did you know that, are you okay?" But that the ACPO investigation guidance[13] which we may come onto which was developed, they took legal advice and that advice clearly said duty of care didn't impinge on this. So that was very useful in trying to intervene and stop this fishing for cases basically.

Robert: On that balance of public health and criminal law, I can remember amongst activists there was quite a lot of discussion of, "We need to use public health", and then when there were things like Matthew's research from Scandinavia and others, which suggested that public health doesn't actually always provide the answer, and that we could end up in a much worse situation. And we had the one case, I believe, in Manchester in the very early part of the epidemic where someone was held for an afternoon on quarantine grounds[14] because it was a gay man who had sex with other people, I don't know if there was disclosure or not but it was seen as a positive person putting others at risk. I can remember those discussions where it was assumed that public health was the solution, the answer, that it would just get rid of it if we could all force the legal system to adopt a public health approach, and then somewhat reining back when there were those sorts of concerns.

Lisa: I remember at quite an early stage using the argument about, I think it was Sweden, where they had a sex worker under house arrest for something like five years until the European…

Matthew: Yes, seven years.

Lisa: I was always very dubious about public health laws because of that, because basically if you've got a law and you want to do something with it, nine times out of ten you can, and actually public health laws potentially were actually far more draconian because they didn't involve juries and things like that. Although juries were hopeless in HIV cases, because once we started talking about phylogenetics and stuff like that, I can remember watching juries' eyes just glaze over, and there were a couple of cases where I remember the judge having to direct

[13] National AIDS Trust and Association of Chief Police Officers (2010)

[14] In 1985 the Public Health (Infectious Diseases) Regulations 1985 extended certain provisions in the Public Health (Control of Diseases) Act 1984 to include AIDS. This introduced powers to detain a patient who was thought to be a risk to others and in a 'dangerously infectious state'. This legislation was only used once, in September 1985 in Manchester.

the jury because I could see from the juries' faces, one case in particular which was two gay men. Frankly, if they'd had a chance to they would have convicted both of them just for being poofs who had a lot of sex. But it was complex, and it's as complex as fraud cases actually, and a lot of juries were very thrown by phylogenetic evidence. But it was very useful as well.

Catherine: I remember a particular point, and other people may have different timelines on this, but it felt to me that by 2005, which was the year of the ESRC seminar event at Keele, that started to become the time when collectively we were much more in problem solving mode, we were thinking through and past some of the problems of what we have just been discussing about the limits of the public health argument to try and influence changing criminal law and that kind of stuff. And we invited colleagues working on the same problems from South Africa, America, Canada, to help us to think through what some of our own solutions might start to look like, and to me that started to feel like a bit of a sea change. I remember walking away from those events at Keele University thinking, I seem to remember us having a bit of a mantra about dealing with it the easiest… picking the lowest fruit on the vine, trying to tackle some of the issues that we had access to, and trying to ensure that we had a very much united message so that communications were streamlined, people being referred in were streamlined, straight through to Lisa and Yusef, so that there was actually a plan and an approach. But other people might not see that in the same way that I recollect it.

Yusef: No, I think that's right, it's about… Well I wasn't there before 2004, but I certainly think that conference that Matthew organised at Keele was a very important one in terms of getting some degree of consensus and forward vision. It was about the time we were beginning to grapple with the CPS who in October 2004 had at last agreed to develop a working group and develop some guidance on the issue, but it hadn't yet… we were in process, and it was often painfully slow depending on the official that we were dealing with.

Lisa: But let's be honest, the first official we dealt with actually hid in the toilet rather than come to the meeting with us at one point, and it changed… What made me often angry about this was that it was so much down to personalities, because we had real trouble with the CPS, and I'll hold my hand up that I was nibbling at them by sending them naggy letters, and it wasn't until Yusef threatened them with equalities legislation because it was migrants, particularly black migrants who were suffering clearly disproportionately, that they came to the table at all, and they started off by giving us an official who was utterly useless and didn't do anything. It wasn't until we hit the right official that things really started to motor, as with so many other things it was getting the right person.

Matthew: Yes, it's certainly the case I think that if the first cases had been of heterosexual white men that would have had far less purchase, and I think that you're absolutely right, it goes back to that earlier point about the way in which race, ethnicity, being a member of a group at heightened risk, or a key population member like a drug user or injecting drug user, was in a perverse but useful way a good lever into some discussions with people who were conscious. Because it was relatively recent I think that the CPS had had experience of being subject to judicial reviews and reviews based on race discrimination around process and the way that they were organised. I think they were very acutely sensitive at that time, and you hit that at exactly the right moment for them to think that this was potentially an issue that they had to address.

Yusef: I think that's right. There's that whole thing when looking at the history of any movement about, and both Lisa and Matthew have hit on it, that luck is a very significant explanation of what happened. We got, in the end, the right official at the CPS, but the CPS were also in a place, and had begun doing this in 2002, where they had begun to develop guidance around socially sensitive areas of prosecution policy, for instance domestic violence, and rape, and race hate, etc. So, they had worked out a process and we were plugging in to a system that had got up and running in the previous two or three years, and that was, agreeing with what you said, very helpful and timely from that perspective.

Robert: I think also, though, whilst we hit on the right time and got a procedure for developing policies, they were scared around issues of racism because of other issues that had happened, the fact that they started by prosecuting black African migrants was I think because they were seen as much more of an 'evil figure,' and it was easier to get a prosecution and a conviction and that's why you went for them to start with.

Lisa: Well, you say that but there were a couple of white UK women prosecuted at a very early stage as well, and particularly a very young very vulnerable girl in South Wales, and both the cases against the women were, to put it politely, egregious in one way or another. But the same issues applied, but I think the thing was it was just ridiculous. There were all these cases about heterosexuals and particularly migrants, and not about gay men, and when it boiled down to it once we started to get the CPS guidelines in place, and once phylogenetics started to play a position, the issue was that most gay men were having more sex and it was bloody difficult to prosecute, because you couldn't tell who had given what to who.

Yusef: I agree with what Robert said that at some fundamental level, how can it be surprising that the first infectious disease prosecuted was HIV? How is it surprising that the first man

prosecuted was an African asylum seeker? And we know the social construct that made that possible, and I don't think we can brush that under the carpet. But Lisa is also right, and I did an analysis – the cases are few in number – but of the cases that went to court, the identities in terms of gender and ethnicity of the accused and the identities of the accuser, and the bias in the cases is in fact, in my view, more to do with the bias amongst complainants that they tend to be British born heterosexual women or…

Matthew: You are absolutely right, that's exactly right.

Yusef: And given epidemiology will mean that there is then a bias towards African partners because there's high prevalence in the African community. Then they are poorly treated because of racism in the court system.

Matthew: But also, which is very interesting on that point, is that when you look at the biographies of those female complainants who brought the cases, I think of the person who was known as Deborah who was the complainant in the Dica case who I subsequently met in another context. I sat through the third Dica trial all the way through and saw the back of Deborah's head through the entirety of that trial. What was very interesting is that they were quite often, I can't say quite often because again I don't have the empirical evidence, but certainly from the newspaper stories of those cases that went forward they were quite often women who had been married, with families, who had been – and I don't mean this in any negative way – they had been seduced by the possibility of an affair, they had put a lot of trust, they'd given up a lot of security in order to enter into an exciting sexually fulfilling relationship with somebody they didn't know terribly well, and so the fall, if you like, was all the greater. Because I remember in Deborah's case, she was as I recall married with kids and a husband, she met Mohammed Dica in a nightclub in Thornton Heath (how glamorous can it be?) and she had an affair with him and…

Catherine: Hey! I used to live there.

Matthew: Yes, well I know it very well, I'm from around the corner. But the point is that for many of these complainants the person… it wasn't necessarily, I don't think, and I still hold to this, the fact that they had HIV. I think what marks nearly all the cases of course is people who felt let down by somebody in whom they had placed explicit or implicit trust, because the number of cases where people weren't disclosing their HIV status which could have gone to court but didn't because they wanted to remain in the relationship – they wanted to sustain a

relationship, and you don't go to the police if you want to sustain a relationship – is of course much greater than the ones that we saw. But it's that biographical story about trust and relationships, so I think that's a bit of the analysis that we've never really focused on, because we have focused on the doctrine and the law reform rather than looking at the empirical, the biographies of the complainants which I think is one of the most significant drivers of criminalisation, not the law itself.

Lisa: My observation in dealing with a lot of cases where there were investigations but never made it to court, because we would get them through the helpline and through local offices, was that there were a very large number of cases where people brought a case or made a complaint not when they discovered they had HIV, but when the relationship broke up, and it was grudge complaint over and over again. We even had a couple of cases where basically people had been barred from contacting their ex because they were stalkers, and they then made a complaint about HIV because it was the only way that they could get through that barrier. So yeah, it was absolutely an issue of it being something you could throw at people.

Matthew: The law being used to deliver a sense of restorative justice in an intimate context, and in that sense it has a lot of parallels with historic child abuse prosecutions, where people don't necessarily think they're going to be successful, because they're usually advised by counsel that the chances of success in a prosecution are very slim, but what they want to do is confront the person with their moral turpitude in a forum where they're treated seriously and they have the opportunity to have that articulated. They don't as you said earlier, Lisa, realise that they will in the criminal justice process as it's constructed be treated as much to very invasive questioning, medical testing, contact tracing as the person who is the person complained against, and that is quite often the reason why people don't pursue. And of course that raises a whole other set of questions about, and I know that was a debate at THT, representing as it were the interests of both parties is very problematic because if the law is available to people then they shouldn't be denied the opportunity of using it if it's there. We might have our own policy views or own views on it, but the discriminatory deployment of the law against 'good' complainants and 'bad' complainants is also very problematic.

Catherine: I remember George House Trust had a very firm policy on that at that time.

Matthew: Yeah, in Manchester.

Marsha: Can I just play a bit of devil's advocate here, because what I'm wondering is this, if we're talking pre-treatments so…

Matthew: No, all post treatments.

Yusef: And that's the interesting thing, that actually when HIV transmission and diagnosis did really mean that you had a very high chance of dying and fairly soon, there were no prosecutions, and…

Matthew: Well people wouldn't turn up being alive.

Yusef: The interesting thing to speculate about when it was mainly a gay epidemic and with horrific consequences in terms of life expectancy there were no prosecutions, and prosecutions actually began at the time where there was the beginning of a significant increase in heterosexual transmissions and antiretrovirals were on the scene, and it was almost as if the 'normalisation,' (I'm using that word with heavy quotation marks) of HIV, prior to those, when it was just a gay epidemic, and it was a death sentence as it were or deemed that way, it was almost beyond the law. But when HIV suddenly became something you could live with and heterosexuals and gay men were both experiencing it, it came within the compass of social norms and expectations.

Lisa: But people hadn't picked up on treatment being lifesaving still, the message had not got through, yet you're absolutely right about the timing. But I would say that actually most people hadn't had that message, and particularly the heterosexuals who were becoming infected, you're absolutely right about that point as well, because it was clearly a case of "How could this happen to me?" syndrome, and I don't believe they understood treatment.

Matthew: Coming back to what Yusef said because, I have thought this for really quite a long time, is that living with HIV then exposes some people who are living with HIV to an enduring experience of discrimination and stigma potentially, and therefore it's a life of living with that rather than as you say a death or an illness associated with living with it, and that's really critical, because people have time to think about the law. Before 1995 I think it's fair to say that what I recall of cases was that there was pity, tragedy, a significant amount of fear, which moved into something slightly more subtle. Because once you could live with it you could take responsibility, and we knew about how it was transmitted and prevention and treatment became available, then responsibility for keeping it in *you* became a discourse which framed the

accountability and responsibility which then translated into the use of criminal law to shore that up.

Yusef: That's what I was trying to say because the point about treatment was not that complainants were aware of it, but that the people prosecuted, as it were, as people now living for longer with HIV became people who were subject to expectations of responsibility, both internally and externally, and social discipline. When you are deemed to be, as it were, on your deathbed there is a hesitancy I think about the law intervening, and going back to the CPS public interest test, the public interest test would apply in terms of whether you prosecute someone who is really terminally ill…

Lisa: But also, quite a lot of not just the early cases but for quite a long time great play was made of stuff which was no longer scientifically accurate. I can remember women complainants sobbing in the witness box that they could never have children now.

Yusef: Absolutely, there was a Scottish case.

Lisa: Which was utter bollocks and we knew it. But defence solicitors were saying, "We don't want to challenge any of that because it makes us look unsympathetic".

Yusef: Well we still have that problem with the prioritising of the victim's statement. I do understand where it comes from and respect that but actually it is very problematic in HIV transmission cases, where people say, "I can't have children," or what have you, but also going back to the point about assault cases, we see it almost every week or two in the press, a police officer saying, "I wasn't able to touch my children for six months whilst waiting for an HIV test result," and the court just laps it up, and no one challenges it, so it's still a problem.

Robert: That is interesting. I tried to do some research going back as far as any cases around transmission, and the only one I could find before 2002 which was when Dica started, other than that there was a surgeon or something who was prosecuted for herpes, there was one in '95 but it was a woman stabbing someone with a syringe[15], and there was no discussion of… There was nothing in it which said whether there was transmission or not. But at the point when there was no treatment or a perception of no treatment it had to be an assault of a different sort, there just wasn't those types of things, other than that brief period with Roy Cornes around,

[15] A 25 year old woman was convicted of administering a noxious thing and spent two years in prison before being deported (Bowcott, 1995; Horsnell, 1995)

"This should be brought in as a law," I remember. And also with his case I can remember when I was reading it, and I knew it was obviously wrong because of the way they described the system of how they were giving money out to the number of women who had become infected, it didn't make any sense, because obviously I knew what the system was and they wouldn't have got money in those circumstances.

Matthew: And of course it's also really interesting, I've become, I think, much more radical in my thinking about this than I was ten years ago, in that I would now think that there are arguments for decriminalising intentional transmission that I'm working on, on the basis that I don't want to think of HIV as a harm that the criminal law should concern itself with. I know it's a more radical position than lots of other people take, but it's interesting that when you think about the Danish case for example, in 2011 they suspended the law, they haven't reintroduced the law for the last seven years[16]. People are acquiring HIV, not as many as used to be the case, and the only thing that's different is that you can't go to the police and use that law, and Luxemburg forgot to criminalise I think, Bulgaria I think is another country in Europe which doesn't have an HIV law, because they just didn't do it, and all that happens is that somebody who acquires HIV in the context which in England they could go to the police treats it as a health issue, or under the general criminal law if it meets the general standard for an assault, which of course is what we do in this country too. But there, you don't get prosecutions, and it is framed within health.

One of the things that makes me more angry, I think, than anything, is the accidental nature of how this happened in this country and the lack of any kind of strategic engagement. But then I became convinced, partly through conversations with Yusef, about the fact that we really shouldn't be arguing for decriminalisation on a radical basis because it just brings it above the parapet. Whereas, it's actually being managed through relationships with the police, relationships with prosecutors, building up education with people so that they recognise that they are going to filter out the least worthy cases or the least egregious cases. And we leave it on the books because symbolically it's important for the public to know that it's there, but you do the decriminalisation activism through management of process rather than what's on the books. And I think there's been a long debate for a long time.

Lisa: It's frankly a very English response to do what we did.

[16] Article 252 of the Criminal Code was suspended 17th February 2011 (see Bernard, 2011 for more detail)

Yusef: It was a harm reduction.

Matthew: Yes, it's a harm reduction mechanism, exactly right.

Lisa: I did a piece of comparative work between England and Wales, Denmark, which you've just brought up, and the Netherlands, and we each approached it in very different ways and came to roughly the same conclusions, and the Netherlands has now actually really motored ahead. But I think it's fair to say that there are a number of different ways of approaching it, and none of them is perfect unless you can actually get the laws abolished, if you've got an actual HIV law. But all of them have risks attached to things possibly being revived.

Catherine: I recently asked Yusef if he could get a colleague to send me an updated table, because NAT collects data on publically available information about prosecutions, and Yusef I was so glad to get it, but it didn't tell me what I hoped it would, because looking at it, it did really surprise me. I wanted to be able to use it to say that there's been an extraordinary reduction in the number of prosecutions for HIV transmission in England and Wales, and it doesn't tell that story.

Yusef: No, it's pretty steady.

Catherine: There's been a reduction probably in complaints, although we can't…

Yusef: We don't know that.

Catherine: For sure. But there hasn't been the… We can make an argument that we've probably kept things to a bare minimum and I very much believe that we have. But what do you think about that?

Yusef: I think that's right. I think, talking to Ellie O'Connor who is a police officer who worked with us on the ACPO guidance and got a lot of calls from police officers asking for advice, she did have the sense that the number of cases being investigated had decreased, but of course that's just anecdotal. But I think the fact that there's a complete disjunction and it goes to Matthew's point about the whole arbitrariness of all of this, there's no real relation between a prosecution that gets to court and the epidemiology of HIV in the UK. These are weird cases that somehow get through all the various evidential hurdles or what have you, and so they don't really tell us much about anything… One or two a year, what does that tell us about either who is getting HIV or indeed what people think about prosecutions? The numbers are so low it's so hard to infer anything. I think it will be interesting to see with now the new policy of immediate

treatment on diagnosis, the extent to which that has an impact. It will certainly mean that people prosecuted and get to court will be people who often have chaotic lifestyles or poor mental health or some other ways can't access services, and so are actually in need of something very much other than a prosecution. But yeah, I think you're right that there's no evidence at the moment of decline in the actual cases.

Lisa: When I was looking at cases, and this would be in 2008 to 2012 maybe, one of the markers was having a very persistent complainant because quite often police would take a look… There were a lot of complaints where police looked at a case and quite often decided that it was more trouble than it was worth basically, although that was cloaked in a number of ways. But if there was a very aggressive or persistent complainant it would get taken up again, and those were some of the cases which took the longest to go through the justice system because the police would haver about them. They would let them lie around, then they would go to the local CPS and the local CPS would haver and they might drop them and then the complainant would come back and have a go and they would pick them up again, and that was quite difficult.

Yusef: I think that's right and I think the other thing, definitely a persistent complainant but the other thing is the persistent police officer, because we often found cases – and Lisa and I have talked about this – where it's clear there is no case to answer, for example no HIV was transmitted, and yet the police officer clearly thinks it cannot be right for someone with HIV probably to have sex at all, and certainly not to have sex without disclosing their status. And so there was one case that we dealt with where someone was being investigated, had been arrested and was on bail, and was being investigated for actual bodily harm for the psychological distress of having had sex with the complainant and not having told them and she claimed the psychological distress was such that she had been effectively assaulted, and that case ran on well over two years as I recall with the guy on bail, possibly chargeable, and we knew there was no case to answer, and it was immensely difficult to get the system to function, because the police officer was so insistent that something should be done.

Lisa: Well I think that case is actually in… I've got a document, I actually did investigate the timings of a whole bunch of cases. But there is a clear pattern in some cases of the police holding on to hopeless cases, and I've seen this in other bits of criminal justice as well, dragging things out because they can't actually prosecute someone but they can make their life a misery for a year or two.

Yusef: And I think in parenthesis, the problem of views of HIV amongst police officers really feeds in to the experience of these criminalisation cases, and the argument that the police have recently put forward to impose spit hoods on people has been about risk of HIV and hepatitis[17]. You simply cannot get HIV or hepatitis from spitting, and there is a bill currently going through parliament which has every chance of becoming law that would allow police to compulsorily test people for HIV and hepatitis if they assault emergency workers. Again, there's no risk of transmission, so one driver of this whole thing is, in my view, police officers feeling something should be done about HIV and it relates to the function psychologically that I think HIV has for many police officers as a signifier of the risks they undertake in going out into the streets, which of course I have every sympathy with. But somehow there's this cultural fixation on HIV and maybe now to a degree hepatitis too, as an indicator of their vulnerability as they go out and deal with difficult people, chaotic people.

Marsha: So, you're saying something more than because HIV is a sexually transmitted infection, and that this is an issue about… a moral anxiety about sex, you're saying actually there was something more happening?

Yusef: Well it's both, and certainly moral views about sex and disapproval of the sex lives of people living with HIV is absolutely at the heart of a lot of what drives us. But I just wanted to broaden it out slightly to say that actually within, certainly the legal enforcement system and amongst police officers there is a wider and very deep seated and utterly un-evidenced worry about HIV, which I do think feeds in to how many of them, not all of them, approach and deal with a complaint, even when you have it on paper that there's no case to answer.

Matthew: Of course this is right. One of the things HIV does, is it troubles victimisation and agency significantly, so that there are worthy and unworthy complainants, there are worthy and unworthy experiences of risk. The gay man who agrees to have sex with a person who may or may not be positive without taking precautions is an unworthy complainant. The police officer who goes out will be a worthy complainant by virtue of status, and therefore is in a much

[17] From around February 2017, a number of police forces announced trials to use 'spit hoods' to stop officers being bitten or spat at (Avon and Somerset Police: BBC News, 2017; for example, The Metropolitan Police: Metropolitan Police, 2016; Humberside Police: Wood, 2017). Press coverage and debate regarding the use of spit hoods has often made either an implicit or explicit link between spitting and HIV and Hepatitis C. In response to wide debate about the issue following announcements that a number of police forces would be trialling the use of spit hoods, Terrence Higgins Trust (2017) and National AIDS Trust and the Hepatitis C Trust (National AIDS Trust, 2017) put forward statements urging police forces to stop linking spitting with the transmission of HIV and, in the latter, Hepatitis C.

broader social understanding of the role that the person is playing in the moment that risk is… It doesn't matter whether it's a real risk or not but what the risk moment happens or crystallises is the roles which people are playing at that moment. This is absolutely determinative in some sense of what the subsequent outcome may very well be. I think it was Paula Treichler (1987) who wrote this phrase 'epidemic of signification,' and absolutely that has not changed, and when the number of cases doesn't diminish over time it doesn't surprise me in the slightest because we only know about those cases that are reported, and my guess is that there is a certain editorial hunger and value to, I'm sure it's not done in a strategic way, to having every three to six months an HIV transmission case on page two or page one of the local or national press depending on how serious it is. Because what it does is it reinforces a sense of HIV as being a marker not necessarily of risk to health anymore because it's very difficult for that narrative to be told, but a narrative around securitisation, and it doesn't surprise me at all, and I think I wrote about this when I wrote my book (Weait, 2007), but I haven't read the chapter for a long time, but it was very interesting how the cases on criminalisation from the late 90's into the 2000's onwards mapped – certainly from 2000 onwards – an entirely different approach towards terrorism and the way in which people were marked out as being people who should be investigated at airports by virtue of belonging to a particular category.

Their risk was instantiated and imminent in them being somebody who wore a niqab, or somebody who wore a turban, or somebody who presented as Muslim or something. And that story about, it wasn't about real risk, because 99.999% of people travelling with a turban or wearing a niqab or presenting as Muslim present zero risk, but it was a very attractive narrative if you want to reinforce a particular notion of the security state. I don't want to overblow it in this conversation about HIV, but it was fascinating to me that HIV narrative about risk really embedded and ran parallel to that as if HIV was… and there's a Michigan case[18], some of you will know about it, where this man… The prosecution was stopped because Lambda[19] did its work. But it ran for about a year and he was prosecuted after a cat fight with a neighbour, and he was living with HIV but there was no transmission of course, but there was a biting, and he

[18] After entering an altercation with a neighbour and biting him on the lip, the accused was initially charged with assault with intent to maim. After later revealing his HIV positive status in a television interview, the additional charges of bioterrorism and assault with intent to do great bodily harm less than murder. See Sinclair (2010) for more details.

[19] Lambda Legal are a non-profit organisation who provide legal assistance, lead education campaigns and advocate on public policy in the interests of advancing the civil rights of lesbians, gay men, bisexuals and trans* people.

was prosecuted under Michigan's bioterrorism legislation on the basis that his body was a biological weapon within the meaning of the statute. And that case really said it all, it really was so absurd but it carried through the process because it fitted into I think, well law operates by analogy, this is one of its biggest problems, and why not? Why shouldn't it?

Yusef: In the early days of the media narratives around the HIV cases, people with HIV were called ticking time bombs, you couldn't have a better terrorist framework for it.

Catherine: And judges were using the word biological, wasn't it in the reporting I think from the Dica case, wasn't the word biological used?

Robert: Biological GBH.

Lisa: Yeah, biological GBH. But also in France the early cases were prosecuted under a poisoning law.

Matthew: And we could have done that here but nobody ever bothered.

Catherine: [joking] Don't tell them!

Matthew: We could have done but we really can't. Is this being recorded? We can redact that bit [laughs].

Lisa: But I think using the very loose 1860's assault law was both a burden and a help in some ways. It enabled us to find an awful lot of loopholes and an awful lot of ways of tying people up in red tape, which is a very British response to a problem like that. But it was at least as effective as a number of other countries who went much more for the jugular but had much less success in changing rather unpleasant egregious laws.

Robert: That issue around risk and the status of having HIV and securitisation also had a history in the US just by banning people with HIV from entering the country[20], and that was very much on the grounds of risk. They will come here, they will have sex, they will spread this disease, and yes this bizarre idea that everyone with HIV went on sex tourism trips to the US.

[20] People living with HIV were not able to enter the USA from 1987 onwards, following a U.S. immigration measure which prohibited people living with HIV from obtaining tourist visas or permanent residence. These measures were later repealed in 2010.

Catherine: We started touching on it, it was in my mind right at the beginning so it's worth saying for the record that the issue that we were talking about a little while ago about the vulnerability of complainants, the particular biography of complainants, and that at the outset there was a narrative about this being, not entirely, but a lot of women complainants who were white heterosexuals, and the fact that we never really did explore the gendered dimension, feminist dimension of some of the challenges that presented us with. And I know a number of us found ourselves in public spaces, sometimes with these women in the room and were talking about the theoretical problems of the law, the structural issues that are going on, and then a woman would approach you and say, maybe Debra or a number of women involved across some of these cases. And there was a fair amount of emotional labour to be done there amongst ourselves and some real thinking to go into how we think about vulnerability and trust, how we pitch a position that is very significant and important at a population level but what obligations do we still have to help an individual feel like they're heard and supported. And that matter of retributive justice continues to underpin this, and I was thinking, I think it might have been Chief Justice Wolf who was sat on the appeal for Dica's case, I might have that wrong, and he was quite a leader in thinking and academic writing about restorative justice.

I did a lot of thinking about that at the time, and just for me it doesn't really take this conversation we're at right now in any particular direction, but I just think it's something that will certainly create… It was a very productive part of what we all went through and what a lot of our colleagues went through in those earlier days perhaps. And because I am not close to any of the cases that are happening now it still might be the case that that's an ongoing sense of challenge for people who are close to the cases but worried about the harms brought about by the law in general.

Lisa: I could certainly say talking to women who have been complainants in prosecutions between the mid-2000s and past 2010 as well, being brought in even after I'd left THT to talk to people sometimes, women had often been told that it was important for them to put this person away so that they could not do it to someone else, and they hadn't thought through the fact that actually what they were going to do was get someone two years in a nick where they were quite likely to pass it on anyway because they might not have access to prevention measures, and then they would be out again having had absolutely no kind of support to change their behaviours. So that wasn't going to work. They were also frequently given very misleading timescales, they thought the whole thing would be over in a few months, whereas in fact it often spread out for a very long time, causing them significant mental health issues.

And the other thing was that far too many of them had watched CSI and Law and Order and things like that, and they thought we had an American justice system here where they would have their own attorney, and the idea that actually they did not have a place except as a witness effectively in the whole prosecution and court case, and also that if they got cold feet they could be threatened with a prosecution for wasting police time, came as a hell of a shock to some of them.

Catherine: But at the same time and in the narrative right now that's gone on about rape cases and difficulty of police collecting evidence from rape cases, and I do wonder actually within the current context just how much of this has to be collected for an HIV case if that's also an issue to be considered. There is a tension there in terms of what's being said and what we think and what's being discussed, I think with women in particular, because I wouldn't want women to be told not to pursue a rape case because it's really intensive and people might find out who they are, and yet we have competently handled, and I think with good reason making some of those arguments about these cases to women, and I don't want to derail he whole conversation with…

Lisa: But it's not about deterring people. We thought this through quite a lot because we were often dealing with complainants, and it's about letting someone know what they're in for, and it's up to them to decide whether they can handle that, but it's not giving them a false impression of what's going to happen in order to get them on side, which was what the police very often did.

Yusef: But I think you've hit on an important point Catherine which is, I have always been against prosecutions for reckless transmission, but I've always felt the force of the argument the other way, if you see what I mean? But for me the problem is not that these people who take cases in many instances have not been badly treated (it depends a bit on the case) … many of them <u>have</u> been badly treated by their partner. But there are also a lot of other people who get HIV get it from a partner who says, "Yes, I will be faithful to you," and then sleeps with someone and then someone else and passes HIV on, they can't be prosecuted because they passed it on before they were diagnosed. So, for me the fundamental problem with the current state of the law is that actually reckless and irresponsible sexual behaviour is endemic in society and has been ever since we existed as human beings, and we are picking on one group who happen to have an HIV diagnosis as symptomatic of a much broader ethical failure, and you either prosecute more or less everybody, or you stop prosecuting at all, and that's the position that we hold. Because actually, and particularly with immediate treatment the vast majority of

transmission will be from people who are undiagnosed, many of whom however will know that they have put themselves at risk and are putting sexual partners at risk but nevertheless carry on and do something, and they are completely outside the scope of the criminal law at the moment. So that for me is what's fundamentally wrong about the current situation. It's discriminatory, to put it simply.

Ceri: It's interesting, when we launched the declaration I remember there was that moment where you had 'fought the dragon' in terms of the nasty Tory campaigns in circulation, and then things died down, and then there was a, "So what now?" moment. So the UK Forum on HIV and Human Rights, which continued after that initial launch had to think, "Okay, we created this because we know that the rights of people with HIV and AIDS are threatened or being undermined so what is the best thing to do now?" And what we did was have a series of working groups which looked at specific institutions – prisons for instance – and/or target groups (such as children, or women), and essentially considered HIV and human rights issues through a much more specific prism of those institutions, or that target group.

I was just thinking about that when listening to people because it connected in my head with what you were saying, Yusef, about the policemen and the testing from the perspective they fear that they may be being assaulted by somebody with HIV and so want to introduce a completely pointless measure – the spit hood – to 'defend' themselves against that. What I think we were aware of right after the launch and in the thick of 'the crisis' was that the way forward really was towards a more robust, all round human rights approach for everybody rather than disaggregate people with HIV and AIDS as 'special cases,' and that was the route we pursued, with various degrees of success. And what struck me about that spit hoods story was that the gradual erosion of human rights and decreasing popularity of them and the way in which they're viewed has an undertow effect on our capacity to assert human rights of anybody, including of those with HIV, doesn't it? I see it in refugee and migrant discourse as well, where the unprovable, what you can't actually defend is held up as, "Well I don't care, that's what I need in order to feel safe". So around migrants you see it all the time, "Migrants take jobs," no they don't, there's evidence, "Well I don't care," and constantly there's that picking away of the rational and the evidence-able in favour of emotion-led measures and policy. Actually if you just have a robust approach to human rights that solves an awful lot. But 20 years down the line we're in a very different place from where we were in terms of an acceptance that 'human rights' are a good thing.

Matthew: I think that's a really good point Ceri because I think one of the things that is very easy to… It's very difficult to do the double blind control experiments about what would happen if you've had the law and didn't have the law because you simply can't do them, and yet one of the things that's quite often prayed in aid by advocates, so I'm going to say advocates for the status quo, not necessarily advocates for introducing criminal laws but people who don't buy the argument for decriminalisation, is that they don't need to provide any empirical evidence to keep it on the books, but those who wish to remove it from the books are held to a very high evidential standard. And if you say, "Well, we haven't got the evidence but we think it's wrong and you're saying we should have it because we think it's right," those are unequal power moments, and it's incredibly difficult, which is why I think Ceri's point about broader rights based framing of some of these issues and thinking about it in the context of what Lisa defined as the very English or British way of doing it, about the process, is very important, because it's judicial review.

It's rarely the case that you will win on substantive merit, you will quite often win cases on process, procedure, the evidence was flawed, it was introduced when it shouldn't have been. If you're going to win an appeal it will be because the jury were misdirected as to the weight they placed on evidence or it should never have been admitted, and those are procedural adjectival wins if you like rather than arguments about substantive principle. And that's why the CPS and the prosecution guidance work, the ACPO guidance, the work that I don't think was as mature as it could have been and was very problematic about providing bench books for judges, but that work that was done as well about judicial training is in fact the level or the stratum within which this work needs to happen. Because the point that you made about the migrant and refugees Ceri about saying, "I don't care whether there's no evidence that they don't take our jobs, it matters to me in terms of my national identity, that I believe that they do," and that's really difficult, because if people are working on that kind of alt-fact fantasy world of outside logic or outside reason the only way in which you can engage with that to try and deliver some progress is by playing the same sort of game.

I was reminded of N[21] the case of the woman who lost her appeal in the House of Lords as it was about being returned to Uganda, and one of the things that was most grotesque about that case was that if she had been on her deathbed she would not have been returned. And so the success of treatment if you like was, and the fact that she was well, and the fact that she might

[21] N v. Secretary of State for the Home Department [2005] UKHL 31

go back to somewhere where there was less effective treatment, and an acknowledgement by those judges delivering their opinions including Brenda Hale, now president to the supreme court, recognising that she would die earlier or die sooner was not a relevant consideration for the determination of the court. And it struck me as being one of those grotesque legal logics that if you are really, really, really sick and about to die you can take advantage of human rights, but if you're actually fine it's okay to put you on a plane, and that has been a logic that has followed through in this in so many cases, we've just got to accept that we're living in a topsy-turvy looking glass legal world where you take what you can get and you use the best activism you can and you take the small victories and in aggregate they actually have achieved a lot.

Marsha: I was going to say because some of you may want to leave quite soon, how you feel about the current situation? Is there anything that you would want to add to what we're currently dealing with, if anything?

Yusef: I'm not sure. I think at least in theory the number of people who have a diagnosis that are infectious and thus can be prosecuted, or at least get to court will become lower and lower, and of course we're also seeing declines in HIV diagnosis at least in London amongst gay men. So, you would have thought whilst accepting the point that these cases are always the ones that got away and so we may not see much of a decline from one year for a while, there may be a decline in investigations and prosecutions. I think though, that, I don't want to change the subject but to talk about the spit hoods again briefly, and this Assaults on Emergency Workers Bill[22], this is redolent of fears of HIV from the 80's and early 90's, and so I think there's a broader concern about the policing in my view. Why is the government supporting and the opposition frontbenchers supporting this private members bill, Chris Bryant's bill? So, I worry that in the broader scheme of things as HIV to some extent comes off the political agenda there will be a going back to automatic default responses rather than well informed responses because the powers that be are in ongoing conversation…

Matthew: I think one of the reasons why the struggle, if you want to call it the struggle, must go on is because although we know it goes back to the 1920's, the first AIDS cases in the early 80's in the west, within ten years there will be another disease. There will be another disease which is not HIV, which is possibly even harder to treat than HIV. HIV is relatively easily treatable now. I am not talking about scare stories about drug resistant TB and those things, but human history shows us that as climate change happens, as overcrowding happens, processing

[22] Assaults on Emergency Workers (Offences) Bill 2017-19. (see NAT, 2018 for more information).

of food, there's all sorts of risks associated with zoonotic disease developing, and if we end up with another disease and we haven't, as it were, sorted out the arguments for why it's wrong in principle, counter effective, it doesn't help, it reinforces non-disclosing behaviour, it marginalises people who are already vulnerable, it will be another group of people.

One might imagine that there could be a virus which for pre-existing genetic reasons impacts on people with other comorbidities more so, that people who have heart problems or people who have, I don't know, let's think of an example which would be an awful… Not an awful example but for illustrative purposes, let's suppose that there was a proportion of the population who had blue eyes, and it affected people with blue eyes, it was a recessive gene associated disease more prevalent among that group, well we've got to sort out in advance how we would manage that. Because it won't be HIV, but it might be something, and the arguments must be strong.

Marsha: I think there's much to learn from what's happened in the history of the epidemic in relation to Ebola, and the methods of quarantining during the West African epidemic are quite horrifying, but I don't think they had to be like that, and I think we know that early on in the HIV epidemic that people like yourselves worked hard for those kinds of approaches to not be instituted, and yet the global health world has not learnt from what was achieved with this epidemic I think.

Lisa: But over and over again it's also a question of how you handle something where logic and science is not getting through, because to go back to what Yusef was just saying, the MP who is pushing the spit hoods as part of this bill is a gay man who is very knowledgeable about HIV transmission and risk, I know for a fact from personal communications that he has been sat down and hammered about the pointlessness of this particular clause by other gay MPs who are very experienced around HIV and risk, and he's not listening because he knows that if he takes the clause out he will upset some of the popular press, and I cannot give you any other excuse why he is not listening, none whatsoever. And that is a disgrace as far as I'm concerned on his part, but I'll deal with that another time.

Matthew: Of course, on Ebola the really important thing which is way beyond the time we have for this seminar, but the thing about HIV was that the people who were the activists in the early stage in the west had a lot of cultural social capital and wealth, and people who get Ebola don't. In other words, there have to be people acting on behalf of people. Once people became more aware of the prevalence in Africa it was a different story, but among the gay, white

epidemic it was a very different early history from one where you get a very sudden massive increase in a poor part of the world, and those people don't have access to the kinds of media, they don't have Elton Johns in their community. There may be advocates on their behalf, there may be the Gates and the philanthropists who are willing as it were to put on the money, but they're not generally going to also be poorer black African people living in Sierra Leone in conditions of what we would consider to be impoverished conditions compared with us.

Yusef: I guess the question for both of you because you've mainly been talking about public health law and so what would be the circumstances, would there be specific conditions where criminal law would apply to something other than HIV/STIs? And I think there's something about sexually transmitted disease because of the degree of one on one, though sometimes one on more than one, but the degree of agency that makes it particularly susceptible to criminal as well as public… I mean public health law should only be used, if it should be used at all, we can debate that, for highly contagious diseases where simply walking in the street as it were or coughing on a bus could put someone at risk of very serious harm. HIV doesn't fall into that category, which is why one of the reasons, in addition to Matthew's point about political capital, why you could push back on it. So, I think the point is there's also a lot of history of lots of new STIs coming up from time to time so it needn't be very different, it just can be a new sexually transmitted infection.

Matthew: Yes, and it's also a question of scientific accident. The proportion of women living with chlamydia and the impact of pelvic inflammatory disease and fertility is that by the time a woman learns that she is infertile because she had untreated chlamydia it is scientifically impossible to determine who it might be unless she has only ever had one sexual partner up until the point where she is attempting to conceive a child. Now one of the things that's most interesting about the HIV cases is they are… HIV criminalisation is absolutely – in the transmission not exposure cases – determined by the sensitivity of assays. It's Latour, this is actor-network going on, this is HIV and the laboratories and the testing mechanisms and the accessibility to treatment which are causative of new transmissions, are part of a network of transmission events, and the decision to isolate the human actor with moral responsibility as the focal point is very handy politically because as with the causes of crime argument, it takes away the responsibility of the state to put the resource where it's needed, which is in public health, education, enabling people to access treatment, making PrEP available to everybody because they need it. If you focus on individual human actors who are, who can be characterised

as inhuman and irresponsible and morally worthless like the most recent case in Lewes[23], it's incredibly handy, because you just deny that it's a structural or economic problem. Criminal law has always been used for that.

Lisa: But the real giveaway about why it's about sex and not really about disease is the way that the criminal justice system for a while started to give people Sexual Offence Protection Orders.

Matthew: Yeah, still does.

Lisa: Which should only be used for sex offences, it's got nothing to do with offences against the person. I can remember Yusef and I arguing fairly vigorously with the CPS that it should be Antisocial Behaviour Orders (ASBO) and not Sexual Offence Protection Orders (SOPO) if you were going to use something like that.

Yusef: Then they later found that it wasn't lawful to use an ASBO either in relation to people who were cohabiting or something like that, so it got even more complicated.

Matthew: That's right because they had to keep more than 100 feet away from their partner at all times, it was quite complicated.

Marsha: Thank you all very much. I think that Emily will agree with me that this has been immensely productive, I think we're going to have a very rich transcript.

[23] This is in reference to the case of Daryll Rowe who was convicted on November 2017 of five counts of causing grievous bodily harm and five counts of attempted grievous bodily harm.

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APPENDIX

PROPOSED DISCUSSION TOPICS CIRCULATED PRIOR TO SEMINAR

- Legal issues for people living with HIV before/beyond transmission cases
- The role of civil society
- Pre-2003
    - Transmission cases which didn't go to court
    - Support and advice services
- The first court cases
    - Response from the HIV sector
    - Media attention and response
- Relationship between civil society and prosecutorial authorities
- Preparing the prosecutorial guidance and responses to the guidance draft
- How the Crown Prosecution Service guidance was used/what it changed
- The roles and actions of other stakeholders
- Investigation and prosecution
    - Reports and research into police investigation
    - The role of science/it's use in cases (e.g. phylogenetic testing)
- Criminalisation of HIV transmission in the context of U=U