STABILIZING THE TECHNOSCIENTIFIC WITNESS: A HISTORY OF CONTROVERSY, MEDICOLEGAL PRACTICE, AND THE ONTARIO SEXUAL ASSAULT EVIDENCE KIT

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ABSTRACT

Over its thirty-four years in Ontario, the Sexual Assault Evidence Kit (SAEK) has gained credibility as the objective *technoscientific witness* of sexual assault. This dissertation traces the Ontario Sexual Assault Evidence Kit (SAEK) and how it gained stability through ongoing anti-rape activism, technoscientific and legal controversy, and shifting medicolegal practice. It draws on 62 interviews with medicolegal professionals and rape crisis centre workers in Ontario, archival data, media articles, and medicolegal texts to examine how the SAEK was (re)assembled in meaning and in material form alongside new technologies, medicolegal practices, spaces, actors, and expertise.

The dissertation's theoretical/methodological approach is guided by Donna Haraway's diffraction metaphor and tools from Actor-Network Theory. The study *diffracts* the SAEK to examine it as a historicized *actor* involved in medicolegal practice within shifting heterogeneous networks of medical and legal professionals, anti-rape activists, survivors/victims, and texts, tools, and technologies. This dissertation argues that the design, credibility, and continued use of the contemporary SAEK as a technoscientific witness has been fuelled by legal histories and practices based on distrusting women who report sexual assault.

Several key questions are examined in detail: how did the contemporary SAEK gain stability as the technoscientific witness of sexual assault, how were the SAEK and its medicolegal network assembled and reassembled, for what purposes, and for whose benefit? By untangling the histories of the SAEK, this study charts the historical and contemporary controversies amongst scientists, nurses, doctors, lawyers, and feminist

rape crisis centre workers about who should use the SAEK, where and how they should use it, with what tools and technologies, and for what and whose purpose. Through this history, the dissertation finds that the contemporary SAEK's stability benefits many medicolegal actors but few survivors/victims. By offering a historicized account of the SAEK, this study contributes to existing literature on the SAEK, anti-rape activism in Ontario, and forensic and medical technologies. The dissertation diffracts the SAEK to contribute to future feminist efforts to imagine more ethical and responsible ways of assembling medicolegal technologies and practices around sexual assault.

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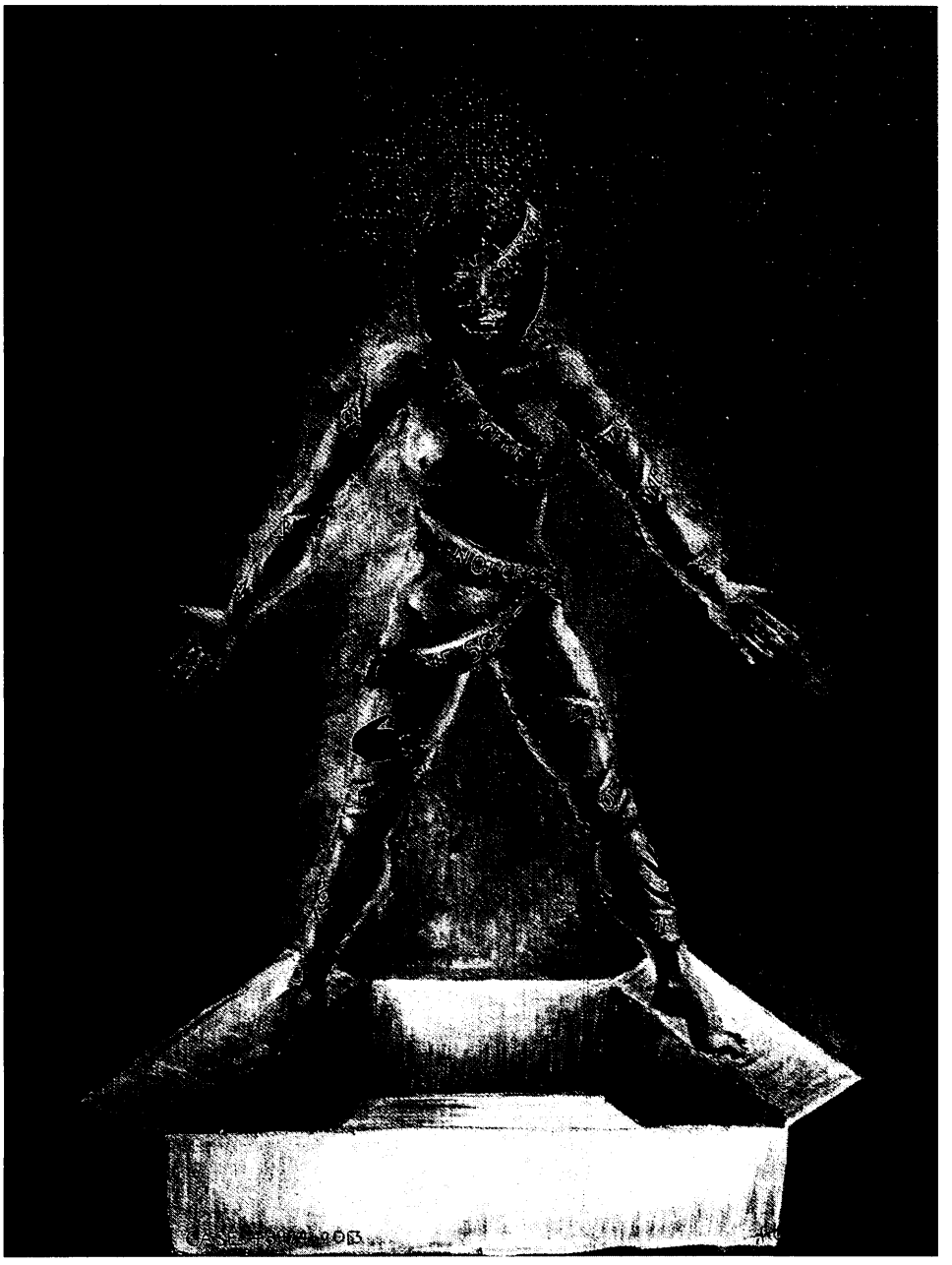
TABLE OF CONTENTS

LIST OF ILLUSTRATIONS



"The Technoscientific Witness"
Andrea Quinlan, 2013

Chapter 1
Introduction

In the late 1960s and 1970s, Canadian feminist activists were bringing women's experiences of rape into public awareness. Some women gathered in public forums to share personal experiences; others wrote theory and conducted empirical studies on the deficiencies of medical and legal practices. Activists established community-based rape crisis centres and built expertise in feminist, anti-rape peer advocacy to fill the void of medical services and legal protections for women who had been raped. In the flurry of this activity, anti-rape activists began organizing to transform medical and legal practice.

Forty years later, in 2013, there is an elaborate medicolegal network of expert services, actors, practices, and technologies for treating, investigating, and prosecuting sexual assault. Within this network, the Sexual Assault Evidence Kit (SAEK),[1] a standardized forensic tool for collecting evidence, has gained credibility as the *technoscientific witness* of sexual assault that objectively identifies and convicts sexual offenders. In this elaborate network of practices and technologies, medical and legal actors continue to disbelieve many women who report sexual assault and see them as non-credible witnesses of their own experiences (Doe, 2012; Crew, 2012; Parnis & Du Mont, 1999). Ironically, many of the anti-rape activists in rape crisis centres who

[1] The SAEK is the forensic evidence collection tool used in sexual assault cases in Ontario. Other jurisdictions use different names such as, rape kits, sexual assault kits, crime kits, forensic kits, sexual assault forensic kits, sexual investigation kits, and sexual assault care kits (Du Mont & White, 2007). Appendix A lists all acronyms that I use in this dissertation.

instigated changes in medical and legal practice in the 1970s have been pushed to the margins of practices within this contemporary network. This dissertation begins with the questions: How did this network come to be? And how did rape crisis centre workers[2] come to be situated in its margins?

Answering these questions requires a detailed tracing of the complexities, uncertainties, and controversies that surround medicolegal practice and technoscientific[3] objects. It requires attending to practices that involve human *and* non-human actors building networks of action. In this dissertation, I chart this history of network building through the history of a single forensic evidence collection tool: the Ontario SAEK. As I will show, the SAEK bears the traces of medicolegal network building, ongoing anti-rape activism, shifting medicolegal practice, and technoscientific controversy.

To trace the SAEK and its medicolegal network, I employ Donna Haraway's (1997, 2000) diffraction metaphor and use tools from Actor-Network Theory (ANT), an approach for tracing shifting networks of material relations between human and non-human actors in technoscientific practice (Law, 2004; Latour, 2005). I *diffract* the contemporary SAEK by illustrating it as a historicized *actor* involved in shifting

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[2] I use the name *rape crisis centre* to refer to community-based organizations that provide advocacy, public education, and support for survivors/victims. Since legal reforms in 1983 that removed rape from the Canadian Criminal Code, many centres have adopted new names, such as sexual assault crisis centres and sexual assault survivors' centres. For clarity, I use the name rape crisis centre throughout this dissertation. I use *rape crisis centre workers* to refer to staff and volunteers who work as advocates for women who have experienced sexual assault. I also use the broader term, *anti-rape activists*, to refer to feminist and women liberation organizers, scholars, lawyers, and advocates involved in political work around rape.

[3] I draw the term *technoscience* from Bruno Latour (1987) and Donna Haraway (1997), who both argue that the division between science and technology is a construction that is often, in practice, collapsed. For Haraway (1997), the term technoscience offers a "non-hyphenated energy...[that] mimes the implosion of science and technology" (p. 51). This is the understanding of technoscience that I use.

medicolegal *networks* of medical and legal professionals, anti-rape activists, survivors/victims, and texts, tools, and technologies.

I trace the SAEK's thirty-four year history in Ontario and examine how it was reassembled in meaning and in material form alongside new technologies, medicolegal spaces, actors, and expertise. I sketch the shifting relations between rape crisis centre workers, the SAEK, and medicolegal practice and examine how the rise of medicolegal experts, expert spaces, and expertise around sexual assault coincided with medicolegal actors displacing rape crisis centre workers from the SAEK's network and transforming feminist rape crisis centre advocacy and agendas. I illustrate medical and legal actors' efforts to *stabilize*[4] the SAEK as the technoscientific witness of sexual assault in medicolegal networks and how these efforts were tied to legal histories and practices of labeling women reporting sexual assault as inherently unreliable and non-credible witnesses. Through these histories, I argue that the SAEK's credibility as the technoscientific witness of sexual assault was fuelled and maintained by medicolegal practices that involve distrusting women reporting sexual assault.

The Contemporary SAEK

The SAEK is a standardized forensic tool used in Ontario to collect bodily fluids and to document physical injuries on a survivor/victim[5] of sexual assault. The SAEK contains swabs for collecting traces of foreign bodily fluids, vials for urine and blood samples, envelopes for hair and foreign debris, paper bags for clothing, and standardized

[4] As I elaborate below, this term is drawn from Science and Technology Studies (STS), where it has been employed in varying ways (Latour, 1987; Akrich, 1992; Star, 1991; Bijker, 1997).

[5] I provide a justification and definition of this term below.

forms for detailing injuries. Nurses and/or doctors conduct SAEK exams, which involve multiple steps of swabbing, plucking, and combing, a process which can last as long as 4-6 hours (Parnis & Du Mont, 2002). Medical experts can analyze SAEKs to determine the degree of force that a perpetrator used and forensic scientists can analyze SAEKs to identify perpetrators of sexual assault, confirm recent sexual activity, and to demonstrate a survivor's/victim's inability to legally consent due to the influences of alcohol and drugs (Du Mont & White, 2007).

In Ontario, the SAEK is designed, distributed, and analyzed by the Ontario Centre of Forensic Science (CFS), which is a publically funded and administered forensic laboratory under the Ontario Ministry of Community Safety and Correctional Services. The lab analyzes forensic evidence in crimes against persons and/or property (Centre of Forensic Science, 2013). Outside of Ontario, other laboratories design and analyze sexual assault kits.[6] These kits are similar to the SAEK and Canadian laboratories use similar practices to analyze them (Quinlan, 2008). In this study, however, I focus on the history of the standardized SAEK in Ontario to sketch the specificity of this technoscientific object and its medicolegal network.

Medicolegal networks

I situate my discussion of the SAEK in medicolegal networks. I use the term *medicolegal* because it usefully collapses the lines between medicine and law and conveys how medical and legal practices are entangled. I draw the term *networks* directly

[6] Here, I use the generic name, sexual assault kit, to refer to kits in other jurisdictions. In Quebec, sexual assault kits are analyzed by the Laboratoire de Sciences Judiciaires et de Médecine Légale du Québec. In other parts of Canada, sexual assault kits differ in design and contents across jurisdictions but all are analyzed by the Royal Canadian Mounted Police (RCMP) Forensic Identification Services or RCMP-contracted private DNA laboratories (Quinlan, 2008; Quinlan, Fogel, & Quinlan, 2011).

from ANT. As I describe in greater detail in chapter 2, ANT scholars have defined networks as "webs of relations" (Law, 2007, p. 1) between human and non-human actors who are related through their practices. This study illustrates how networks are not inherently stable, but constantly shifting and changing form through varying practices.

In the contemporary medicolegal network there are many actors involved in the SAEK's work: nurses, doctors, police, forensic scientists, lawyers, texts, tools, and technologies, and to varying degrees, anti-rape activists and survivors/victims. This dissertation shows how within this network, the flurry of activity, uncertainties, and controversies around the SAEK and sexual assault moved from rape crisis centres to hospital emergency wards to scientific laboratories and legal courtrooms. It examines how material things – texts, tools, technologies, DNA profiles, treatment centres, etc. – shaped the SAEK and its network.

Through this changing network, I illustrate how rape crisis centre workers were pushed to the margins of SAEK practices and situated as *non-users* of the SAEK. Additionally, I show how survivors/victims were similarly pushed to the margins and situated as *implicated users* of the SAEK.[7] In doing so, I examine how shifting networks redefine relations between actors.

The technoscientific witness.

In the criminal courtroom, according to legal scholar Sheila Jasanoff (1998), "seeing is an essential precondition for believing" (p. 717). Whose sight counts as credible in court is often a site of negotiation (Jasanoff, 1998). This precondition that

[7] I describe both of these terms in greater detail in chapter 2.

Jasanoff describes, in which legal actors believe only what they can see, is intensified in sexual assault cases when legal actors label women reporting sexual assault as non-credible and untrustworthy witnesses of their own experience. For sexual assault to be believed in criminal courtrooms and police investigations, it must not only be described, but it must also be *seen* by a witness who legal actors deem credible. At one time, this requirement was quite literally encoded in Canadian sexual assault law. Prior to 1983, an independent witness's testimony, in addition to other corroborative evidence, was commonly required for a sexual assault conviction (Backhouse, 2008). Although this requirement was written out of the Criminal Code of Canada in 1983, its remnants remain in medicolegal practice (Feldberg, 1997; Parnis & Du Mont, 1999; Doe, 2012).

I begin this dissertation with the assertion that the contemporary SAEK *acts* as a witness of sexual assault in the medicolegal network. Although the SAEK does not witness literal acts of sexual assault, I show in this study how the SAEK witnesses[8] sexual assault as it is defined in medicolegal practice as visual traces of bodily fluid and physical injury. On the basis of the *act* of witnessing, the SAEK provides a witness's testimony[9] of sexual assault after forensic scientists have analyzed its contents of bodily fluids and medical experts have interpreted its documentation of physical injuries. I argue that contemporary legal actors commonly see this technoscientific testimony as being more objective and credible than women who report sexual assault.

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[8] Here, I deliberately use the verb *witness* in relation to the SAEK to illustrate the possibility of a non-human object acting. This notion comes from Actor-Network Theory. Significant to this approach is the understanding that non-human actors do not act alone. Instead, they act in a network of action that is composed of many actors. I describe this idea in greater detail in chapter 2.

[9] Again, this construction grants the SAEK agency. I expand further on how the SAEK speaks and is made to speak in chapter 5.

In this dissertation, I ask the questions: How did the SAEK gain stability as the technoscientific witness of sexual assault? How were the SAEK and its medicolegal network assembled and reassembled? For what purposes? And to whose benefit? I chart the controversies amongst scientists, nurses, doctors, lawyers, and feminist rape crisis centre workers around the questions of who should use the SAEK as a witness of sexual assault, where they should use it, with what tools and technologies, and for what, and for whose purpose. By doing so, I illustrate how the SAEK as the credible technoscientific witness gained stability in the contemporary medicolegal network. In the concluding chapters of this dissertation, I argue that the SAEK's stability benefits many medicolegal actors but few survivors/victims.

SAEK Literature

There is a limited body of scholarly research on sexual assault kits, particularly in Canada. Much of the research has focused on the development and effectiveness of professional groups associated with sexual assault kits (Stermac & Stirpe, 2002; Du Mont & Parnis, 2003; Sievers, Murphy & Millers, 2003; Campbell, Patterson, & Lichty, 2005), the institutional settings where sexual assault kit exams are done (Sampsel, Szobota, Joyce, Graham & Pickett, 2009; Hatmaker, Pinholster, & Saye, 2002), and the influence of sexual assault kit evidence on arrest and conviction rates (Feldberg, 1997; McGregor, Du Mont, & Myhr, 2002; Johnson, Peterson, Sommers, Baskin, 2012; Campbell, Patterson, Bybee, & Dworkin, 2009). This work has generally focused on the users, settings, and effects of sexual assault kits and in so doing, has left the sexual assault kit itself largely untouched.

In recent years, some scholarly and activist researchers have moved the focus onto the sexual assault kit. Most notably in Canada, Janice Du Mont (now White) and Deborah Parnis' formative research on the SAEK examines levels of standardization in the Ontario SAEK exam (Parnis & Du Mont, 2002; Du Mont & Parnis, 2003), the technologies used in the SAEK exam (White & Du Mont, 2009), the discretionary uses of the SAEK (Du Mont & Parnis, 2001), and the values tied to the SAEK (Parnis & Du Mont, 1999; 2006). Building on this work, Jane Doe (2012) has examined the efficacy and harms the sexual assault kit causes through the perspectives of women who have experienced the kit exam, and their advocates. These formative studies in sum have focused on contemporary uses, perceptions, and consequences of the sexual assault kit.

The literature on the sexual assault kit, Canadian and otherwise, has raised questions about how the SAEK came to be and for what and whose purposes. More specifically, existing work has raised questions about the historical controversies and practices that shaped the SAEK's meaning and material form and the contemporary medicolegal practices in which the SAEK has stability. By turning my attention directly to the SAEK and its shifting medicolegal network, this dissertation builds on existing work to provide a historicized account of the assembly of the SAEK as the technoscientific witness of sexual assault.

Tracing Objects and Histories of Practice, Controversy, and Stabilization

By framing this study around a single technoscientific object, I draw on a well-established tradition in Science and Technology Studies (STS) and feminist STS in which technoscientific objects and their histories have been the focus of much critical inquiry.

Work in this tradition challenges the view that technoscientific objects are simply outcomes of technical or scientific discovery by arguing that objects arise from complex interplays of technical, scientific, social, political, economic and cultural processes (Winner, 1986; Latour, 1987; Law, 2002). Langdon Winner's (1986) well-known article on the politics of technological artifacts illustrates how artifacts are not only the effects of political, social, and cultural processes, but also *have* effects, and are therefore not neutral and are instead, inherently political. He shows how political, social, and cultural conditions that shape an artifact's development are embedded in their design and play out in their use. Adopting a similar orientation, some feminist STS scholars have examined histories and politics embedded in technoscientific objects that act on (women's) bodies, such as the pap smear (Singleton, 1996, 1998; Casper & Clarke, 1998), the IUD (Dugdale, 2000; Takeshita, 2012), the cervical stabilizer (Hasson, 2012), birth control pills (Aengst & Layne, 2010), and the tampon (Vostral, 2011). While this feminist work on technology has made significant strides into medical technologies, less attention has been given to forensic technologies.

In other branches of STS, some scholars have investigated forensic technologies, such as fingerprinting (Cole, 2001) and forensic DNA typing (Rabinow, 1996; Gerlach, 2004; Lynch, Cole, McNally, & Jordan, 2008). Although the SAEK is a forensic technology, it is distinct from other forensic technologies in several ways. Fingerprinting and DNA analysis *use* bodies to construct truths about crime; however, they do not *act* on

bodies as the SAEK does.[10] The SAEK physically touches and at times hurts bodies in ways that other forensic technologies in the laboratory do not. It is, unlike many other forensic technologies, an object that entangles not only science and technology, but medical and legal practices as well. By examining the SAEK, a forensic medicolegal technoscientific object that acts on (mainly female) sexually violated bodies, this dissertation contributes to existing STS literature on forensic technologies and feminist STS literature on medical technoscientific objects and women's bodies.

Tracing histories.

My focus on the SAEK's history is drawn from STS and feminist STS traditions. Many scholars in these fields have used historical analyses to show how science and technology "might have been otherwise" (Hughes, 1971, p. 552). Shapin and Schaffer's (1985) history of the development of experimental science, and the many others that followed on the pasteurization of milk (Latour, 1988), the development of the bicycle (Bijker, 1997) and the rise of the IUD (Takeshita, 2012), have used history to reveal the uncertainties, controversies, and negotiations that are involved in assembling scientific knowledge and technological objects. In this tradition, this dissertation charts the SAEK's history to suggest that it "might have been otherwise" (Hughes, 1971, p. 552).

Donna Haraway's (1997, 2000) diffraction metaphor guides my historical investigation. For Haraway, diffraction is a tool for producing feminist accounts of technoscience. It involves, "see[ing] both the history of how something came to 'be' as

[10] The SAEK acts on not only survivors'/victims' bodies, but also, in some cases, on their emotions, psychologies, minds, politics, etc. In this study, I am interested in the "semiotic materiality" (Law, 2004, p. 15) of the SAEK, which I describe further in chapter 2. This focus directs me to the material and physical relations the SAEK has with other actors, such as sexually violated bodies, and the meanings that have been and continue to be made from these relations.

well as what it simultaneously is" (Haraway, 2000, p. 108). Diffraction, according to Haraway, is a way of "make[ing] a difference" (Haraway, 1997, p. 16) in the technoscientific worlds that we study, a way of "interfering" (Haraway, 1991, p. 101) with technoscientific objects to seek out more ethical and responsible alternatives. In this study, I diffract the contemporary SAEK to ask how it came to be, what it is, and in the concluding chapter of this study, what the SAEK might be.[11]

To diffract the SAEK, I adopt the descriptive approach in Actor-Network Theory (ANT) that involves tracing science and technology "in the making" (Latour, 1987, p. 4). Seeing how technoscience is made, according to Latour and other ANT scholars, requires thick description of complexities, uncertainties, and instabilities between actors and within practices and networks (Akrich, 1992; Law, 2004; Latour, 2005). Akrich (1992) describes this approach as "the inventory and analysis of the mechanisms that allow the relation between a form and a meaning constituted by and constitutive of the technical object to come into being" (p. 209).[12] I argue that through this descriptive approach, it is

[11] These seemingly simple questions – how the SAEK came to be, what *it is*, and what *it* might be – risk conveying the SAEK as a singular object. Haraway, however, does not use them in this way and nor do I. For her, diffraction is a way of seeing historical and contemporary complexities, multiplicities, and uncertainties in an object. These questions simply guide her diffracted analysis. In this spirit, I employ Haraway's questions to guide my venture into the SAEK. This dissertation illustrates how the SAEK is *not* a singular object and is rather a multifaceted technoscience with many histories and possible futures.

[12] Importantly, this approach combines what Akrich (1992) calls "inventory" (p. 209), or description, *with* analysis. In ANT studies, description and analysis are not easily separated: the theoretical analysis is part of the empirical description, as many ANT scholars have demonstrated (Latour & Woolgar, 1986; Callon, 1986; Latour 1988; Singleton, 1988; Akrich, 1992; Mol, 2002; Law, 2002; Latour, 2010). This particular aspect of ANT is common to many branches of Science and Technology studies (Shapin & Schaffer, 1985; Bijker, 1997; Cole, 2001; Takeshita, 2012) and has intellectual roots in Ludwik Fleck's (1935) early history on the development of scientific facts and Thomas Kuhn's (1962) historical analysis of scientific revolutions. Law (2008) explains this when he says "how Kuhn *describes* science resonates with his theory *of* science. Theory, he is telling us, cannot be detached from its instances…theory and data are created together" (p. 629).

possible to see how the material form of the SAEK came to have meaning as the technoscientific witness of sexual assault in medicolegal practice.

Tracing practice, controversy, and processes of stabilization.

Studying scientific practice, or what scientists actually do, has a long tradition in STS, which arose from Thomas Kuhn's (1962) formative work on scientific revolutions and other notable works that followed, such as Shapin and Schaffer's (1985) historical study of experimental science and Latour and Woolgar's (1986) study of practices in a scientific laboratory. These works illustrate how science is an activity; a process of constructing knowledge. I take up this tradition by examining *medicolegal practice*: what nurses, doctors, police, and lawyers do to investigate sexual assault, treat survivors/victims, and prosecute and defend those charged. By examining medicolegal practice historically, I reveal how practices have changed through technoscientific and legal controversies between scientists, nurses, doctors, lawyers, and anti-rape activists.

Controversies, according to many STS scholars, reveal how science and technoscientific objects are developed through ongoing negotiations, disputes, and uncertainties amongst actors involved (Latour, 1987, 2005; Epstein, 1996). Some STS scholars have shown how controversies about technological objects are resolved when actors reach consensus about an object's design and purpose (Akrich, 1992). Some have called these moments of consensus about objects points of *stabilization* (Latour, 1987; Akrich, 1992). Stabilized technologies, in this view, are those "in which the conflict and heterogeneity inherent in technology building is overcome…and the social relations which lie behind the technology are made either invisible or unquestionable" (Halfon,

1998, p. 802).[13] Within this tradition, stabilization often appears to be a static outcome of controversy.

Other scholars have argued for more fluid understandings of stabilization. In Bijker's (1997) history of the bicycle, he suggests that technological development is a process that involves "degrees of stabilization" (p. 271), where consensus building about an object's design and purpose is non-linear, tenuous, and easily disrupted with new controversies.[14] Star (1991) proposes a feminist intervention into stabilization when she argues that technologies and networks are only stable for some actors. She writes, "a stabilized network is only stable for those who are members of a community of practice who form/use/maintain it" (p. 44). Actors who are not part of a community of practice, she argues, but who rely on stabilized technologies and networks, rarely feel their stability.

In this dissertation, I adopt these more fluid readings of stabilization. Here, stability is not a static place or a definitive outcome of controversy. Instead, like Bijker (1997) and others in this tradition, I use stability to characterize historical moments when many actors reach consensus about an object's design and purpose. Stabilization in this dissertation is a non-linear process that can be easily disrupted with new controversies, actors, expertise, and practice. Like Star, I do not assume that consensus about a stabilized object and network is universally shared. Instead, I show how technologies and

[13] This understanding of stabilization stems from some branches of ANT (Latour, 1987), which have proposed that complexities in science and technology can become black boxed and hence invisible after controversies have been resolved, and some branches of the Social Construction of Technology (SCOT) (Pinch & Bijker, 1987), which have proposed that controversy in technology building can be overcome and *closure* can result.

[14] However, he does also suggest elsewhere that the common outcome of degrees of stabilization is *closure* where controversies and uncertainties about a technological object are resolved (Pinch & Bijker, 1987).

networks can be stable for some actors but not for others, something which I explore further in chapter 6.

By untangling the SAEK's histories of stabilization, practice, controversy, its historical and contemporary complexity will become visible. I hope that interfering with the contemporary SAEK in this way will contribute to future feminist efforts to imagine more ethical and responsible alternatives.

A Partial History

This study is a partial documentation of the SAEK's history. Partial histories are not failed or inadequate histories. Rather, as Law (2003) reminds us, "any way of imagining technologies is partial" (p. 2). According to Law (2004), method is a process of bringing certain actors, practices, and relations into the visible foreground and pushing others into the invisible background. While partial histories may be inevitable, they come with risks.

By focusing on the medicolegal practices, I risk erasing survivor's/victim's *experiences of* medicolegal practice. To avoid this, I provide glimpses into the experiential to ensure that survivors'/victims' experiences are not completely invisible in this account. I insert pieces of survivor's/victim's narratives of their experiences with the SAEK in between and inside my own text.[15] I situate these experiences on the page so that they seemingly interfere with the flow of practice. In doing so, the text's placement visually illustrates how medicolegal practice can at times operate in full disregard of

[15] I have collected these narratives from survivors/victims in Ontario through oral history interviews and publically available archival and textual sources. The narratives have been inserted in the text according to their date and content.

women's experience of the SAEK exam. These narratives are not meant to represent *all* survivors'/victims' experiences of medicolegal practices. Rather, they give a sampling of what some have been.

I also punctuate my text with a series of historical texts from archival sources. In doing so, I illustrate some of the textual actors in the SAEK's ever-changing medicolegal network.

Notes on Language

I employ particular terms in this dissertation to describe sexual violence, and individuals who experience and perpetrate it. While there are many vibrant scholarly debates over this terminology, charting them in full is beyond the scope of this work. However, a brief reporting of some of these debates is necessary to situate my own language in its broader context.

Rape and sexual assault.

Throughout this dissertation, I refer to both *rape* and *sexual assault* to reflect the historical shifts in language in the SAEK's 34 years in Ontario. As I describe, rape in the 1970s was an offence under the Criminal Code of Canada and a term that many anti-rape activists used to convey the gendered nature of sexual crimes against women. However, this usage changed part way through the SAEK's history, when rape was removed from the Criminal Code and replaced with sexual assault. Rape had been narrowly defined as unwanted vaginal penetration, a definition that sexual assault offences broadened to forced sexual activity. Some feminist scholars have argued that the specificity of rape and the generality of sexual assault make both terms unhelpful to feminist scholarship and

activism (Sheehy, 1999; Doe, 2012). However, in this dissertation, I use both terms as actors used them in the historical moments I describe. My usage depicts the shifts in discursive terrains of law and anti-rape activism.

Survivor/victim.

I use the term *survivor/victim* to refer to women who have experienced rape and/or sexual assault. In the past two decades, there has been heated controversy amongst feminist scholars over the term victim (Wolf, 1993; Allard, 1997; Lamb, 1999; Atmore, 1999; hooks, 2000; Doe, 2012). While some argue that *victim* can be useful in labeling violence and conveying a shared experience of male violence amongst women (Lamb, 1999), others contend that it connotes passivity and denies women's agency (Wolf, 1993). Some feminists of colour argue that the term fails to take into account racialized and classed experiences and falsely assumes a homogenous gendered experience of male violence (Allard, 1997; Collins, 1996; hooks, 2000). As an alternative to victim, many scholars, rape crisis centre workers, and activists and have adopted the term *survivor* in the hopes of emphasizing women's agency and strength (McCaffrey, 1997). Some feminist scholars have, however, criticized both survivor and victim for limiting women's narrative agency and for implying a passive female body that is victimized by or survives the active male body (Spry, 1995; Doe, 2012).

In the face of scholarly debates on language, multiple studies have found that women who have experienced sexual assault identify themselves and their experiences in varying ways (Reavey & Gough, 2000; Young & Maguire, 2003; Ovenden, 2012).

Young & Maguire (2003) found that some women feel that survivor acknowledges agency, whereas others feel that it presupposes a recovered state that they do not feel they portray or embody. In their study, some women identified as survivors, others identified as victims, and still others identified as neither survivors nor victims. In response to this evidence and the lively scholarly debates about language, Young and Maguire, along many other scholars, have called for new, more inclusive language for women who have experienced sexual assault (Kelly, Burton, Regan, 1996; Reich, 2002; Doe, 2012).

Exploring innovative language for sexual assault would mark an important contribution to sexual assault literature; however, it is beyond the scope of this work. Instead, in this dissertation, I adopt the imperfect term *survivor/victim*. The forward slash serves a distinct purpose. It acknowledges that women's identities in relation to their violent experiences can be complex, multiple, and changing. The term survivor/victim offers the possibility of women claiming one or both identities and the forward slash proposes the possibility that women may claim identities in between or beyond survivor and victim.

Adult women as survivors/victims.

This study concentrates on *women* who experience and report sexual assault. In adopting this focus, I do not mean to suggest that men do not or cannot experience sexual assault. There is a growing scholarly recognition of male experiences of sexual violence (Graham, 2006; Light & Monk-Turner, 2009; Ralston, 2012). However, Canadian victimization surveys and crime statistics continue to illustrate that women experience substantially higher rates of sexual assault: the most recent estimate is that women are 5.6

times more likely to be sexually assaulted than men (Brennan & Taylor-Butts, 2008).[16] Scholars have also found that women are far more likely than men to seek medicolegal services (Washington, 1999; Light & Monk-Turner, 2009). In light of these current understandings, I use the female pronoun to refer to survivors/victims accessing medicolegal services. I narrow my focus even further to *adult* female survivor/victims. Medicolegal practices and sexual assault laws for youth and children are markedly different than for adults, and are beyond the scope of this study.[17]

Perpetrators of sexual assault.

I use the term *perpetrator* to refer to those who commit sexual assault. I do not adopt the legal terms suspect or accused to refer to those before a trial, or offender to refer to those who have been found guilty as a result of a trial. This language is based on the assumption that truth about sexual assault can only be found in the courtroom and not in women's reports of sexual assault. Instead, I assume that in most cases women's reports of sexual assault are true and so I adopt their definitions of the men who sexually assault them.

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[16] Crime and victimization survey statistics are based on sexual assaults that people *report* to police and data collectors at Statistics Canada. Anti-rape activists have argued for several decades that women rarely report sexual assault and have shown that women of colour, women experiencing poverty, and women with disabilities and mental health diagnoses are significantly less likely to report their experiences of sexual assault (Griffin, 1971; Clark & Lewis, 1977; Doe, 2003; Johnson & Dawson, 2011). Any statistical estimate based on reported sexual assaults is therefore, at best, a glimpse into a much larger and pervasive issue.

[17] In Canada, the age of sexual consent is 16. For this reason, in cases involving survivors/victims under 16, physical evidence of sexual activity from the SAEK exam is usually read as evidence of guilt. The technoscientific witness thus carries greater weight in cases involving youth and children. Beyond differences in legal definitions, medicolegal practices around the SAEK differ for youth and children. In Ontario, pediatricians must conduct SAEK exams on youth and children in hospitals that offer pediatric care. Additionally, different SAEK protocols and timelines exist for forensic evidence collection from youth and children. Exploring the SAEK in relation to youth and children would require a separate and detailed analysis.

I use the male pronoun to refer to perpetrators of sexual assault. This is not to suggest that women do not and cannot perpetrate sexual assault; however, this gendered language reflects the current statistical estimates that men commit the vast majority (97%) of sexual assaults in Canada (Brennan & Taylor-Butts, 2008).

A Road Map

In the following chapter, I outline the study's theoretical/methodological approach. I describe how I use tools from ANT to diffract the contemporary SAEK and its meaning as the technoscientific witness. I also explain the samples and the methods of data collection and analysis I use in this study.

Chapters 3-5 sketch the history of how the SAEK and its meaning as the technoscientific witness of sexual assault came to be. In chapter 6, I use this historical sketching of the SAEK to explore what the contemporary SAEK is and how it works in contemporary medicolegal networks. As a way of conclusion, in chapter 7, I explore what the SAEK could be in future networks. Taken together, these chapters perform what Haraway suggests diffraction implies: examining "the history of how it came to be, as well as what it simultaneously is" (Haraway, 2000, p. 108), and, my addition, what it could be.

I begin my history of the SAEK in the 1970s, a decade of rising anti-rape activism, heated controversies over medicolegal practice, and changing forensic technologies and sciences. Alongside all of this movement in the 1970s were firmly entrenched legal histories and practices in which legal actors labeled women reporting sexual assault as unreliable witnesses. Chapter 3 traces these entangled histories and

charts the design of the first SAEK in Ontario. I use Akrich's (1992) notion of "inscription" (p. 208) to describe the SAEK's design as a process that involved *inscribing* meanings, practices, and histories into the first Ontario SAEK in 1979. I argue that in this design work, medicolegal actors imagined a technoscientific witness of sexual assault that promised to give testimony that legal actors would deem credible.

Chapter 4 charts the medicolegal efforts in the 1980s to stabilize the first SAEK in Ontario as the technoscientific witness of sexual assault. I illustrate the controversies that the SAEK prompted amongst medicolegal actors and rape crisis centre workers. Through this, I sketch how medicolegal actors used the SAEK in varying ways and how it enacted new meanings of rape and sexually violated bodies. I examine the rise of new expertise, experts, and expert spaces around the SAEK and trace how these developments contributed to redefining the SAEK, medicolegal practice, and rape crisis centre advocacy in medicolegal networks. This chapter shows how the SAEK was reassembled through controversy, legal reform, and shifting practice, and how through this history, the SAEK gained stability as *the* technoscientific witness of sexual assault.

In chapter 5, I explore how the SAEK was destabilized and restabilized in the late 1980s and 1990s with the introduction of forensic DNA analysis. I describe how the technoscientific witness of sexual assault was transformed into a *genetic* technoscientific witness that, in the eyes of medicolegal actors, gave more objective and reliable accounts of sexual assault. I show how the genetic witness was stabilized amidst legal battles around women's credibility in the sexual assault courtroom, opposition from some anti-rape activists, and legal and technoscientific controversies around forensic DNA analysis.

Chapter 6 turns to the contemporary SAEK and its medicolegal network. In this chapter, I ask: how does the SAEK *act* in the contemporary medicolegal network, for what purposes, and to whose benefit? I trace the shifting terrain of medicolegal practice and expertise in which the SAEK acts and is enacted as the credible and objective technoscientific witness of sexual assault. In this chapter, I describe how police and defence lawyers routinely rely on the technoscientific witness to test the veracity of women's reports of sexual assault. Through an analysis of contemporary medicolegal practice, expertise, and continued technoscientific controversies, I argue in this chapter that the SAEK has stability as the technoscientific witness that benefits many medicolegal actors but few survivors/victims.

I conclude the dissertation in chapter 7 where I briefly sketch how the SAEK and its networks may (de)stabilize in the years to come. I explore possible future shifts in the SAEK and its networks as a way of imagining more ethical and responsible ways of enacting the medicolegal technologies and practices around sexual assault.

Chapter 2
Diffracting the Sexual Assault Evidence Kit

This chapter outlines the theoretical/methodological approach that I use in this study to *diffract* the contemporary Sexual Assault Evidence Kit (SAEK). I begin the chapter by describing a set of diffraction tools that I have assembled from Actor-Network Theory (ANT) and outline how I use these tools to create feminist *interference patterns* in the SAEK. I then explore my situated use of these tools and how it shapes what of the SAEK I can see and feel. I conclude by outlining the methods and samples that this study employs.

The Diffraction Metaphor

Tracing entangled histories and contemporary uses of a technoscientific object calls for new epistemological metaphors, according to Haraway (2000) and Law (2004). Both contend that well-used metaphors, such as representing or reflecting, falsely imply an "innocent" (Law, 2003, p. 6) act of observing phenomena from afar. Untangling the SAEK's histories will not be innocent and will instead involve meddling and "interfering" (Haraway, 2000, p. 101) with the contemporary SAEK and its meaning as the technoscientific witness. To guide this work of untangling the SAEK, a metaphor that conveys how my methodological treks through the SAEK's histories and contemporary uses might "make a difference" (Haraway, 1997, p. 16) would be more useful. For this project, I employ Donna Haraway's (1997, 2000) diffraction metaphor.

Haraway proposes diffraction as an optical metaphor for seeing and interfering with technoscientific objects. She draws her understanding of diffraction from Newton's experiments on the physics of light waves and Goethe's experiments with diffraction

crystals (Haraway, 2000). As Haraway (2000) describes it, when a literal beam of light is shone through slits, or diffraction crystals, as Takeshita (2012) has later expanded, the light becomes fragmented into many smaller rays of coloured light. If a screen is held close by, patterns of coloured light rays will appear on the screen. These patterns, according to Haraway (1997), represent the "interference patterns" (p. 14) the slits or the crystal has made in the single beam of light. Diffraction, for Haraway (1997, 2000), is a useful metaphor for the methodological practice of breaking up the solidity of technoscience. It involves fragmenting singular visions of technoscientific objects to reveal what has been obscured or made invisible within their histories and contemporary uses.

I use the diffraction metaphor to guide my efforts to see and interfere with the contemporary SAEK. Following the metaphor, the contemporary SAEK, its meaning as the credible technoscientific witness, and current material form, make up a single beam of light. By holding up several crystals, or as I call them, diffraction tools, to the contemporary SAEK, I can see the many smaller rays of light that make up the contemporary SAEK. I can see how the SAEK's meaning and material form came to be, as well as the many things that the SAEK simultaneously is. Even further, I can see how the SAEK gained stability that benefits many medical and legal actors but few survivors/victims. This diffraction work creates *interference patterns*, in which the many rays of the SAEK's history and present use become visible.

Creating interference patterns in technoscientific objects affects them and the worlds they inhabit. Here, according to Haraway (1997), lies the political imperative

within diffraction work. She writes, "what we need is to make a difference in material-semiotic apparatuses, to diffract the rays of technoscience so that we get more promising interference patterns on the recording films of our lives and bodies" (p. 16). Adding to this, Law (2008) states, "the question becomes: how to interfere in and diffract realities in particular locations to generate more respectful and less dominatory alternatives" (Law, 2008, p. 637). Following Haraway and Law, I do not diffract for diffraction's sake. Instead, I diffract the contemporary SAEK in the hopes of creating interference patterns that may contribute to imagining more ethical and responsible ways of assembling the SAEK and medicolegal practices. Like Haraway, I call these types of interference patterns, which are geared towards finding more ethical and responsible ways of assembling technoscience, *feminist* interference patterns.

Tools for Diffraction

I draw my diffraction tools from Actor-Network Theory (ANT), which is a theoretical/methodological[1] approach in Science and Technology Studies (STS) for tracing human and non-human actors and their relations in technoscientific practice. After describing my ANT diffraction tools in detail, I consider their utility for making feminist interference patterns in the SAEK.

Diffraction tools make a difference to the types of interference patterns that are made. When a technoscientific object is diffracted, not all of its rays will be visible; some will be vibrant and colourful, while others more pale and transparent. The tools that are

[1] As I describe later on, many scholars have asserted that ANT is neither a theory nor a method. I suggest that ANT blurs the division between theory and method: it is a theory of method and a methodology of theory. To reflect this understanding, I refer to ANT as a theoretical/methodological approach.

used to diffract, coupled with a researcher's situated use of those tools, will have an effect on which rays become most visible, and consequently, the interference patterns that are made. The diffraction tools I have assembled from ANT and my situated use of them have had an effect on what parts of the SAEK's entangled histories and contemporary uses are visible in this study. For this reason, it is necessary to critically examine these tools and how I have put them to use in this study.

Actor-Network Theory.

ANT has been described as a "semiotics of materiality" (Law, 1999, p. 4), an approach for tracing material relationality in technoscientific practice: how actors (both human and non-human) are enacted, brought into being and assigned meaning, within sets of relations. This understanding of material relationality has guided many ANT studies on a vast array of topics, such as military aircrafts (Law, 2002), bodies with atherosclerosis (Mol, 2002), the UK Cervical Screening Programme (Singleton, 1998), and the pasteurization of milk (Latour, 1998). Beyond this loosely shared commonality, ANT has been more humbly described as a "toolkit for telling interesting stories" about technoscientific practice (Law, 2007, p. 1). Here, I will be digging through ANT's toolkit in search of the right tools with which to diffract the SAEK.

Much time has been spent amongst ANT scholars bemoaning ANT's name (Latour, 1999; Callon, 1999; Law, 2004; Law, 2006). Despite having the word *theory* in its name, some scholars have gone to great lengths to argue that ANT is not a theory in the sense of being an explanatory framework upon which to hang empirical data (Callon, 1999; Latour, 2005; Law, 2007). Nor, many contend, is the word *network* meant to imply

that ANT is a methodology that stipulates a particular shape into which empirical data is squeezed (Latour, 1999, 2005). Even further, some scholars have regretted the fact that ANT has a name because it misleadingly implies a fixed approach with a singular definition (Law, 1999; Law, 2006). As Law (2007) says, "I have talked of 'it,' an actor-network theory, but there is no 'it'" (p. 1). Law (1999) leaves ANT open for translation and fluidity.[2] He says,

> only dead theories and dead practices celebrate their self-identity...insist upon their perfect reproduction...[ANT] is diasporic. It has spread, and as it has spread it has translated itself into something new, indeed into many things that are new and different from one another (p. 10).

In this study, I rely on Law's optimistic and promising reading of ANT. I do not claim that this study is an ANT study, if that could in fact be claimed. Rather, it is a study that borrows and in so doing, translates, some existing ANT tools for the purposes of diffracting and making interference patterns in the SAEK.

Diffraction tools.

Heterogeneous actors.

If there were a methodological dictum for ANT, it would be that seeing technoscience in action – or, in the making – requires that researchers trace work amongst *both* human and non-human actors (Sismondo, 2010). Technoscientific work, many ANT scholars have argued, is heterogeneous, and thus necessarily involves the

[2] Law's (1999, 2004, 2006, 2007) generous reading of ANT is in many ways a contrast to Latour's (1987, 2005) formative descriptions of ANT. Despite Latour's (2005) claim that his texts are merely "guides...[that] offers suggestions rather than imposing" (p. 17) themselves, they outline a set of strict methodological and theoretical rules for ANT studies. For this reason, I follow Law's reading of ANT more closely.

non-human (Star & Griesemer, 1989; Callon & Law, 1997; Latour, 2005). Callon and Law (1997) describe this further,

> Often in practice we bracket off non-human materials, assuming they have a status, which differs from that of a human. So materials become resources or constraints; they are said to be passive; to be active only when they are mobilized by flesh and blood actors. But if the social is really materially heterogeneous then this asymmetry doesn't work very well. Yes, there are differences between conversations, texts, techniques, and bodies. Of course. But why should we start out by assuming that some of these have no active role to play in social dynamics? (p. 168)

Using this as a starting point for investigating the SAEK, it is possible to see the diverse group of human and non-human actors involved in medicolegal practice: forensic scientists, police, nurses, lawyers, rape crisis centre workers, survivors/victims,[3] *and* the SAEK, and other tools, texts, and technologies.

For Latour (2005) and many other ANT scholars, actors are those people, animals, and things that exert influences and leave traces on and within technoscientific work. Actors build alliances with other actors to make technoscience. In this study, I draw on this understanding to see the SAEK as an actor that aligns with various other actors in medicolegal practice to create both witnesses and testimonies about sexual assault that many legal actors see as credible and objective. The fact that the SAEK aligns with others is particularly significant, as it is this that makes the SAEK an actor. Actors

[3] Rape crisis centre workers and survivors/victims participate in medicolegal work in different ways than other actors included here. I discuss this further below.

do not exist alone. Instead, they exist relationally, for as Mol (2002) says, "to be is to be related" (p. 54).

Seeing the SAEK as an actor shifts my methodological focus away from perceptions and experiences of the SAEK to the object itself. In Mol's (2002) work on disease, she argues that focusing on doctors' and patients' perceptions or interpretations *of* disease leaves the disease untouched. She writes,

> All interpretations, whatever their number, are interpretations of. Of what? Of some matter that is projected somewhere…This is built into the very metaphor of 'perspectives' itself. This multiplies the observers – but leaves the object observed alone. All alone. Untouched. It is only looked at. As if it were in the middle of a circle. A crowd of silent faces assembles around it. They seem to get to know the object but with their eyes only. Maybe they have ears that listen. But no one ever touches the object (p. 12).

Following this argument into the SAEK literature, it could be said that much of the existing work on the SAEK, which has focused on perceptions and consequences *of* the SAEK's use, has left the SAEK itself untouched. The risk of this kind of analysis, according to Mol, is that the object becomes "very solid [and] intangibly strong" (p. 12). If the aim is to diffract the SAEK and make interference patterns in its contemporary meaning and material form, I should not adopt a methodological focus that makes the SAEK appear more solid. Mol proposes an alternative.

Mol (2002) suggests that interpretations and perceptions must be understood as "talk" (p. 12), as meanings that are made about an object and not as single truths about

what an object is made of. This approach, she asserts, must be coupled with a methodological foregrounding of practices and materialities. In this form of analysis, objects are actors participating, and being brought into being, *in* practice. Seeing the SAEK as an actor whose meaning and material form has been brought into being in medicolegal practice fragments its solidity: it becomes an object that could have been, and more optimistically, could be otherwise.

By seeing the SAEK as an actor, I can understand its role in medicolegal practice differently. No longer is it a passive object that human actors use. Instead, the SAEK becomes an active object that works alongside human actors and participates in medicolegal practice as a technoscientific witness. While the SAEK is literally put to work by human hands, it simultaneously exerts influence on what those human hands do in the course of making technoscientific witness testimonies about sexual assault. In order to understand how the SAEK came to be and what it simultaneously is, I argue that the SAEK must be understood as an actor with a long history of participating in medicolegal practice.

Taking the SAEK to be an actor raises the important question: what does it mean for a non-human actor to act? In Latour's (2005) accounts, the non-human actor is just as capable as the human actor of leaving traces and exerting influence. Haraway (1997), however, notes a danger in over-anthropomorphizing the non-human actor. She says "our relationality is not of the same kind of being. It is people who have the emotional, ethical, political, and cognitive responsibility inside these worlds. But nonhumans are active, not passive, resources or products" (Haraway, 2000, p. 10). Although in this study, I

understand the SAEK to be an actor in medicolegal practice, I do not do so to release human actors from their responsibility for ethical medicolegal practice. Instead, as I argue, positioning the SAEK as an actor that has been brought into being through practice demands accountability and responsibility amongst medicolegal actors for the SAEK and its use as the technoscientific witness of sexual assault.

Actor-networks.

Actor-networks refer to the "webs of relations" (Law, 2007, p. 1) between human and non-human actors. This term does not specify a particular shape (Latour, 2005), nor does it imply a functional one (Law, 2003). Rather, it highlights the relationality between actors involved in technoscientific practice. Actor-networks, according to Latour (2005), should be viewed as "work-nets" (p. 132) of heterogeneous actors working alongside one another in technoscientific practice.

In this study, I sketch how nurses, police, lawyers, anti-rape activists, survivors/victims *and* the SAEK work alongside one another within what I am calling a medicolegal network. As I show, this medicolegal network has shifted historically with relational shifts in the SAEK and medicolegal practice. I argue that through these shifting networks, the contemporary SAEK gained stability as the technoscientific witness that does not benefit all survivors/victims.

The two diffraction tools, actor and actor-network, work together in this study to describe what the SAEK is and what it works within. In order to see how the SAEK came to be, two other tools are needed.

Enactment.

To examine how the SAEK has been brought into being in medicolegal networks, I need a diffraction tool that draws attention to action. One commonly used descriptor in STS is construction. I could use this descriptor to suggest that the SAEK has been constructed in different ways throughout particular historical moments.[4] However, as both Mol (2002) and Law (2004) have argued, the term construction can imply that practice in the past and can suggest that an object has already been put together and finalized in meaning and in material form. As I illustrate in chapter 6, the contemporary SAEK has stability as the technoscientific witness for some actors but not others, most particularly many survivors/victims. Using construction might erase the instability the SAEK has for many survivors/victims in medicolegal networks. Instead, I need a tool that will highlight how the SAEK has been, and for some actors continues to be unstable. I need tools that allow me to trace how the object itself has been brought into being through practice.

Mol (2002) offers the term *enactment* as a descriptor for seeing how objects are assembled in meaning and often in material form within practice. Enactment, unlike construction she argues, draws attention to ongoing action, and as Law (2008) says, "shift[s] the verb from making to doing" (p. 635). With enactment, it becomes possible to see how objects are brought into being in multiple ways across different sites. Mol traces how the diseased body is enacted in different hospital locations: in the examining room,

[4] This framing resonates with two traditions in STS: the Social Construction of Technology, which emphasizes how technologies are constructed within social relations (Bijker, Hughes, & Pinch, 1989; Klein & Pinch, 1999), and the Social Shaping of Technology (MacKenzie & Wajcman, 1999), which draws attention to how the social and the technical are co-constructed.

the diseased body *is* pain and visible symptoms, whereas in the pathology lab, the diseased body *is* what is under the microscope. The diseased body thus becomes what actors define and assemble it as in practice.

In this study, I take Mol's notion of multiple enactments and stretch it to fit a historical narrative. I examine how the SAEK has been enacted in multiple ways historically. By looking at the multiple historical and contemporary enactments of the SAEK in medicolegal networks, I will show how the SAEK and its network have changed historically.

Tracing enactments of the SAEK in medicolegal networks requires that I examine material relations that the SAEK has with other actors in medicolegal practice and trace the meanings that have been formed out of these relations. I examine the shifting relations the SAEK has had with anti-rape activists, nurses, doctors, lawyers, and forensic scientists, and survivors'/victims' bodies, and trace the new meanings for the SAEK and medicolegal practice that has arisen from these changes.

I suggest that enactments of the SAEK in medicolegal practice corresponded with enactments of survivors'/victims' bodies as crime scenes. By suggesting that survivors'/victims' bodies are enacted in medicolegal practice, I do not mean to diminish their material existence outside of medicolegal practice. Nor do I wish to imply that survivors/victims have no claim over their own bodies. Instead, I use enactment to place the focus on the SAEK's work on the sexually violated body in medicolegal practice, and, in so doing, illustrate the stakes of medicolegal practice. In looking at enactments in

practice, I am not only looking at what is done, but also how those actions assemble and give new meaning to the SAEK and the sexually violated bodies it acts on.

Enactment not only locates my analysis in practice, but also offers something more optimistic. If the SAEK, and other actors like the sexually violated body, are enacted in practice and are not fixed results of actions in the past, then alternative and perhaps more ethical and responsible modes of assembly become theoretically possible. I explore this discussion of alternative enactments of the SAEK in the chapter 7.

I use enactment as a diffraction tool to highlight the practices through which the SAEK has gained its contemporary material form and meaning as the technoscientific witness. I employ another tool from ANT in order to see how the SAEK has come to be.

Traces.

Latour (2005) argues that sociologists investigating technoscience must study the *traces* that actors leave behind. Mialet (2012) puts it clearly, "Latour's innovation was to direct our attention to the traces left by human and things circulating through the collective, a kind of...materialization of their presence and action" (Mialet, 2012, p.458). The sociologist's work, according to Latour (2005) is to follow actors' traces in order to see technoscientific practice and the objects that are enacted within it. I adopt this approach to follow the traces the SAEK and other medicolegal actors have left within the SAEK's entangled histories.

The notion of traces allows me to diffract the SAEK in two ways. It offers a directive for how to follow the SAEK through time and space by directing my attention to the material signs of the SAEK's presence, such as texts, technologies, and changes in

practice and protocols. Additionally, the notion of traces offers an image of what the SAEK does: the SAEK combs the sexually violated body for traces of sexual assault. As I show in this study, the practices around the SAEK for seeing and collecting traces, and the definitions of what constitutes a trace of sexual assault have changed through technoscientific controversies and legal reform, alongside changes in the SAEK's meaning and material form.

The 'Right Tools'[5] for Feminist Interference Patterns?

The diffraction tools that I draw from ANT have shaped which rays of the SAEK are visible in this study and which rays have faded into the background. Much is at stake when choosing diffraction tools. The pertinent question thus becomes: what effect do diffraction tools drawn from ANT have on my ability to make a feminist interference patterns in the SAEK?

Many feminist scholars have argued that ANT is in opposition to, or at least in tension with, feminist politics and scholarship (Haraway, 1997; Casper & Clarke, 1998; Star, 1991; Wajcman, 2000). No doubt this is at least in part fuelled by Latour's reluctance to cite feminist scholars (Harding, 2008) and his adamant critiques of what he calls "critical sociology" for putting politics first (Latour, 2005, p. 250). Feminist scholars have reproached ANT for being limited to perspectives of powerful scientists and technicians (Star & Griesemer, 1989; Star, 1991; Wajcman, 2000), for being "insufficiently radical" (p. 452), and for ignoring marginalized actors and their restricted

[5] I borrow this phrase from Casper and Clarke (1998), who use it in the context of describing scientific tools that have been constructed to be understood as "the right for the job" (p. 255). "Rightness," in this instance, is not a moral position, but instead, a constructed meaning. Tools are made to fit the jobs they are meant for with "tinkering strategies" (p. 255). I argue that ANT's rightness for the job of making feminist interferences requires some tinkering strategies.

access within the actor networks of technoscience. As Star (1991) puts it, "Latour and Callon's work has opened up a whole new way of analyzing technology...but seem[s] to sidestep traditional questions of distribution and access" (p. 42).

While these critiques might, for some, dispel all hope of ANT tools being made useful for feminist interference patterns, I suggest instead that some "tinkering strategies" (Casper & Clarke, 1998, p. 255) open new possibilities. Several questions inspire and guide my strategies to tinker ANT tools to make them useful in this feminist diffraction of the SAEK.

Who counts as an actor? And why actor-networks?

Many feminist STS scholars have shown that when ANT grants epistemic privilege to marginalized actors, the shapes of actor-networks change (Star & Griesemer, 1989; Star, 1991; Clarke & Montini, 1993; Casper & Clarke, 1998). Star (1991) proposes that the marginalized[6] actor should serve as a point of entry into an actor-network for the "voices of those suffering from the abuses of technological power are among the most powerful analytically" (p. 30). For Star, and other feminist STS scholars, the "non user" (Star, 1991, p. 38) or the "implicated user" (Clarke & Montini, 1993, p. 42) of technology is a more powerful point of analytical entry, which, according to Takeshita (2012), combats the invisibility of women and invites an analysis of power. I adopt this approach, but only partially.

[6] Star, along with others making similar arguments about ANT, has used the term *marginal.* In keeping with this, throughout this dissertation, I refer to actors who have been made *marginal.*

The primary focus in this study is on medicolegal actors who might be described as non-marginal:[7] nurses, doctors, police, forensic scientists, and lawyers. However, I do include, to varying degrees, two overlapping groups of actors who I argue were and are often situated on the margins of medicolegal practice around the SAEK: rape crisis centre workers and survivors/victims.[8] Contemporary rape crisis centre workers, I argue, have been largely situated as *non-users* of the SAEK. They are not involved in consultations, design work, or training on the SAEK, nor do they literally *use* the SAEK in their work, as nurses, scientists, and lawyers do. I show how rape crisis centre workers' positioning in relation to the SAEK arose out of historical action. Rape crisis centre workers did not begin as non-users. Instead, this status was negotiated and was enacted in practice.

Similarly, contemporary survivors/victims, I argue, have been positioned as *implicated users* of the SAEK. As I explain, survivors'/victims' capacities to act in the SAEK exam is often limited by many things and as such, they are more often involved in the SAEK exam as the subjects of the SAEK's action. However, this is not an inherent status. Instead, it emerged in history and as a result of medicolegal practice.

While I do include some of the actors who have been put on the margins of medicolegal practice, I have not used their marginality as an analytical entry point into the SAEK and its medicolegal networks, as Star (1991) suggests. Instead, I focus on showing how their marginality was enacted in practice. In doing so, I follow Michael

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[7] I do not use this term to suggest a stable non-marginal status amongst all of these actors. These actors are instead non-marginal in relation to many rape crisis centre workers and most survivors/victims. However, as I show in this study, their relational status as non-marginal has been enacted in practice and at times, has been the subject of controversy.

[8] As I explain in the next chapter, some rape crisis workers are survivors/victims of rape and sexual violence, and therefore these groups are not mutually exclusive.

Callon's (1986) suggestion that "science and technology are dramatic 'stories' in which the identity of actors is one of the issues at hand" (p. 198). I illustrate how the designations of non-user and implicated user of the SAEK were subjects of historical controversies and results of medicolegal practice. I suggest that showing how actors come to be marginal through practices is a more optimistic approach than what some feminist STS scholars have proposed. If marginality is a product of practice, it could have been, and could be, otherwise.

Although I do include some actors who have been made marginal, my primary focus is on medicolegal actors who are most often not on the margins of medicolegal practice. I am interested in these actors' practices and efforts to stabilize the SAEK and its meaning as the technoscientific witness of sexual assault. I suggest that tracing non-marginal actors can reveal the practices through which technoscientific objects gain stability that does not benefit all actors. I propose that feminist interference patterns in the SAEK can be made by tracing medicolegal actors' practices that enact the SAEK in medicolegal networks. Revealing complexities of practice is a necessary step towards imagining alternatives.

Whose traces should I follow?

According to Latour (2005), a "slogan for ANT" (p. 12) is to follow actors' traces and, in so doing, "grant them back the ability to make up their own theories of what the social is made of" (p. 11). The sociologist, he claims, should not impose her own theories, but rather follow actors' own understandings of the worlds they inhabit. In the context of studying medicolegal actors, such as nurses, doctors, police, forensic scientists,

and lawyers, I run the risk of silencing my own critical, feminist voice in this study if I give actors full capacity to "make up their own theories" (p. 11) of what the SAEK and medicolegal practice is made of. If my aim is to create feminist interference patterns in the SAEK, I cannot afford to let medicolegal actors solely define the traces I follow or the theories I sketch. Most medicolegal actors already have a great degree of power to define what the social is made of – they do not need me to grant them any more. My aim is instead to follow actors' traces with a critical eye to not only what they include, but also what they do not include. I guide my steps through the SAEK's entangled histories with questions that Latour does not ask: What actors have the resources and the power to leave traces? What actors cannot leave traces? Who defines what traces count and get left behind? And how do visible and invisible traces impact the narratives that I can tell?

Whose enactments count? Whose do not? And Cui Bono?[9]

Making feminist interference patterns in the SAEK requires deeper questions than just what objects get enacted through what practices. I diffract the SAEK with larger questions in mind. I focus on what objects get enacted through whose practices, for what purposes, and to whose benefit? As Jasanoff (2012) says of ANT, "there is room in that project to ask not only who wins and who loses in particular struggles over representation, but who benefits and to what end, by what means, and at how great a cost" (p. 439). Using these questions as a starting place, it becomes possible to see the stakes that different enactments and practices around the SAEK have, and for whom.

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[9] This phrase, which means "to whose benefit." comes from Susan Star (1991), who uses it to propose a different analytical starting point for ANT. She says, "I think it is both more analytically interesting, and politically just to begin with the question, cui bono? than to begin with a celebration of the fact of human/non human mingling" (p. 43). It is this question that inspires my "tinkering" of ANT tools.

Situated Diffraction

My interference patterns in the SAEK are shaped not only by the diffraction tools I have used, but also by my situated use of them. They are shaped by how I am "situated"[10] (Haraway, 1991, p. 183), in terms of both my social positioning as a young, white, female academic and my positioning in relation to my object of study. I argue that my situatedness shapes the rays of the SAEK that I can see and, going further, the rays that I can feel.[11]

Obscured rays.

The feminist scholar's work in diffracting technoscientific objects is to make visible the many rays of a technoscientific object (Haraway, 1997, 2000). However, what about the rays that the feminist scholar cannot see and that are obscured from her view? The SAEK is commonly kept out of view from non-medicolegal actors. The contemporary SAEK is considered by most to be the property of the medicolegal system and is therefore heavily guarded by its users.[12] The SAEK's invisibility raises an important question for diffraction: how do we diffract an object whose many rays are kept invisible? And, how does this shape the kinds of interference patterns that can be made?

Seeing medicolegal practice and the human and non-human actors involved in it, is contingent on negotiating access. The medicolegal system has many formal

[10] I draw this term from Haraway's (2000) description of situated knowledges, which draw attention to the "embodied nature of all vision" (p. 188).

[11] Here, I refer to physical and emotional feeling. I explain this further below.

[12] In the 62 interviews that I conducted, I was only once given the opportunity to see a SAEK. There are few pictures of the Ontario SAEK on the internet and the forms within it are not made available to the public. I was forced to use an Access to Freedom of Information request to obtain some of the texts within the SAEK.

mechanisms that keep their practices largely invisible. Many medicolegal actors, both human and text, are not allowed to *speak* to researchers without the permission of a higher authority. Police, forensic scientists, and crown attorneys require approval from their supervisors before they can participate in research. Hospital staff members are similarly governed by hospital ethics boards, which scrutinize research and researchers before granting researchers access and allowing staff members to participate. Many medicolegal texts are kept out of reach of the non-medicolegal actor and can only be obtained if approval is sought and granted through formal procedures like the Canadian Freedom of Information and Protection of Privacy Act, a process that does not always yield results (Yeager, 2006; Larsen & Walby, 2012).

Many critical scholars have argued that researchers' situated locations influence their ability to negotiate and obtain access to actors within powerful institutions (Horn, 1997; Anderson-Levy, 2010). In his recent work on law, Latour (2010) seemingly sailed into the French supreme courts to conduct his legal research uninhibited, just as he did in the science lab in the early 1980s (Latour & Woolgar, 1986). My access story was not so easy. Being a young, white, female scholar, my legitimacy and credibility as a researcher and a scholar was often questioned and used as the basis for determining my degree of access.[13] Gatekeepers assessed the level of threat that both I and my research posed to the stability of the SAEK and its medicolegal networks. As one potential participant demanded, "are you looking at technology as a good thing, a bad thing, or what?!" When

[13] My identities also worked in other ways that occasionally helped to facilitate my entry. In a few cases, participants seem to read my youth, whiteness, and femaleness as signs that I was not threatening. Some referred to my dissertation as "your school project," language that is more often reserved for children and youth. With this frame, some participants saw me and the dissertation as innocent and non-critical and granted me access as a result.

my answers failed to pass access tests like these, potential participants and their supervisors sometimes refused to give me access or imposed additional institutional mechanisms for scrutinizing research, such as hospital research ethics board protocols and review.

These access-regulating practices obscure many of the SAEK's rays. Diffraction, in this context, becomes a more complicated task. It involves creative "muckracking," a term Gary Marx proposed in 1972 for the work of uncovering institutional practices that are deliberately kept from public view. It requires more resourceful efforts to access "hidden and dirty data" (Marx, 1984, p. 78) about medicolegal practice. And, above all, it requires recognition that, despite all efforts to make them visible, many of the SAEK's rays will remain obscured.

Felt rays.

In her list of questions for feminist technoscience, Haraway (1991) asks, "what other sensory powers do we wish to cultivate besides vision?" (p. 194). In cases where technoscientific objects are difficult to see, Haraway's question opens up the possibility of considering other ways of creating interference patterns. In what follows, I ask if physical and emotional feeling might be another sensory power for diffraction. When technoscientific objects are diffracted, where do the rays of the objects go? In Haraway's description of diffraction, the rays only become visible and decipherable, but are never explicitly felt. I propose that some rays may diffract into researchers' bodies and that this may shape the feminist interference patterns that they make.

Although the theme of technoscientific objects acting on and alongside bodies is a common one in feminist STS (e.g., Casper & Clarke, 1998; Dugdale, 2000; Vostral, 2011; Hasson, 2012), the relationship between researchers' bodies and technoscientific objects has rarely been explored. There are a few exceptions. Both Takeshita (2012) and Singleton (1996) briefly describe their bodily relationships to the objects they study, which are the IUD and the cervical smear. In both narratives, they describe the positive ways their objects have acted on their physical bodies. While this points in the direction of felt technoscientific objects, I wish to go further. I am interested in ways that technoscientific objects can act on researchers' bodies in more nuanced and sometimes negative, although not necessarily unproductive, ways, and how this might influence diffraction.

Researching sexual violence can be emotionally consuming, physically depleting, and dispiriting. The close and prolonged contact with stories of brutal bodily violence can leave inerasable marks. Campbell (2002), narrating her research team's experience of researching rape, writes,

> We mourn for the victims and ourselves: our loss of innocence, safety and well-being. Bearing witness to these stories of trauma was painful, and we became saturated with hurt. The constant contact with rape reminded us that we too could be victimized (p. 11).

Campbell (2002) sketches how she and her research team "felt rape" (p. 11) through five emotions: loss, pain, fear, anger, and hope. Stanko (1997) tells a similar story of feeling her own emotional exhaustion and pain during her research on violence against women.

Both women argue that understanding felt emotions must be a central part of researching violence against women. Going further, I suggest that subject matters, or objects of study, can be felt not only through emotions, but also through a researchers' situated body, sometimes in ways that are physical, with physiological effects. I suggest that these felt responses can serve as important sensory powers for diffraction.

While I have never felt the SAEK in the same physical, painful, and intrusive way that many survivors/victims have, I have felt the SAEK during my research.[14] In suggesting this, I am proposing a more abstracted understanding of feeling, whereby technoscientific objects are felt through the narratives that are written about them, the protocols that exist for their use, and the practices that shape them. Being situated in a female body, I understand the kit to be a technoscientific object that was originally designed for my body. Reading the kit's protocols and associated practices is hard to do without imagining how they *might* act on my own body, and how this *might* feel. Reading about the SAEK's protocol to pluck 50 head hairs and 12 individual pubic hairs (Provincial Secretariat for Justice, 1979c) or about physicians forcefully inserting un-lubricated speculums into women's vaginas (Williams & Williams, 1973) is difficult to do without feeling a twinge in the body, a squeamishness, almost an imagined pain. Alongside these bodily responses, listening to the misogynist, victim hating and blaming talk that at times crept into my interviews with police and lawyers was difficult to

[14] By suggesting this, I do not mean to diminish women's experiences of the SAEK. The way that I have felt the SAEK is significantly different than how many survivors/victims have felt the SAEK.

stomach.[15] At times I had to stop reading, transcribing, and listening to cry, laugh, or just breathe.

Stanko (1997) and Campbell (2002) argue that emotional responses need not threaten our research, but can instead serve as methodological resources. I suggest this is true of all felt responses, including not only emotional, but physical as well. If technoscientific objects can be felt, they can be seen and diffracted in different and sometimes more effective ways. Law (2000) argues, "the body is so important: for it is a detector, a finely tuned detector, a detector of narrative diffraction patterns. It is an exquisite and finely honed instrument that both detects and performs patterns of interference between modes of ordering" (p. 27). My felt responses to the SAEK provide another sensory power beyond vision that shapes how and why I diffract and the feminist interference patterns that I make. To honour and make use of my own experiences of feeling the SAEK, I recorded them as data, logging them alongside the medicolegal traces that I followed. I now turn to a description of the other bodies of data this study uses and the methods that I employed to assemble them.

Methods

The SAEK is a technoscientific object that is particularly difficult to trace through historical and contemporary medicolegal networks. Compounding the difficulties of access, much of the SAEK's history has been erased or forgotten. High turnover rates in

[15] My use of a bodily descriptor here is purposeful.

forensic nursing and sexual assault policing[16] makes it difficult to find people whose memories of the SAEK extend beyond a few years. Since the SAEK is a relatively new technology (34 years old), many of the texts that have historically mediated and recorded its use have not yet found their way to the archives. To sketch the SAEK's histories, I had to uncover and thread together many traces of practice. This historical "muckracking" (Marx, 1972, p. 1) required a large sample of interview data, both oral history and contemporary, as well as textual data, both archival and current.

My reliance on interview and textual data departs from the ANT tradition of using participant observation to study scientific practice (Mialet, 2012), which was largely initiated by Latour and Woolgar's (1986) formative laboratory ethnography. Participant observation of contemporary practice is near impossible in the medicolegal system, due not only to known ethical issues of witnessing trauma as a form of data collection, but also to institutional assurances of medical confidentiality and privacy, liability, and accountability to the legal system. As for the historical traces of the SAEK, only oral history and textual data collection are possible. To diffract the SAEK, I thus use a combination of data.

Interviews.

I conducted sixty-two[17] semi-structured interviews with medicolegal actors and rape crisis centre staff in 26 cities and communities across Ontario (see Appendix C for

[16] Many participants in this study spoke directly to high turnover rates in sexual assault policing and nursing. Both fields involve on call work, with pay that for some does not outweigh the emotional drain the work can cause. This is discussed more in Chapter 6.

[17] Sixty of 62 interviews were conducted for the purposes of this study. I added two interviews with forensic scientists in Ontario, which I conducted in a previous study on a similar topic (Quinlan, 2008), to this study's sample. Because in this study, I was only given permission to speak to one forensic scientist

sample distribution). The participants' geographical locations of the participants stretched as far east as Ottawa, west as Thunder Bay, north as Kenora, and south as Niagara Falls. The participants included rape crisis centre workers (both currently employed and retired), Sexual Assault/Domestic Violence Treatment Centre (SACTC)[18] medical staff (sexual assault nurses, a doctor and a social worker), police (investigators, forensic identification officers, and OPP administrators), victim service staff, and lawyers (crown, defense, and civil attorneys). Prior to any participant recruitment, I sought and obtained ethics approval from the York University Ethics Board (see Appendix E for ethics approval certificate). To increase diversity and geographical representation in the sample, I used both purposive and snowball sampling techniques.

All participants were given a code, which included a letter indicating their role in medicolegal networks and a unique number (eg. P1, SANE2). I use these participant codes to identify participants throughout this dissertation (see Appendix B for complete list of codes).

Participation in research is highly regulated in medical and legal institutions, often through formalized research approval processes (Parnis, Du Mont, & Gombay, 2005; Rowe, 2007). These processes limit researchers' access to institutional practice and monitor and at times, prevent employees' participation in research. I used a variety of techniques to negotiate access, some of which involved going through, and others around,

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and one forensic lab manager, these two additional interviews with forensic scientists provided a necessary supplement to this study's data.

[18] This acronym, which denotes Sexual Assault Care and Treatment Centre, reflects the original name these centres held before they began offering domestic violence treatment in 1998 (KPMG Consulting, 1999). For consistency, I refer to SACTCs throughout this dissertation.

formalized approval processes. This combination of access strategies was crucial to tracing the SAEK.

Contact information for individual police officers and forensic scientists is not readily available online. To gain access to these groups, I sought formal approval from directors of the Ontario Centre of Forensic Science to interview forensic scientists and from 10 police sergeants in sexual assault units across Ontario to interview police. I sent these supervisors and directors an outline of the research, the interview questions, and proof of York University's Ethics Board's approval of the study.[19] I explicitly stated that I was interested in conducting my own recruitment. However, all the supervisors and directors selected participants for me.

To recruit medical staff and crown attorneys, I adopted a different approach. Instead of seeking formal approval through the hospital ethics boards to access the medical staff and the Ministry of the Attorney General to access crown attorneys, I contacted participants directly through the SA/DVTC websites and the Ministry's online directory of crown attorneys. I selected participants purposively to ensure breadth in geographic representation.

Defense lawyers, victim service employees, and rape crisis centre workers generally do not require formal approval to participate in research. I obtained contact information for defense lawyers through Google and the Directory of Certified

[19] The challenges of researchers gaining access to police have been well documented (Horn, 1997; Rowe, 2007; Dafnos, 2012) and while parallel challenges for forensic scientists have not been explored to the same extent, similar challenges exist. By including a description of my study on York University letter-head, my list of interview questions, and proof of university ethics approval in my access requests, I aimed to strategically present both myself, and the research project, as credible and institutionally sanctioned. This proved to be a relatively successful strategy for gaining access to both of these groups.

Specialists in Criminal Law produced by the Law Society of Upper Canada. I found Victim Service employees in online victim service directories. I recruited rape crisis centre workers through the Ontario Coalition of Rape Crisis Centres list serve and by email and phone. I obtained several names of retired lawyers and rape crisis centre workers from archival records and sought their contact information through online searches and phone inquiries.

Although the focus of the study is not on the survivor's/victim's experiences of the SAEK, three participants identified themselves as survivors[20] during the course of my interviews and shared their experiences of the SAEK exam with me. In all three cases, the participants had heard about the study from others and contacted me, asking if I would be interested in hearing their stories. I did not want to say no. I handled this data differently from the rest. I ensured that these participants were given the chance to review and revise the interview transcript and provide feedback on any parts of my writing where their words appeared. These additional steps were taken to ensure that I used these stories in respectful and accurate ways, which honoured the participants' experiences and their willingness to share them with me.

The geographical breadth of the sample, as well as restrictions on time and resources, precluded me from conducting all interviews in person. While I conducted some interviews in person (13), others were done over the phone (44) and email (5). Interview length ranged from 30 minutes to two and a half hours, with a mean of one hour. All participants signed an informed consent form prior to the interview and were

[20] All three of these participants were or are rape crisis centre workers. Given this, and the fact that they all identified as survivors, I refer to these participants as *survivors/advocates.*

asked for permission to be audio taped throughout. The majority of the interviews, short of two phone interviews and four email interviews, were audio taped. All participants were offered a copy of the transcript.

Texts.

In addition to interview data, I collected and analyzed a variety of archival and contemporary texts. I collected archival documents from six archives across Ontario, which spanned national, provincial, municipal, and institutional levels: National Archives of Canada, Archives of Ontario, City of Toronto Archives, Clara Thomas Archives and Special Collections (York University), the Miss Margaret Robins Archives (Women's College Hospital), and the Canadian Women's Movement Archives (University of Ottawa, Archives and Special Collections). I used online archival search engines and consultations with archivists to generate lists of relevant archival materials, which I viewed onsite. The texts I collected included reports, contracts, manuals, pamphlets, posters, internal memos, letters, press releases, newspaper clippings, audio recordings, and a training video.

To gain access to other historical and contemporary texts, I used several different methods. Through online databases, I collected legal case files (45), media articles (170), newsletters from the Provincial Network of Sexual Assault and Domestic Violence Treatment Centres (26), and issues from Broadside, a Canadian feminist newspaper (18), medical and forensic science journal articles, and national, provincial, and municipal

government reports. I used Access to Information requests[21] to access both historical archival texts and contemporary texts.

Tours.

To supplement the interview and textual data, I conducted several tours of medicolegal spaces. These tours provided depictions of the tools and technologies that work alongside the SAEK and the spaces that they all work within. I toured a Sexual Assault Care and Treatment Centre (SACTC) with a Sexual Assault Nurse Examiner to see an unoccupied medical exam room, and counseling and waiting rooms. The nurse showed and described the SAEK and its accompanying forms, along with many of the medical tools and forensic lights involved in the forensic exam. While I did not see these devices in action, they were brought to life through the nurse's vivid description. Additionally, I toured two sexual assault police investigation units where I was saw both interrogation and interviewing rooms, as well as the general office where investigators work. I was also given a brief tour of the Centre of Forensic Science Receiving Office, where SAEKs are initially processed when they arrive at the CFS. While the tours of the police units and forensic offices did not include descriptions of the tools used, they provided me with visual pictures of the spaces and actors that work with the SAEK. I used detailed notes and in some cases visual sketches to record what I observed during these tours.

[21] Many scholars have shown that requests for information under the Canadian Freedom of Information and Protection of Privacy Act are a useful research tool for critical scholarship on institutional practice (Yeager, 2006; Larsen & Walby, 2012). Through such requests, it becomes possible to obtain institutional traces that would otherwise be unobservable.

Tracing obscured practice.

During the interviews, tours, and textual gathering, I was often confronted with descriptions of the SAEK and its medicolegal networks that obscured medicolegal practice with abstracted terms and generalized accounts of efficacious institutional action. These accounts not only erased action, but also conveyed an arguably idealized image of medicolegal networks as being collaborative, effective, and empowering for survivors/victims. Smith (2005) suggests that abstracted institutional accounts, in which practice is obscured, are crucial sites of interrogation for the critical feminist scholar. Drawing on some of Smith's techniques as well as my own, I developed several approaches to address these abstracted descriptions when I encountered them.

Medicolegal practices were obscured during my interviews with medicolegal actors when they summarized their work with abstract and abbreviated descriptors, such as "our process" or "our protocols." Following Smith's (2005) work, Campbell and Gregor (2002) suggest that abstracted generalities can be hazardous for researchers investigating practice because they can blur, and at times, completely eliminate actual doings. They suggest that researchers should ask participants to speak in narrative terms to describe the specifics of their work, the steps taken, the materials used, and the time required, so as to ensure that the account is "no longer…an abstract undertaking" (p. 72). In many interviews, I adopted this approach by encouraging participants to give narrative accounts of practice with questions such as, what are the steps involved in a forensic examination?, what tools do you use when you analyze forensic evidence?, and how have the materials in the SAEK changed and what initiated these changes? When participants

used abbreviations, I asked them to describe the work behind the abbreviations. The interview questions I used in all the interviews followed this similar theme. The questions were, however, not standardized, and instead were built on one another to thread together depictions of medicolegal practice.[22]

In addition to abstracted generalities, institutional success stories of caring, effective, and empowering services for survivors/victims of violence often crept into my interviews with medicolegal actors. Police asserted that their units were "victim-centered," victim services volunteers stated that they are "very big on letting the victim choose their path" (V3), and nurses claimed that the "fundamental principle" of SA/DVTC units is to "not only empower them [survivors/victims], but to leave all of the choices up to them" (SANE7). These descriptions portray medicolegal practice as safe and functional and erase the ways that medicolegal practice can be otherwise for some survivors/victims. To capture a more nuanced picture of medicolegal practice in my interviews, I interrogated moments of interaction between institutional actors by asking participants to comment on the practices of other actors. I asked nurses to describe what police officers say to survivors/victims at the hospital and asked forensic scientists to describe how lawyers speak to them about forensic evidence. By asking actors to narrate stories about each other, success stories were occasionally broken down and the controversies and tensions within practice became more visible.

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[22] This approach to interviewing stems from Dorothy Smith's (2005; 2006) Institutional Ethnography (IE), which is a methodology that aims to map relations that coordinate and organize institutional action. Although this study is not guided by IE's explicit interest in mapping "ruling relations" (p. 227), which are those social relations that are mediated through institutional texts, I adopt some of IE's interview techniques for investigating institutional action.

Like the interviews with medicolegal actors, many of the government, medical, and legal texts reflected sanitized depictions of institutional accomplishment and success. For example, in 1978 at the Ontario Consultation on Rape Honourable George Kerr, the Provincial Secretary for Justice, announced to his audience of police, doctors, lawyers, and rape crisis centre staff that the recent rise in rape statistics could only mean that "your efforts in supporting victims of this despicable crime are proving successful" (Provincial Secretariat for Justice, 1978, p. 6). Expressing a similar sentiment in 2003, the provincial coordinator of the Ontario Network of SA/DVTCs, wrote to the member centers in her quarterly newsletter, "the progressive development of our programs demonstrates your dedication and care to women, men and children who have been sexually or physically assaulted. We've certainly come a long way!" (Macdonald, 2003, p. 1). These depictions construct medicolegal practice as effective, collaborative, and accountable and erase what actors actually do in the course of their work.

In order to interrogate practice through these texts, I used several different methods. I filed Freedom of Information requests to access texts that contained narratives of action, such as meeting minutes and memos. I also used the many texts that I gathered against one another. I used critical accounts from feminist archival documents, contemporary feminist reports, and survivors'/victims' narratives to interrogate and critically read institutional success stories. For texts where neither strategies were available, I adopted a feminist "ethnographic attitude" (Haraway, 1997, p. 190) to guide my reading, which ensured that I was attentive to questions about how practice can work to benefit some but not all.

My final method of interrogating practice involved overlapping textual and interview data collection. In several interviews, I used historical and contemporary texts as interview cues to illicit discussion about medicolegal practice. Interview cues can help ignite memory (Kuhn, 2007) and encourage participants to move away from "well-rehearsed stories" (Stephanson, 2005, p. 37). In some cases, I introduced the textual cues and in others, the participant had brought cues to the interview. For several of the oral history interviews, I introduced media files and archival reports to the discussion and asked participants to comment on their contents. In all cases, I chose texts that the participants had been at one time familiar with, such as reports from meetings they attended or media quotes reporters had taken from them over thirty years ago. In other interviews with contemporary medicolegal actors, participants shared some of the texts that they use in their work, such as the SAEK forms, volunteer training booklets, and promotional pamphlets. In all of these interviews, the texts helped to mediate the discussion away from generalities and towards the specifics of practice.[23] In speaking to the text's content, the participant often provided a story behind its lines, one that avoided abstractions and highlighted action and feeling.

Methods for Assembly

According to Law (2004), many existing social science methods for data analysis do a poor job of capturing the "messiness" (p. 5) of technoscientific practice. As Latour (2005) argues, these methods often encourage us to reduce complexity into "neat little pots" or themes (p. 141). Law (2004) concurs, but is perhaps more generous when he

[23] Smith (2005) describes this approach in her discussion of Institutional Ethnography.

says, "these methods are often extremely good at what they do, [but] they are badly adapted to the study of the ephemeral, the indefinite, and the irregular" (p. 4). To see the messiness and historical contingency of practice, both Law and Latour argue that we have to undo many of our old habits.

Diffraction calls for a different set of methods. Methods that reduce historical traces into a finite number of commonalities and/or themes have limited use for diffraction, as they are more likely to diminish complexity than to reveal it. Instead, diffraction calls for methods that make complexities visible. I used various techniques to *assemble* the traces that I found into a detailed story about the SAEK. I "assembled" (Latour, 2005, p. 7) rather than analyzed. Assembly, unlike analysis, blurs the distinction between collecting data and making sense of it by folding the two processes into one. Assembly is the work of building stories about technoscientific objects and their histories and contemporary uses.

I transcribed all interviews verbatim, resulting in 630 single-spaced pages of interview transcription. I examined the interview transcripts and textual data with a particular eye to the historical moments when the story shifted, when controversies erupted and practices changed. When these moments were identified, I used three different means of assembling a historical narrative of the SAEK.

Maps.

Following the approach some ANT scholars have taken (e.g., Halfon, 1998; Berg, 1998), I literally mapped medicolegal networks and controversies as a tool for interrogation. I created a visual map of the medicolegal actor-networks the SAEK works

within as a preliminary step into the data I collected. In these images, I aimed to map how medicolegal practices hang together, in some ways that were coordinated and in others that were conflicted in controversy (see Appendix D). While this type of mapping did help me visualize many important medicolegal actors, practices, and controversies, the boxes and arrows that I used seemed to impose an unintended linearity and simplicity on the SAEK's story. This pointed to a need for other forms of visualizing. Visual mapping thus served as a preliminary step towards a more complex analysis of the complexity of practice and controversy.

Images.

As a way of exploring my felt responses to the SAEK, I experimented with other visual forms, ones that were not confined to boxes and arrows and used more creative modes of expression. Through the course of this study, I kept a sketchbook of drawings and paintings that I would turn to in moments when I wanted to capture my emotional, psychological, and physiological responses to the SAEK (see image on page vii). I used this artistic work as an "alternate writing technology" (King, 1994, p. 2) for exploring the felt effects of my object.

During my writing of this text, I used the images to remind myself about my relationship to the SAEK. They reminded me that the SAEK is not a distant thing that acts outside of the body, but is instead, an object that was designed to be used on bodies – and perhaps my body – in ways that can be painful, distressing, traumatic, and even violent. I returned to these images during my writing to remind myself about how I feel about the SAEK and about how my felt responses were shaping my analysis. These

images reminded me of the "non-innocence" (Haraway, 1994, p. 63) of this project and the aims of my diffraction.

Text as Laboratory.

For Latour (2005), the academic text plays a crucial role in assembling stories of technoscience. He explains,

> Writing has everything to do with method…the text, in our discipline, is not a story, not a nice story. Rather it's the functional equivalent of a laboratory. It's a place for trials, experiments, and simulations (p. 149).

The chapters that follow served as my laboratories where I visualized different interference patterns in the SAEK. Once they appeared on paper, I assessed the patterns for their potential to make feminist interventions in the SAEK and searched for ways to make "more promising interference patterns" (Haraway, 1997, p. 16) in the SAEK and medicolegal practice.

As will become apparent through the pages of this dissertation, assembling histories of technoscientific objects requires *thick descriptions* of controversies, uncertainties, and instabilities. This level of description is crucial to my project of diffracting the SAEK. Thick description is the means through which the SAEK's many diffracted rays become visible. Latour (2005) says there are no short cuts for an ANT study. Rather, this is "*slow*ciology" [emphasis in original] (p. 122) that requires trudging through shifting terrains of practice and controversy, much like, as Latour observes, the ant insect does over and through hills of dirt and grass.

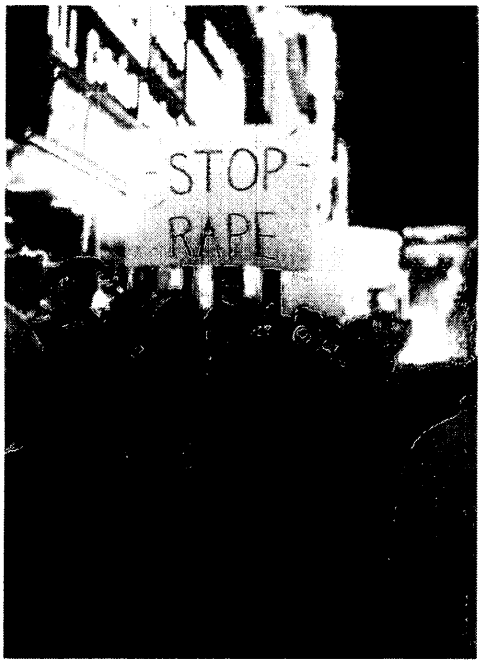
Latour (2005) explains that "the reason for this change of tempo is that...ANT claims to be able to find order much better *after* having let actors deploy the full range of controversies in which they are immersed" (p. 23). Only by tracing many of the controversies and instabilities involving the SAEK will I be able to discuss how it was assembled and given stability in medicolegal practice. In this approach, Latour states, "the search for order, rigor, and pattern is by no means abandoned. It is simply relocated one step further into abstraction so that actors are allowed to unfold their own differing cosmos, no matter how counter-intuitive they appear" (p. 23). Here, I search for order in the SAEK's history through a description of disorder. When I reach the end of my story about the SAEK, it will be clear how the tool came to be, some of the many things it currently is, and what it might be in the future.

The following chapter opens the SAEK's history with the 1970s and the complexities, controversies, and tensions surrounding the design of the first SAEK in Ontario. In this chapter, I begin my story about how the SAEK came to be, and in later chapters, I trace the many things the SAEK and its network currently is and may be.

Chapter 3
Inscriptions and Located Design: Anti-Rape Activism and the Emergence of The Sexual Assault Evidence Kit

"Rape is too serious a crime to simply accept a woman's word"
("OPP Rape Report Prepared Impartially," 1979).

"No longer will we cry softly, padded by the courtroom walls.
We will scream out our collective fear, anger, and rage" (Zook, 1980, p. 27).



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An anti-rape protest in Toronto, n.d.

The first Ontario Sexual Assault Evidence Kit (SAEK) emerged out of rising anti-rape activism, vibrant controversies about medical and legal practice, developing forensic technologies and sciences, and legal practices that were based on distrusting women reporting sexual assault. In this chapter, I chart the SAEK's design in the late 1970s by sketching the histories and practices that were "inscribed" (Akrich, 1992, p. 208) in the first SAEK. I "locate" (Suchman, 2003, p. 5) the SAEK's design in particular actors, practices, controversies, and medical and legal actors'[1] claims about rape, women, and credibility. I argue that with the SAEK's design, a technoscientific witness of sexual assault was devised, which medical and legal actors hoped would offer more credible testimony of sexual assault than the women who report it.

[1] In much of this chapter, I do not use the term *medicolegal*, and refer instead to *medical and legal* practices and actors. I do this deliberately to differentiate the period before the SAEK was introduced to Ontario from the period after, which I describe in chapters 4-6 where I use the term medicolegal. This language usage reflects that the SAEK's development marked a historical moment when medical and legal practices became formally joined in a technological object.

I begin this chapter by sketching the legal histories and practices in the 1970s that arose from legal actors not believing women reporting sexual assault and describe how medical evidence has been historically used in Canadian law to corroborate women's sexual assault reports. I then turn to the rise of the anti-rape movement in Ontario and describe how anti-rape activism challenged the medical response to rape and contributed to initiating the first SAEK. I trace the relations between anti-rape activists and medical and legal actors and illustrate how activists' expertise and marginality was enacted in medical and legal practice. I conclude the chapter by sketching the series of consultations between anti-rape activists and medical and legal actors where the SAEK was first proposed and later designed to reveal the contexts out of which the first SAEK emerged.

In the 1970s, rape – defined in the Criminal Code of Canada as forced vaginal intercourse – was a common term that anti-rape activists used in public education and feminist literature (Brownmiller, 1975; Medea & Thompson, 1975; Clark & Lewis, 1977). To reflect this historical context, I use the term rape throughout this chapter. I refer to the *anti-rape movement*[2] to describe the interconnected political work that many feminist and anti-rape activists were involved in during the 1970s. I refer to *anti-rape activists* to describe the feminist and women liberation organizers, writers, and advocates involved in political work around rape. I also employ the more specific term, *rape crisis centre worker*, to refer to anti-rape activists who worked in rape crisis centres. Some anti-rape activists and rape crisis centre workers were themselves survivors/victims of rape

[2] In using this term, I am not suggesting a homogeneous entity that existed outside of activists and their political work. Instead, I understand the anti-rape movement as I do medicolegal networks: as a collection of interrelated actors engaged in collective work.

and sexual violence and had personal experiences of medical and legal practice that sparked and fuelled their political action. My references to anti-rape activists and rape crisis centre workers thus include politically active survivors/victims and their allies. As with the other chapters, I also insert segments of survivors'/victims' narratives in between and inside my own text to capture how some experienced medical and legal practice in the 1970s.

Locating Design

Locating technological design in particular actors, practices, and controversies has the potential to be a radical act of interference. According to Suchman (2003), technology stories that *locate* technological design in designers and users of technological objects can demand a renewed responsibility for what the objects are and how they are used in practice. In contrast, Suchman argues, stories that do not locate technological design turn technological objects into ahistorical commodities that are detached from the "sites of their production" (p. 5) and "obscure responsibility for the relations of technology production and use" (p. 6). In this chapter, I locate the SAEK's design to reveal a partial history of how it came to be, as a way of interfering with the contemporary SAEK and its meaning as the technoscientific witness.

Technological design involves more than just the production of material objects. Instead, as Akrich (1992) argues, it involves "inscribing…vision[s] of the world in the technological content of the new object" (p. 208). By locating the design of the SAEK, I illustrate the histories and practices that became *inscribed* in the SAEK, focusing particularly on the distrust of women reporting rape, the demand for corroborative

medical evidence in rape cases, and the prevailing views of forensic science as objective and credible amongst legal actors.[3]

Technological design is not a singular process. As I show in this chapter, the design of the SAEK cannot be easily traced back to a single historical moment or actor. Rather its initial design was the result of many entangled histories of activist, medical, and legal action.[4] The events that I trace here are not ordered chronologically, but instead represent many overlapping histories.

Manufacturing Distrust: Histories of Rape Law in Canada

The first Criminal Code of Canada of 1892 defined rape as an act of "carnal knowledge" (s. 266) committed by men against women who were not their wives. This definition remained relatively consistent until 1983, when it was significantly reformed. In 1970, the Criminal Code defined rape as follows,

> A male person commits rape when he has sexual intercourse with a female person who is not his wife, (a) without her consent, or (b) with her consent if the consent (i) is extorted by threats or fear of bodily harm, (ii) is obtained by personating her husband, or (iii) is obtained by false and fraudulent representations as to the nature and quality of the act (s. 143)

This narrow definition excluded rapes committed by husbands, rapes of men and boys, and rapes and sexual assaults that did not involve vaginal penetration. Some of these

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[3] In this chapter, I build on Feldberg (1997) and Parnis and Du Mont's (1999; 2006) analysis of the SAEK as a "cultural artifact" (2006, p. 76) that was built on values of technical rationality and rape mythology. I expand this analysis beyond values to trace the entangled histories and practices that were inscribed in the SAEK's meaning and material form.

[4] The SAEK was redesigned many times in its 34-year history in Ontario in ways that I describe in the subsequent chapters. In this chapter, I focus on the design of the *first* SAEK.

exclusions were delineated elsewhere in the Code as general sexual offences, which included attempted rape (s. 145), indecent assault on a female (s. 149), and indecent assault on a male (s. 156).

Rape trials in the 1970s were shaped by a common belief amongst many legal actors that women were inherently untrustworthy. Clarke and Lewis's (1977) detailed analysis of rape investigations and trials during this time reveals that legal actors routinely viewed women's reports of rape with suspicion and as a result, women's credibility as witnesses was under constant challenge in court. Other accounts suggest that defense lawyers commonly used woman's sexual history to attack her credibility as a reliable witness (Backhouse, 2008). Defence lawyers often argued that a woman's sexual history implied her consent to all sexual acts, indicated her diminished moral character, and suggested that she would likely give false testimony (Clarke & Lewis, 1977).

This practice rose directly out of 19th century English law where a woman's unchaste character was often used to determine her consent to the sexual act and her credibility as a witness (MacFarlane, 1993). The practice was solidified in 1904 in Wigmore's (1970) treatise on evidence, which stated that, "no judge should ever let a sex-offence charge go to the jury unless the female complainant's *social* history and mental make-up have been examined" [emphasis added] (p. 736). In 1971, on a CBC radio broadcast, a defence lawyer explained his colleagues' practices by saying, "very often a rigorous cross examination brings out the truth of the matter…it's his word against hers…so it can't be any other way."

In contrast, other people saw defence lawyers' practices as unnecessarily traumatizing and inherently inequitable. A survivor/victim on the same radio broadcast summarized defence practices in the 1970s by saying, "they are there to break you down as a woman." Doris Anderson, a well-known Canadian feminist, expressed a similar sentiment. She described the legal system in the 1970s by saying, "to get a conviction…a woman had to have lived an absolutely blameless life, untouched by human hands" (p. 1).[5]

A woman's class location and racialization had a direct impact on how she was treated in the legal system. One rape crisis centre worker recollected that racialized, impoverished, and working class women were far less likely to be believed: police were more likely to dismiss their reports as unfounded and the courts more likely to dismiss their testimonies as false allegations (RCC4). According to one retired crown attorney, for a woman's testimony to be believed in the legal system, "you had to be practically…a virgin who was kidnapped from the convent" (CA5).

The deep mistrust of woman's reports of rape went beyond the courtroom and into police investigations as well. In 1975, Ontario police deemed 346 of the 860 reports of rape (40%) to be "unfounded," i.e. that no violation of the law took place or was attempted ("Police Crime Statistics," 1975). In the same year, police laid charges in 260

[5] The rape conviction rates for rape in the 1970s were drastically lower than those for other crimes. According to one report, the *acquittal* rate for most crimes was 15% in the mid-1970s, whereas the *conviction* rate for rape cases was 15% (Canadian Broadcasting Cooperation, 1975). Clark and Lewis's (1977) estimate of the conviction rate in Toronto was even lower at 7%. They argue that low conviction rates in rape cases were a function of both courtroom practices and police investigation practices, which both hinged on beliefs that woman lied about rape (Clark & Lewis, 1977).

of the 860 Ontario rape cases (30%).[6] According to Clarke and Lewis (1977), police in the 1970s were far less likely to believe a rape report and lay charges if a woman had been drinking or hitchhiking, was under 19 years of age or over 30, had no injuries, and was separated or divorced. Other historical evidence suggests that it was common practice for police officers to interrogate survivors/victims on the assumption that their report of rape was false (CBC, 1971). The survivor/victim speaking in the 1971 CBC broadcast recalled what a police officer said, "he told me afterwards 'we tried to trip you up a lot. You don't know how many tricks we tried to pull on you to see whether you were lying.'"

"What I went through with the law, right from the first time I walked into the police office, was ten times worse than the actual rape" (Survivor/victim, CBC Radio, 1971).

The prevailing view of women as unreliable witnesses fuelled legal practices in which legal actors demanded independent corroborative evidence of rape. Police used corroborative evidence, which could include third party witnesses and/or medical forensic evidence, to determine if a case was unfounded and courts used corroborative evidence to determine if an accused was responsible for rape (Clark & Lewis, 1977). As I argue in this chapter, the requirement for corroborative evidence laid the foundation for, and became inscribed in, the design of the first sexual assault evidence kit.

The corroborative evidence doctrine.

The requirement for corroborative evidence in rape cases has deep roots in English common law, where notions of women as being untrustworthy and dishonest witnesses were first encoded in law (Tang, 1998; Backhouse, 2008). Sir Matthew Hale, a

[6] In the same year, the unfounded rate for other offences was significantly lower: assault (6.56%), robbery (8.18%), and breaking and entering (5.95%) ("Police Crime Statistics," 1975).

17th century jurist, has often been credited with penning one of the first legal arguments for the necessity of corroborating women's reports of rape. He stated,

> It is true, rape is a most detestable crime....but it must be remembered that *it is an accusation easily to be made*, and hard to be proved, and harder to be defended by the party accused, though never so innocent [emphasis added] (as cited in MacFarlane, 1993, p. 53).

Hale's words became a doctrine that provided the legal justification to doubt women's credibility in rape cases and invited the legal requirement for corroborative, independent evidence that could prove the veracity of her testimony (MacFarlane, 1993). Three centuries later, Hale's doctrine continued to be a powerful influence in English and North American common law. This was evident in the words of one Canadian jurist in the late 1960s, who wrote,

> Surely the simplest, and perhaps the most important reason not to permit conviction for rape on uncorroborated word of the prosecutrix is that the word is very often *false*...Since stories of rape are frequently lies or fantasies, it is reasonable to provide that such a story, in itself, should *not* be enough to convict a man of a crime" [emphasis added] ("Corroborating Charges of Rape," 1967, p. 1138).

Following Hale's argument, this jurist argued that rape cases required more corroborative evidence than other offences because rape was "uniquely difficult to disprove" (p. 1139).

Corroborative evidence was legally defined in Canada in 1916 as "independent testimony which affects the accused by connecting or tending to connect him with the

crime...[I]t must...confirm...not only the evidence that the crime has been committed, but also that the prisoner committed it" (R. v. Baskerville, p. 91). For much of the 20th century, this ruling served as the Canadian common law definition for corroborative evidence. Judges in the early 1970s were mandated to warn juries of the dangers of convicting a sexual offender without independent corroborative evidence that supported a woman's testimony and implicated the accused (Osborne, 1984). Backhouse (2008) notes that the requirement for corroborative evidence was "a substantial deviation from the general principles of evidence" (p. 171), which in most other cases, allowed jurors to determine a witness's credibility on the sole basis of their testimony in court and not on another's testimony. The additional evidentiary requirement of independent corroborative evidence in rape cases made them far more difficult to prosecute in the 1970s (Backhouse, 2008). The demand for corroborative evidence in Canadian courts opened up the informal requirements in rape cases for medical traces of a forced sexual act.

Medical Traces of Rape.

In 18th and 19th century English law, rape was defined as sexual intercourse with a woman that was "by force and against her will" (MacFarlane, 1993, p. 16), which was a definition that sparked the evidentiary necessity of medical traces of rape. Medical expert claims promoted this definition in the 19th century and popularized the myth that it was impossible to rape a woman without extreme force with claims such as the one expressed in 1815 in the *Elements of Medical Jurisprudence*: "you cannot thread a moving needle" (as cited in MacFarlane, 1993, p. 20). MacFarlane's historical research reveals that

medical evidence of vaginal penetration and injurious marks from force and violence was commonly required for conviction in rape cases.

In Canadian law, this evidentiary requirement for visible signs of force was similarly adopted (Backhouse, 2008). While there was nothing in the Criminal Code that required evidence of force for a rape conviction, "judges and juries were historically loath to convict without evidence of substantial force and spirited resistance" (Backhouse, 2008, p. 147). To be considered corroborative, the evidence had to stem from an "independent source" (R. v. Baskerville, 1916) outside of a woman's testimony. At the turn of the century, medical doctors routinely conducted forensic medical examinations on survivors/victims and gave testimony in court on whether physical evidence of force, as well as traces of semen and sexual disease, were present that could corroborate the report of rape (Dubinsky, 1993). According to Mills' (1982) study of medical journals in the 19th and 20th centuries, most doctors saw their role in rape trials as supplying objective truths against women who routinely lied about rape.

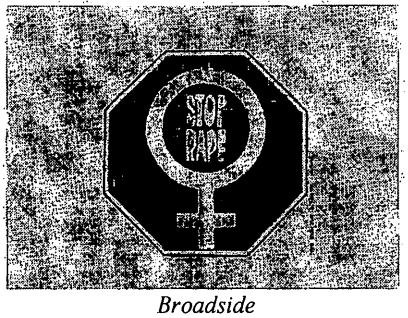
Despite the medical evidence that began to appear in the 1970s that rape was not always violent and visible traces of rape were not always present (e.g. Burgess & Holmstrom, 1973), the evidentiary requirement of force and injuries held strong. Without medical evidence of injuries, convictions were unlikely (Kalven & Zeisel, 1972). Like the doctors at the turn of the century, medical doctors in the 1970s conducted medical forensic exams on survivors/victims to document any visible signs of violence and traces of semen that could corroborate a woman's testimony. The medical forensic exam in the 1970s arose directly from the requirement for corroborative evidence in rape cases, and

the history of legal distrust of women, which the requirement rested upon. I argue that this history of distrust served as the impetus for developing a technoscientific witness of sexual assault and was inscribed in the design of the first SAEK.

The year 1976 marked the beginnings of what would be a significant reform in Canadian rape law in 1983. In 1976, the Criminal Code was amended to eliminate the requirement that judges warn juries about the dangers of convicting without corroborative evidence (s. 8).[7] This change marked a partial step away from a long history of evidentiary requirements of visible signs of rape, but from many accounts, it did not significantly change legal practice (Clarke & Lewis, 1977; Osborne, 1984). Judges continued to warn juries of this practice, using the common law as justification, until 1983, when the more significant legal reforms prohibited this practice (Osborne, 1984).

Anti-rape activists resisted what they saw as the oppressive climate for survivors/victims of rape in the legal system in the 1970s. Their activism fueled rape law reform and helped to transform the medical and legal response to rape survivors/victims. It is to this resistance that I now turn.

Sparks of the Anti-Rape Movement



Broadside
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Anti-rape Logo, ca. 1979

In the late 1960s and early 1970s, the women's movement in Canada was in full swing. Drawing its momentum from what Rebick (2005) terms a "decade of

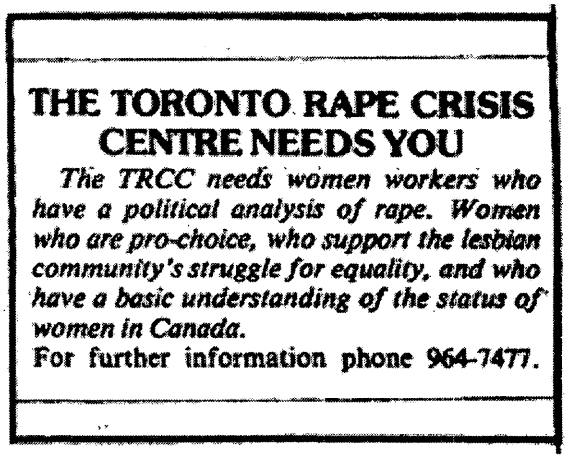
[7] Also significant was the new rule that stipulated that sexual history was only admissible with the permission of a judge, a ruling that marked the beginnings of what would become the rape shield law in 1992 (Osborne, 1984).

revolutionary change" (p. 7) in the 1960s, the women's movement was developing its own language and analysis of gendered oppression. By 1966, the Equality of Women in Canada committee had formed, met, campaigned for, and won, a Royal Commission on the Status of Women, which developed 167 recommendations "to ensure for women equal opportunities with men in all aspects of Canadian society" (Royal Commission on the Status of Women, 1967, p. 13). New feminist literature in Canada, such as Chatelaine Magazine in the years 1957-1977 under the editorial leadership of Doris Anderson, and in the United States, Betty Freidan's (1963) *The Feminine Mystique* and Kate Millet's (1969) *Sexual Politics*, had inspired a new feminist consciousness and organizations across English-speaking North America. Many women's liberation groups emerged in Canada in the late 1960s, such as the Toronto Women's Liberation Movement, the Fédération des femmes du Québec, and the Vancouver Feminine Action League. Women were organizing women's caucuses in labour unions, instigating collective childcare, establishing safe houses for women fleeing from violence, and organizing to legalize abortion (Rebick, 2005).

Out of this diverse movement, Cohen (1993) and others suggest that women discovered similar experiences of gendered oppression and violence at the hands of men. In feminist consciousness-raising groups, according to Cole (1989), women "uncovered the truth that sexual abuse was epidemic, not occasional, [and] more normal than marginal" (p. 12). Speak-outs provided a public forum for women to share stories of violence and instigated the public face of the anti-rape movement in the 1970s (Kinnon,

1981).[8] With the release of Susan Brownmiller's *Against our Will: Men, Women, and Rape* in 1975 and the first Canadian book on rape in 1977, Lorenne Clark and Debra Lewis's *Rape: The Price of Coercive Sexuality*, the anti-rape movement in Canada was well underway.

One of the most visible signs of the anti-rape movement was the development of rape crisis centres (RCC) across Canada. In 1973, the first Canadian RCC opened in Vancouver under the name Vancouver Rape Relief.[9] One year later, the Toronto Rape Crisis Centre (TRCC) opened its doors. The TRCC began with a few women and a small $8,000 grant from the city of Toronto (Parent as cited in Rebick, 2005). In one of the first advertisements for the centre, the TRCC was described as "a place where women who have been raped can go and be helped...where she can sit and talk with sympathetic women, [and] have a warm drink" ("Rape Crisis Centre Opening," ca. 1974, p. 1). In their first year, the TRCC took 2,600 calls from women seeking advice and support, and as the years followed, the numbers rose rapidly ("Brief Submitted," 1974). In the early years of



Broadside
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Call for TRCC Volunteers in Broadside, 1979

[8] While the 1960s and 1970s were decades when feminist consciousness around male violence solidified, the movement had historical roots that were much deeper. Gavey (2005) estimates that women's organizing against male violence and sexual exploitation began as early as the 19th century. Much of women's early activism around sexual violence in Canada is not well documented; however, Backhouse (2008) notes that as early as the 1900s, women were publically challenging existing rape laws and organizing for legal reform.

[9] Vancouver Rape Relief was predated by several rape crisis centres in the United States, the first of which was the Bay Area Women Against Rape that was organized in 1970 (Gornick, Burt, Pittman, 1985).

RCCs in Canada, many activists hoped their organizing would combat and eventually eliminate male violence. One recalled, "we all believed that we could put ourselves out of business" (RCC4).

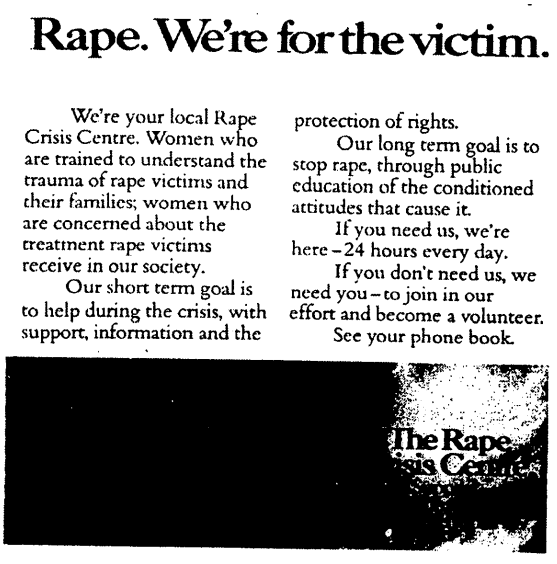
According to many historical records, RCCs in the 1970s sought to fill the "vacuum of services" ("The Experience of Rape Crisis Centres," ca. 1977, p.1) for survivors/victims of rape. One volunteer training manual (1977) states that RCCs aimed to provide women with "an alternative to dealing with often brusque, uncaring, superficial health and legal systems" (p. 2). Many centres began with women running 24-hour crisis lines from their homes (RCC10). Others rented space in community buildings and with primarily volunteer labour, they offered individual and group counseling and accompaniment for survivors/victims to the hospital, police station, and court. A member of the Ontario Coalition of Rape Crisis Centres (1991) wrote about these beginnings,

> There were no guidelines to draw from, other than our own and other women's experiences. We were faced with the necessity of developing our own training materials as well as developing expertise required to provide help to many different women (p. 1).

For many anti-rape activists, the centres provided more than just a service for women. The centres were instead, according to one activist, "riding the wave of the women's movement" (RCC4) and were thus part of a larger feminist effort to develop alternate practices and discourses that challenged oppressive forms of power. Many centres offered "feminist peer counseling" (RCC4), which resisted medicalized expert definitions of therapy and insisted instead that women's experiential knowledge could be the basis of

support for other women. Deb Parent, an early TRCC member, explained in an interview with Judy Rebick (2005) that "the principle of peer counseling with a feminist approach was revolutionary...every feminist service was a reaction to patriarchy" (p. 82).

Many RCCs adopted methods of organizing from the women's and other social justice movements. Instead of depending on hierarchical structures, many centres organized as collectives (Cohen, 1993). One activist described the collective model her centre used by saying, "the whole idea was to share the work, rotate the authority, and follow emerging leadership" (Lakeman in Rebick, 2005, p. 71).



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National Network of Canadian Rape Crisis Centres Advertisement, ca. 1978

However, according to many anti-rape activists whom I interviewed, organizing as collectives did not come without its challenges. Another activist reminisced, "we were attempting to break down power structures...and work across the table from each other...sometimes this was very unyielding, [and] sometimes a fucking pain in the ass [laughs]" (RCC4). Some centres, largely as a result of pressures from funders, moved quickly to instituting a hierarchical model with a Board of Directors, but most maintained their collective model for much of the 1970s.[10]

[10] In chapter 4, I discuss this further and outline some of the contextual reasons that some centres developed hierarchical models.

The RCCs in the 1970s became a hub of anti-rape activism in Canada. In addition to the centres' support work for survivors/victims, many rape crisis activists took on the task of educating the public and medical and legal actors about violence against women. According to one rape crisis centre worker, there was a prevailing mythology around rape that blamed the survivor/victim for the violence she (or he) experienced and labeled the rapist as a perverted stranger (RCC4). To counter this, many anti-rape activists drew on feminist analysis of rape that saw it as an expression of sexism: and act "by which all men keep all women in a state of fear" (Brownmiller, 1975, p. 4). Many argued that, "rape reaches women of all socio-economic backgrounds and is a reality regardless of life-style" (Toronto Rape Crisis Centre, 1979, p. 3).

> *"Right from the very beginning I always spoke out as a survivor... My mother was a nurse, and she had all these medical books with pictures of patients that had black strips over their eyes so you couldn't identify them. And I thought, no I am not going to be that. I will not wear that black strip over my eyes. I did nothing wrong, I have nothing to be ashamed about here" (SA3).*

Describing rape as a function of sexism politicized rape and may have challenged prevailing myths of the rare survivor/victim and the *sick* rapist. However, it glossed over the way that sexual violence can be also motivated by race, class, and ability, something which many anti-rape activists asserted in the following decades (e.g. Davis, 1983; Harris, 1990; Monture-Okanee, 1992). In the 1970s, however, most anti-rape activists were rallying around analyses of rape as a form of sexism and were challenging prevailing myths about rape in public educationals, media, and collective actions. (Pierson, 1993). Remembering this work, one activist said, "we were in unchartered territory" (RCC4).

Anti-rape public education work was met with much resistance. Some religious groups, according to Kinnon (1981), criticized the work for "threatening sexual morality and the natural order of things" (p. 71) and many schools prevented anti-rape educators from speaking to the students "on the grounds that they might create paranoia among the students" (p. 71). One activist recalled some of this resistance and said,

> when we talked about child sexual assault people would stand up in the room and tell us that we were lying... and no matter how many times we would say here are the numbers, here are the stories, people would just refuse to believe (RCC4).

Despite the opposition, political organizing around violence against women intensified. By 1977, there were eleven RCCs across Ontario, and an Ontario Coalition of Rape Crisis Centres (OCRCC) had been initiated (Ontario Coalition of Rape Crisis Centres, n. d.). In 1978, a National Network of Rape Crisis Centres was formed ("Minutes of AGM," 1978). With this collective strength, many anti-rape activists turned their attention to transforming medical and legal practice.

"A pitched battle": Relations with institutional actors

Many of the existing archival records on Ontario rape crisis centres in the 1970s portray a collaborative relationship between RCCs and medical and legal actors. In most of the publically available government records on rape services in the 1970s, rape crisis centres are figured as community-based extensions of medical and legal services. In the 1979 provincial handbook on *Helping Victims of Sexual Assault*, rape crisis centres are depicted as a non-political service that collaborated with institutional actors to "provide continuity" (1979a, p. 37) in legal and medical services. This depiction is also mirrored in

many RCC's own promotional pamphlets, where their mandates included "co-operat[ing] with other institutions" (Rape Crisis Centre Hamilton, ca. 1978, p. 1) and providing "a valuable liaison" ("Why Invest," 1979, p. 9) between hospitals, police, and survivors/victims.

These portrayals convey an uncomplicated relationship between RCCs and medical and legal actors. What these portrayals conceal are the tensions and struggles between RCCs and medical and legal actors in relation to anti-rape activists' efforts to institute change in medical and legal practice. As I show here, although there were times when medical and legal actors acknowledged and relied on anti-rape activists' expertise on rape, this was punctuated by practices that moved rape crisis centre workers to the margins of medical and legal practice. These tensions shaped the relations within which the SAEK was imagined, designed, and brought into being in medical and legal practice. In order to set the stage for the design consultations for the first SAEK, I trace the complex relations between anti-rape activists and medical and legal actors at three meeting points: 1) rape law reform, 2) training, and 3) rape crisis centre funding negotiations.

Rape law reform.

In the late 1970s, largely as a result of anti-rape activists' political work, efforts were underway to reform existing laws on rape and other sexual offenses. In 1975, anti-rape activists from across Canada met in Vancouver and Ottawa to draft recommendations for the Law Reform Commission, the committee responsible for redrafting Canadian rape law (Vance, 1978). The activists made 24 recommendations, the

most significant of which proposed eliminating rape as a distinct offence in the Criminal Code and reclassifying it as a form of sexual assault in section 244 of the Criminal Code ("Preamble," 1975). Many activists hoped that this reform would encode law with feminist understandings of rape as an inherently violent and not sexual act (Johnson & Dawson, 2011).

Over the eight years of negotiations that ensued before the eventual 1983 rape law reform, many anti-rape activists actively lobbied to ensure that their political analysis of rape was represented in the revised Criminal Code (Sheehy, 1999). In corresponding with the Law Reform Commission and other government bodies, many anti-rape activists positioned themselves as experts on rape. In doing so, they enacted a radical reformulation of expert knowledge, one that rooted expertise in practical experience of advocating for rape survivors/victims. One collective of activists wrote,

> Rape crisis centres' staff and volunteers have acquired *considerable expertise* on the issue of rape and sexual assault. They have studied the law relating to the issue and have a *wealth of practical experience* in dealing with the implications of the law as well as implementation of the procedures and policies of institutions. Women who work in rape crisis centres are in a *key position* to recommend improvements in legislation concerning rape and sexual assault [emphasis added] ("Relevance of Rape Crisis Centres," ca. 1977, p. 103).

Anti-rape activists' experiential knowledge was at times recognized by medical and legal actors, not only during the negotiations around legal reform, but also during their efforts

to transform medical and legal practice. However, as I show, the extent to which medical and legal actors valued their expertise varied significantly.

Training the troops.

Many rape crisis activists saw themselves in direct opposition to the medical and legal systems responding to rape. In an interview with Scott Neigh (2012), Lee Lakeman, a well- known Canadian anti-rape activist, said,

> I think it is very important to realize that we have a relationship with the state that is not friendly, and we have a relationship with professions that is not friendly...neither the police nor any...profession is committed to establishing women's equality....they are agents of the status quo, and so we are in a pitched battle (p. 83).

The so called "battle" often took many forms, some which involved bending to requirements set by medical and legal actors. A training manual for rape crisis volunteers from 1977 described police and emergency room personnel as "people we can't afford to alienate" (p. 28). The manual outlined the importance of challenging oppressive medical and legal practice but also warned that volunteers' antagonism towards medical staff could "backfire" (p. 28), particularly on survivors/victims. According to one anti-rape activist, striking the balance between recognizing some medical and legal practices as unjust and resisting without confrontation was challenging for many (RCC10). However, for those who struck the balance, it became possible to work to institute change in medical and legal practice from within.

In the 1970s, many rape crisis centres took on the responsibility of filling the void in workplace training on rape for police and hospital staff. They provided educational sessions that were built from political analyses of the anti-rape movement and the experiential knowledge anti-rape activists had gained supporting survivors/victims (RCC10). At the time, rape crisis centres were the only organizations offering this kind of professional, expert training on rape. This work, however, often resulted in conflict. One retired crown attorney remembered,

> There was a certain amount of strain between the women's groups and the law enforcement administration of justice...I think there is always a tendency to say ... you can't tell me that I'm not doing a good job. And to be fair to myself and the people that I worked with, there was a certain amount of maybe overzealousness, stringency in the special interest groups that were trying to generate change (CA5).

The accusation of stringency went both ways. Some rape crisis activists saw workplace training as ineffective in addressing the inequalities that medical and legal institutions perpetuated. In an interview with Judy Rebick (2005), Lakeman said, "at a certain point...we stopped training cops and emergency room nurses, because these were black holes where you could be taken up forever" (p. 75). She went further in an interview with Scott Neigh (2012) by saying, "I think it is much more important to realize that these are hierarchies and what you have to do is affect the top...You're not going to have much impact training the troops" (p. 85). While Lakeman's centre did not continue training, many other rape crisis centres did well into the 1980s (RCC12). Workplace training, as

well as advocating for legal reform, was, however, contingent on rape crisis centres having the necessary funding to survive, which, for many centres, was extremely uncertain.

Funding rape crisis centres.

Despite the growth of rape crisis centres in 1970s, many struggled to find adequate funds to support basic costs of rent, phone lines, and for some centres, one or two staff members. Most centres opened with funds from non-renewable, short-term government grants, but when these expired, centres had to turn to charities such as the United Way or private sector donations (Ontario Coalition of Rape Crisis Centres, 1979). In an effort to maintain their centre in the late 1970s, the Toronto Rape Crisis Centre sought and received donations from many unlikely sources such as Canadian Tire ($100), Proctor and Gamble ($200), and Imperial Oil ($1,000) (Chase, G., 1977, Chase to Alderman, July 26, 1977). While these donations provided some temporary support, the meager amounts threatened the sustainability of the centre and in 1978, the TRCC announced in a press release, "we currently have only about one third of the money required to operate for another year. We cannot sustain our present level of service without on-going funds for staff and core programs" (Toronto Rape Crisis Centre, 1978). TRCC's funding challenges were shared by many others centres in the province (RCC10). At the National Day of Protest against violence in 1977, activists spoke to the funding shortages that threatened rape crisis centres: "we are faced with the loss of what little we have gained in the way of assistance to women...this is not accidental. It is systematic. Women, always and everywhere, have had to accept the burden of worsening

economic conditions" ("National Day of Protest," 1977). In 1980, 11 out of the 14 centres in the Ontario Coalition of Rape Crisis Centres were threatened with closure (Morton, 1980, Morton to Unknown, January 14, 1980).

With increasing media attention on pending RCC closures across the province in the late 1970s, public pressure was applied to the provincial government to provide more permanent funding. The Women Teachers' Association of Ontario argued in their "Women in Crisis" report in 1980 that "the province must take responsibility for helping women who have been raped, assaulted, abandoned or are victims of incest" (Unknown, 1980).

According to many anti-rape activists I interviewed, the prospect of securing provincial government funding was, for many centres in the Ontario Coalition of Rape Crisis Centres (OCRCC), both promising and unnerving (RCC10; RCC12; RCC13). These activists recalled that although many viewed government funds as having the potential to save many RCCs from closing, it was also widely understood that government funds could be used to suppress and control feminist politics and activism. The Canadian Rape Crisis Centres' (1979) funding manual warned prospective grant writers, "if you accept the funds, you accept all the strings that are attached" (p. 9). Considering this possibility, one Ontario activist wrote about her deep concern that government funding could de-radicalize anti-rape activism and force rape crisis centres to become merely "appendages to the existing social service delivery system" ("The Experience of Rape Crisis Centres," ca. 1977, p. 5). Government funding agencies, she argued, "have their own hidden agendas" (p. 5). Despite these hesitations, the increasing

pressures from lack of funding led the OCRCC in 1979[11] to apply for $750,000[12] from the Ontario Provincial Secretariat for Justice (PSJ).[13]

"Gloves from my mother."

The OCRCC funding application unleashed a series of funding negotiations between the PSJ and the OCRCC. OCRCC representatives (themselves rape crisis centre workers) were flown to Toronto and given rooms at the Delta Chelsea Hotel, where they stayed during the many days of negotiations (RCC10). One OCRCC fundraiser told me that early on in the negotiations, it became clear that the government's primary interest was in gaining access to the information that centres had on women's experiences of rape. She said,

> I think it was pretty clear to all of us that we were maybe going to have to do some things that we didn't want to do in order to keep the money... I remember we sat in each other's hotel rooms...into the middle of the night having those conversations...convincing each other that we were doing the right thing (RCC10).

According to this fundraiser, after lengthy discussion, the OCRCC representatives agreed that they would be willing to make some concessions; however, breaching the confidentiality they promised women would not be one of them.

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[11] The OCRCC's first funding proposal in February 1979 was declined with a recommendation from the PSJ that the Coalition seek funding from community agencies instead ("Rape Crisis Centre may have to close," 1979). The Coalition publicized the PSJ's decision in the media and applied again in November 1979. With the mounting public pressure, the PSJ conceded to negotiations.

[12] The OCRCC requested yearly salaries of $15,000 for each of the fifteen centres (Kitchener-Waterloo's centre had closed, but was included in the count) for three years (Ontario Coalition of Rape Crisis Centres, 1979).

[13] The PSJ was the predecessor to the current Ontario Ministry of Community Safety and Correctional Services.

During the negotiation meetings, the fundraiser recalled, the OCRCC representatives tried to present themselves and the RCCs as non-threatening and apolitical. In preparation for the meetings, they solicited help from women politicians on how to dress, who told them, "if you turn them off by your appearance, they may not listen to what you have to say. If you are coming in to their world, you need to dress like you are in their world" (RCC10). The fund-raiser I interviewed remembered this with laughter and continued the story by saying,

> So we did. Yah it's quite comical when you think back [laughs]...But I remember borrowing gloves...from my mother. Yup we wore gloves to the meeting. And you are talking about a group of women who didn't own a pair of white gloves [laughs] (RCC10).

The fund-raisers presented the rape crisis centres as a service that the government had an obligation to support. The feminist politics and analysis that grounded many of the RCCs were, according to one fundraiser, intentionally kept out of view, as were the internal political debates within the OCRCC.[14] She explained,

> We rarely talked to them about it from a feminist point of view. And if anything, we worked together, if we thought somebody was a little bit out of control, under the table we would pat their hands. I remember doing that [laughs] (RCC10).

[14] At the time of these negotiations, there were heated debates in the OCRCC on whether rape crisis centres should support and facilitate survivors'/victims' confrontations of their rapists. I discuss these alternative paths to justice in greater detail in chapter 4.

Through these moves, the fund-raisers enacted the OCRCC as a credible, apolitical service provider. With a smile, the fund-raiser recalled, "I don't think they had any idea who they were dealing with" (RCC10).

In June 1980, the OCRCC was granted $450,000 over three years ("Statement," 1980). The amount was significantly less than the OCRCC originally requested, and as was predicted, it came with many strings that the OCRCC had to confront in later years. However, in 1980, it offered much needed financial support for the RCCs in Ontario.

The dynamics between the OCRCC and the PSJ in their funding negotiations were far more complex than the governments' historical records suggest. From the archival records and oral histories I have described here, it is clear that the talks were not purely collaborative, equitable meetings between service providers and funders. Instead, the funding meetings were complicated by tensions around political differences and plays of power. The government negotiators dictated not only the terms of the funding, but also the terms by which the negotiations took place. Activists used strategic devices to heighten their appearance of femininity and their class positioning to make themselves and RCCs appear less politically threatening.

I suggest that the eventual government funding was a nod to RCCs' expertise around rape advocacy and support. However, it also placed RCCs in a largely dependent relationship to government funders.[15] This was the context in which many anti-rape activists were organizing to improve medical and legal treatment of rape survivors/victims and were engaged in consultations where the SAEK was imagined and

[15] I describe the effects of this dependent relationship further in chapter 4.

designed. To chart what led up to the design consultations for the SAEK, I now turn to the medical practices for rape survivors/victims in the 1970s.

Contentious Medical and Legal Practice

Technoscientific proof of rape.

The 1970s saw some developments in forensic technology. Since the previous decade, forensic technology had, according to some forensic scientists, "undergone a revolutionary change" (Krishnan, 1978, p. xi) resulting from new technologies that offered increased magnification and precision in chemical analysis.[16] Forensic science, according to Dr. Krishnan, a scientist at the Ontario Centre for Forensic Science (CFS), had been "propelled into the modern age" (p. 5) by these new technologies,[17] which were inspired by increasing crime rates and resulting increases in criminal investigation funding in Canada and the United States. In 1978, Krishnan stated, "the analytical capabilities of a crime laboratory today in providing scientific evidence are indeed enormous" (p. xi).

Alongside the developments in forensic technologies, Krishnan claimed that there was an "ever increasing demand for scientific evidence" (p. 9) in legal trials. He asserted that forensic evidence was valuable because it was impartial: it was, as he wrote, "objective by nature" (p. 9). He stated, "physical evidence by nature is not subject to

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[16] Some of these techniques included: a) the scanning electronic microscope, which unlike its predecessor, the optical microscope, could magnify objects up to 300,000 times, b) gas chromatography, a more precise technique for detecting and separating chemical compounds, and c) mass spectrometry, a more sensitive technique for identifying chemical compounds (Krishnan, 1978).

[17] In retrospect, Krishnan's proclamation might appear somewhat exaggerated. In some cases, the technologies he describes, such as gas chromatography, were born from only slight variations of those technologies that came before them. Krishnan's confident words are important, however, for they depict the excitement with which these new forensic technologies were greeted by the scientific community.

lapse of memory, confusion, and perjury, as are human witnesses" (p. 11). Reflecting this sentiment, one defense lawyer that I interviewed claimed that "science was worshipped" in the courtrooms of the 1970s and forensic scientific evidence, when it was available, was taken "as gospel" (DL6). It was assumed that forensic technoscientific evidence, unlike human witnesses, had the capacity to speak unbiased, objective truths about crime.

Legal actors' assumption that forensic evidence was inherently objective fit neatly alongside their distrust of women's testimonies of rape. According to some anti-rape activists' observations, legal actors commonly saw the medical forensic exam in rape cases as "proof of rape" ("Training Manual," 1977, p. 63). Forensic trace evidence of semen, hair deposits, and drugs in the blood stream and medical evidence of scratches, bruising, and a broken hymen were taken to be important corroborative evidence that "substantiat[ed] her story" of rape (p. 77). Medical forensic evidence was "almost a prerequisite for conviction" ("Present Laws," ca. 1980, p. 5). In the context of this valuing of forensic evidence, some survivors/victims of rape in the 1970s arrived in Ontario emergency wards to have medical care and forensic examinations.[18]

Medical practices and experts on the margins.

For many rape survivors/victims, medical practices in response to rape in the 1970s were everything from inadequate to thoroughly traumatic (Clarke & Lewis, 1977). One-third of survivors/victims who visited Ottawa hospitals in 1976 reported feeling

[18] The number of women who sought medical care was likely very few, and the number who sought the medical forensic exam likely even fewer. These numbers are not available in any public records, however, estimates can be made from other pieces of evidence. Reporting rates for rape in the 1970s were known to be extremely low, with estimates being as low as 5% (Brooks, 1975). To have a medical forensic exam done, a survivor/victim had to report their rape to the police, something that many were not prepared to do ("Training Manual," 1977). From this, it can be assumed that the number of forensic medical exams conducted on Ontario women in the 1970s was low.

frightened and intimidated by the medical professionals who treated them (LeBourdais, 1976). Some women reported feeling just as traumatized by their medical treatment as they were by their rape (Donadio & White, 1974). According to some reports, many medical professionals met survivors/victims with "their own verdict" (LeBourdais, 1976, p. 102) about whether the rape had occurred and treated many women as if they "were the criminal" (Miller, 1980, p. 5). Williams and Williams (1974) described these practices through a dialogue they captured between two physicians discussing a survivor/victim seeking treatment:

> 'A: I kind of doubt this one. I can't believe some of these women. B: It figures. You can't trust any of them – not even your own wife…All a woman has to do is scream 'rape' – and a guy is ruined. A: Well what shall we do with this one? B: How about the biggest speculum we've got without any lubricant?'" (p. 391).

These physicians' hostility and disbelief of the survivor/victim was, according to many other reports, far from unusual in emergency wards (Donadio & White, 1974; Burgess & Holmstrom, 1973; Miller, 1980; Kinnon, 1981).

Popular conceptions of rape as being either a female fantasy or a woman's fault filtered into medical practice. Some physicians reportedly told survivors/victims that "there is a fine line between rape and promiscuity" (Kinnon, 1981, p. 27), and others, that "there is no such thing as rape" (LeBourdais, 1976, p. 12). One survivor/victim had a gynecologist say to her, "a hospital should not be considered to be a counseling service or a haven for the unloved or the unwashed" (LeBourdais, 1976, p. 102).

Many historical records indicate that a survivor/victim's social location had great bearing on her treatment by medical actors and the extent to which her experience of rape was believed ("Training Manual," 1977). According to some anti-rape activists, physicians and nurses often treated middle class, married, white women as "one of their own" (RCC10); however, racialized, impoverished, sexually active, young women were more commonly treated as either deserving or lying victims (RCC14). One Toronto gynecologist was quoted as saying "there is one type of woman I would have a hard time believing was raped: a woman between 16 and 26, on the pill and no longer a virgin" (LeBourdais, 1976, p. 102).

Survivors'/victims' experiences in the emergency ward and their understandings of the medical system that arose from them were often pathologized and deemed to be a stage of the "rape trauma syndrome" (Burgess & Holmstrom, 1974, p. 981).[19] According to the medical descriptions of this syndrome, stage three featured survivors'/victims' experiencing a "silent suspicion...[and] a sense of betrayal from those she looks to for support (i.e. police, medical professionals)" ("Training Manual," 1977, p. 51). With medical diagnoses such as these, survivors'/victims' experiences of trauma at the hands of the medical system could be easily discounted as fictional.

In the emergency ward, many rape crisis centre volunteers were trained to work as "buffers" ("Training Manual," 1977, p. 43) between survivors/victims and the physicians and nurses that attended them. Being a "buffer" involved not only responding to the

[19] From the archival records on RCCs, the rape trauma syndrome, which was meant to describe women's experiences of rape trauma, appears to have been a mixed blessing for many activists. The syndrome provided a language that identified and legitimated women's experiences of rape trauma. However, it also pathologized and individualized the traumas of rape and the survivors/victims who faced them, which stood in contrast to the political understandings of rape many RCCs were forwarding.

survivors'/victims' needs, but also ensuring that medical staff offered appropriate and sensitive medical attention. One RCC training manual offered this instruction to volunteers, "you may have to make suggestions to medical folk...about what to do and how to do it. Be firm but *gentle*...say it *nicely*, but do say it. You may be averting disaster" [emphasis added] (p. 43). Training manuals instructed volunteers to remind physicians about their role; "remind him that he need only report on the medical information" ("Legal-Medical Procedures," 1983, p. 2), and how to use medical tools in appropriate ways; "request that the doctor warm the speculum for the examination" (p. 2).

With these training manuals that detailed the intricacies of forensic evidence collection, rape crisis centre volunteers likely knew more about evidence collection than many of the physicians conducting it, who at the time were receiving no formal training on the topic (FS1). Although rape crisis centre volunteers in the medical exam room were most often observing medical practice ("Training Manual," 1977), they became directly involved when they followed the training manuals advice and gave physicians directions on evidence collection. From the training manual instructions, it is clear that volunteers' involvement in medical practice was complex. By directing physicians on how to collect evidence, rape crisis centre volunteers positioned themselves as experts in the medical exam. However, the training manual instructions suggest that volunteers' expression of expertise was tempered by differences in professional status between volunteers and physicians. The training manual instructed rape crisis centre volunteers to express their expertise in "gentle" and "nice" ways that did not threaten or challenge physicians'

medical expertise. The volunteers were thus the experts whose directions could be dismissed and whose presence could be ignored. They were the actors positioned both inside and outside of practice.[20] In this sense, rape crisis centre volunteers in the medical exam, were experts who were often sitting on the margins of medical practice.

The medical forensic exam and traces of the subjective.

Despite the value that legal actors placed on medical forensic evidence in rape cases, there were few standardized protocols for medical evidence collection (Williams & Williams, 1973, Hargot, 1982). While some standardized protocols began to appear in the United States in the early 1970s (Evrard, 1971; Fahrney, 1974), none appear to have existed in Canada until later in the 1970s. Evidence collection in Ontario rape cases was, according to one physician, "dealt with in a haphazard fashion" (Hargot, 1982, p. 126). According to one forensic scientist, there were no consistent procedures within or between Ontario hospitals at the time and individual physicians had largely unregulated discretion to collect medical evidence with whatever materials they saw fit (FS1). Explaining this, one nurse said, "you just used what you thought was supposed to be…give[n] to the police" (SANE5). Spare swabs, vials, and envelopes in the emergency ward were likely used for swabbing, blood and hair collection, when individual physicians deemed these procedures appropriate.

The lack of protocols for evidence collection was accompanied by lack of forensic training for medical professionals (Kinnon, 1981). Before the 1990s, emergency physicians and nurses in Ontario did not have formal training on the contamination of

[20] I borrow this notion of multiple membership from Star (1991), who uses it to describe marginal actors.

evidence and the preservation of samples (FS1). Without much understanding of forensic evidence collection and preservation, the risks were high of samples being contaminated and/or molding before they arrived at the forensic lab (FS1).

According to many reports, insufficient training and a lack of protocols weighed heavily on many survivors/victims in emergency wards (Donadio & White, 1974; Kinnon, 1981). Lengthy delays and extended examinations in the emergency ward were common for many survivors/victims (Kinnon, 1981). Many also reportedly found the forensic exam to be intrusive, painful, and traumatic (Donadio & White, 1974). The exam often included procedures such as plucking pubic and head hairs, clipping fingernails, drawing blood, photographing injuries and undergoing pelvic exams and vaginal aspirates (One day conference, ca. 1975).[21] One survivor's/victim's description of the pelvic exam was quoted in several reports: "what he was doing was so similar to what just happened...it was too much the same, two times in one night...I didn't want anyone to look at me; I didn't want anyone to touch me" (Holmstrom & Burgess, 1979, as cited in Kinnon, 1981, p. 26).

"When I went to the hospital there was a kit. My family doctor was allowed to collect the evidence, which on the one hand was good because I was probably more comfortable with him. But on the other hand, he didn't know anything about it, so it probably took him two or three times as long to even perform the evidence collection because he had to keep reading the instructions and he wasn't sure what he was doing" (SA3).

"The whole process is so intrusive that it is probably a good thing I was in shock otherwise I'm not sure how I would have reacted to it" (SA3).

[21] A vaginal aspirate is a method for collecting semen in the vaginal cavity. It involves filling the vagina with sterile water and then drawing the water out so it can be tested (SANE5). Decades later, this approach was found to be ineffective in collecting semen (FS1).

A reluctance to treat.

Many physicians in Ontario were reportedly reluctant to conduct medical forensic exams on rape survivors/victims (LeBourdais, 1976). Physicians' reluctance was likely due to many things; however, according to Dr. Hargot (1982), much of it stemmed from physicians' lack of training in forensic procedures, their discomfort with becoming involved with legal proceedings, the minimal financial compensation they received for the exam and time in court, and their reluctance to spend the time the exams required. One rape crisis centre worker recalled, "I used to literally go through the phone book when I brought a sexual assault victim into the hospital....to find a doctor who would come in and do the exam" (RCC10). Some survivors/victims were turned away from emergency wards and "forced to shop around for medical treatment" (LeBourdais, 1976, p. 103). One hospital administrator was quoted as saying that "the hospital 'doesn't encourage' rape victims to come in for examinations because doctors lose too much time when cases get to court" (Kinnon, 1981, p. 26).

When survivors/victims and their advocates found a willing physician, it was often not a gynecologist, but an intern or resident staff (Clark & Lewis, 1977). According to Vance (1978), survivors/victims with no visible injuries or trauma were commonly considered to be low priority. One survivor/victim reportedly waited eight hours for a medical exam while the physician finished his office hours (Kinnon, 1981). These delays and refusals to conduct the medical exam, along with the lack of protocols and forensic training, presented tensions and challenges in not only emergency wards, but in court as well.

Forensic Evidence on Trial

For those rape cases that made it to trial, of which there were few,[22] forensic evidence from the medical exam was often contested and deemed inadmissible (Parnis & Du Mont, 2006; Feldberg, 1997). The lack of standardized protocols for evidence collection and handling often invited challenges about its "integrity" (Krishnan, 1978, p. 16). Legal actors argued that the quality of forensic evidence was reduced by the long delays in evidence collection, which was reflected in many forensic scientists inconclusive findings about the presence of sperm after survivors'/victims' long waits in emergency wards (Kinnon, 1981). As the RCC volunteer training manual ("Training Manual," 1977) explained, "evidence is much harder to acquire if some time has passed and the evidence that does remain does not hold the same credibility as that which is 'fresh'" (p. 68). When there was no available medical evidence, either as a result of physicians' reluctance to conduct the exam or degraded or moldy samples that could not be analyzed, rape trials often resulted in acquittals (Marshall, 1980).

Courtroom challenges of forensic rape evidence revealed uncertainties about local medical practices. Without standardized protocols dictating medical practice, local action in emergency wards could more easily be labeled as unscientific and unreliable. Without a formalized system of coordination between institutional actors collecting and handling evidence (physicians, nurses, police, and forensic scientists), the evidence could be more easily dismissed as mishandled and contaminated. The subjectivities and "messiness"

[22] In 1972 in Canada, of the 1230 rape cases reported, only 119 ended up in court and only 69 resulted in conviction (Canadian Rape Crisis Centres, 1975). Provincially, the numbers were similar. In Ontario in 1975, 860 rapes were reported and only 260 went to trail ("Police Crime Statistics," 1975).

(Law, 2004, p. 42) of medical practice that was not guided by standardized protocols was thus visible in the courtroom. These issues in the courtroom inspired calls for standardized medical evidence collection protocols.

Designing the Sexual Assault Evidence Kit

Several years before the standardized SAEK was introduced in Ontario, many were advocating for its creation. Among those advancing this case were many anti-rape activists and several feminist writers. When Clark and Lewis's ground breaking feminist book on rape was published in 1977,[23] it exposed, among many other things, the lack of uniformity in medical practices for rape in Toronto hospitals. They recommended standardized medical protocols. Some rape crisis centre staff and volunteers used Clark and Lewis's assertion to advocate for medical protocols in their own communities (RCC10). Their aim, according to one rape crisis staff involved, was "to make sure that when we got to court things weren't thrown out....that you didn't give the defense the opportunity to challenge how the collection was done...because you had something standardized, it wasn't individual based" (RCC10). Many hoped that with the advent of standardized protocols, more forensic evidence would be deemed admissible and conviction rates would rise (RCC10).

Many of the arguments that RCC staff and volunteers forwarded for standardization tied standardized medical protocols to more sensitive responses to survivors/victims. Vance (1978) argued in her funding proposal to the National

[23] Clarke and Lewis's (1977) book, *Rape: The price of coercive sexuality* is considered to be the first Canadian book on rape. It provided comprehensive data on the medical and legal response to rape in Toronto. The book's wide-sweeping influence in the late 1970s is evident in both rape crisis centre and government policy archival collections, where it is repeatedly referenced as one of the definitive sources on rape.

Department of Health and Wellness, "standardizing protocols for the treatment of victims of sexual assault is necessary at every level...if the sensitive handling of all victims is to be assured" (p. 3). According to one RCC staff person who was active at the time, the motivations behind the argument for standardized procedures was,

> to make sure that regardless of the hospital that you went to, you were going to receive the same care, the same procedure was going to be followed so that if you did decide to go to court, you would have the same evidence, whether you were in St. Catharine's, Welland, or Niagara Falls (RCC12).

For some activists, standardized protocols would mean better medical care and legal handling of rape.

Standardized medical protocols for many activists held the potential of eliminating uncertainties about medical and legal practice and removing traces of individual action in medical forensic evidence. Stipulating particular steps and tools for evidence collection would make individual choice and the subjectivities of medical practice less visible to those outside of the exam room. By eliminating marks of the individual, it was believed that standardized protocols held the much larger promise of making forensic evidence appear more objective and credible in court.

The arguments to standardize Canadian medical practice around rape coincided with developments of standardized protocols in the United States. In 1974, Dr. Fahrney, an American physician, proposed a "sex assault kit" (p. 340) for emergency wards and vowed that it would "speed up the proper examination of the patient, the adequate collection of the medical evidence, the labeling of specimens, and [be] a method by

which the data can be submitted rapidly to law enforcement officials" (p. 340). This kit, he suggested, could be a solution to "one of the most difficult problems for the busy emergency physician to handle" (p. 340), which was in his estimation, the rape case.

Tensions between actors: "Paradigms not of our choosing."

In the late 1970s, some Ontario rape crisis centres began working with hospitals and police in their communities to develop medical protocols for rape treatment (RCC13). Not all rape crisis activists supported this work and controversies waged in feminist publications. Krin Zook (1980), in an article in the Canadian radical feminist newspaper Broadside, criticized the anti-rape movement's reliance on institutions to enact social change and condemned the efforts to transform medical and legal actors and their practices. She wrote,

> Rape crisis centres are developing as traditional institutions by rationalizing that it is important to show doctors, lawyers, police and social workers how to better do their jobs...This supporting of institutions institutionalizes rape as an accepted social reality. This is only adjusting, not facilitating value changes (p. 27).

Maureen Fitzgerald (1982) penned a direct counter to Zook's criticism in a later issue when she wrote, "there is a growing and understandable impatience with the band-aid solutions...[however]...when we put pressure on the state to provide services for women, we are putting the pressure where it belongs" (p. 4). These debates challenged the meaning of activism around medical responses to rape and addressed larger issues about the anti-rape movement's relationship to institutions and its role in transforming medical and legal practice.

For those rape crisis centre workers who did take up the struggle in hospitals, this work, for some, meant, "having to work in paradigms not of our choosing" (RCC4). In their negotiations with medical and legal professionals, rape crisis activists had to accept the value of the medical exam, at least enough to argue for its improvement. According to those I interviewed, some activists readily accepted the medical exam and forensic evidence as important tools that lent credibility to women's experiences of rape. However, others did not. One rape crisis staff explained,

> You could sort of see how things were going...as long as the justice system and the media were going to refer to this as evidence, as long as the police felt that this was necessary in order to bring a case to trial...then we wanted women to have the best care possible. But we didn't agree with the basic premise [of the medical exam] to begin with. I think that was often a position that the centre was in, we wanted to advocate on behalf of women, but the basic premise that we were working from was wrong (RCC4).

Despite these internal struggles, the anti-rape movement had an undeniable influence on medical and legal practice, one that directly contributed to the development of the standardized Sexual Assault Evidence Kit.

A project of inscription: "Just a bit of folklore."

In November 1978, the Cooperative Care Project in the Niagara Region was initiated (RCC12).[24] The project's mandate was to test the value of a standardized

[24] Much of the detail in this section was collected from a phone interview with a RCC staff who read sections of CARSA's Annual Reports from 1979 and 1980 to me. These reports are not publically available, and so I am indebted to this participant for her willingness to share them with me.

protocol for medical forensic evidence collection in rape cases. Driving the Cooperative Care project was the Niagara rape crisis centre, the Committee Against Rape and Sexual Assault (CARSA). Why CARSA took on the task of developing a standardized SAEK is unknown. However, it may be that CARSA's initiative was cultivated through its diverse Board of Directors, which included not only rape crisis staff but also nurses and police officers.

In the months preceding the project's unveiling, experts gathered to design a standardized kit for evidence collection for the seven Niagara region hospitals. Elgin Brown, a forensic scientist from the Toronto Centre for Forensic Science, flew to St. Catharine's to hold a series of design consultations with Niagara police, physicians, and rape crisis centre staff (RCC12). I found no record of what went on in these design meetings. If a record does exist, it is likely being stored in a private collection that is not publically available. However, from the traces of relations between anti-rape activists and medical and legal actors that I have charted so far in this chapter, it is possible to imagine how these design consultations may have unfolded.

Anti-rape activists' expertise on rape was acknowledged to the extent that activists were invited to the design consultations. However, their marginal positioning in medical practice, coupled with the differences in professional status between many of the activists and the scientists, lawyers, and police, was reflected in the activists' limited capacities to shape the SAEK's design. One rape crisis centre volunteer, recalling her encounters with medical professionals at the time, suggested that the activists involved in the design of the SAEK likely had little input. She said, "the medical system was pretty

arrogant about 'they knew what was best'" (RCC13). Following this characterization, it could be imagined how the activists' expertise was overshadowed by the doctors' assertions about rape treatment, the police officers' claims about evidentiary requirements in rape law, and the scientists' statements about proper evidence handling and preservation.

Designing the SAEK meant visualizing a new forensic tool that would standardize medical forensic evidence collection and act as the new credible witness of sexual assault in medicolegal practice. It involved selecting and assembling the swabs, envelopes, slides, and combs that medical actors could use to collect evidence, writing the standardized forms and training manuals that described the steps of evidence collection, and designing a container that would protect the evidence collected.[25] The work involved imagining how a technology could be used to witness sexual assault, what this act of witnessing might entail, and what of sexual assault the technology would witness.

By assembling swabs, envelopes, slides, and combs, the designers assembled a technology that would witness sexual assault through the *visible* traces on a survivor's/victim's body. The technology could not witness or capture less visible traces, such as her psychological and subjective experiences of rape. As I have shown, legal actors had long deemed women's articulated experiences of sexual assault as unreliable evidence and as a result, they often required visible evidence of sexual assault that was independent of a survivor's/victim's subjective experience. This emphasis on visual traces of sexual assault became reflected in the technology's material form.

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[25] In chapter 4, I describe the SAEK's forensic script that arose from this design work, which stipulated how the tool was to be used, by whom, on whom, and with what purpose.

Legal histories and practices that were based on legal actors distrusting women reporting rape were inscribed in the SAEK's design. The evidentiary requirement for corroborative medical evidence and the legal definitions of rape as forced vaginal intercourse shaped the types and amounts of evidence that the SAEK was designed to collect. The complex relations between anti-rape activists and medical and legal actors shaped whose purposes the SAEK was intended to serve: it was to be a tool for medical and legal actors. The prevailing view of forensic science as objective and credible shaped the ways in which the SAEK would witness. These contexts were inscribed in the SAEK to produce a tool that medical and legal actors believed could be a credible technoscientific witness of sexual assault.

Following the design consultations, medical actors used the new standardized Niagara kit for eight months, after which the committee evaluated its use and sent the results to the Provincial Secretariat for Justice (RCC12). In the provincial consultations that followed, the Niagara kit and the Cooperative Care Project became the pilot for the provincial standardized SAEK.

In CARSA's annual report in 1980, the president wrote, "we asked Robert Welch who was an MP here for official recognition of our work in developing the sexual assault evidence kit, which was to become the model for the provincial kit" (read to me by RCC12). According to the president's report, "due credit to CARSA was given." However, CARSA's involvement in the SAEK's does not appear in many official records. One forensic scientist I interviewed mused, "I think that an agency of police, maybe it was Niagara Police had a rudimentary kit that they put together...and that may

have been the seed of making that idea come across the whole province. But that's just a bit of folklore" (FS1).

A Consultation on Rape

In the late 1970s, news reports that rape rates were drastically increasing started to fill the media. In Toronto, the number of reported rapes had reportedly increased by 37% between 1976 and 1977 (Provincial Secretariat for Justice, 1978).[26] Archive records illustrate the flood of activity amongst police and government agencies to recast the statistics as inaccurate and misleading. The OPP released a report in 1978 that blamed the rise in rape rates on women's "promiscuous" and "indiscriminate behavior" (as cited in Kinnon, 1981, p. 71), which unleashed a wave of anger and protests from anti-rape activists ("Women march," 1977). The Provincial Secretariat for Justice added to the OPP report by claiming in media interviews that the apparent rise in rates was in fact illusionary (Unknown, 1978b). In media interviews, government employees made comments such as, "it is important that alarmist statements not be allowed to remain unchallenged and that women across Ontario be reassured that their safety is not in great jeopardy" (Unknown, 1978b, p. 3) and "we continue to be very sensitive to the needs of actual rape victims, even though their numbers are small" (Welbourn & Lambert to D. Sinclair, December 1, 1977, p. 4). From the historical records, these statements appeared to do little to appease the public and public pressure mounted on the government and medical and legal systems to address the systemic issues in rape response ("Women march," 1977; Landsberg, 2011).

[26] In Toronto, 189 rapes were reported in 1976 and 263 in 1977 (Kerr, 1978, Kerr, G. to Jeffrey R., June 16, 1977).

In response to this flurry of action, the Provincial Secretariat for Justice (PSJ) organized a Consultation on Rape in February 1978. According to some internal PSJ memos, the consultation organizers were determined to keep the Consultation relatively small, so as not to "give credence to the idea that the incidence of rape is rapidly increasing" (Welbourn & Lambert to D. Sinclair, December 1, 1977, p. 4). As a result, only 53 people were invited to the closed consultation. While most of the 53 participants were police, lawyers, doctors, nurses and forensic scientists, eight rape crisis centre staff appeared on the invitation list. Including rape crisis centres in the consultation signaled an acknowledgement of their expertise; however, it was only partial, which a letter from George Kerr, the PSJ clearly illustrates,

> ...While we received an enormous number of requests to attend...particularly from women's groups....we did not accede to those requests...because we wished the Consultation to be oriented to action and could foresee that the presence of a very large number of interested citizens carried with it the distinct possibility that Consultation could become a stage for *political posturing*, or for the achievement of *opinions* rather than *facts*, *emotionalism* rather than an *objective and reasoned approach* to a very real problem [emphasis added] (Kerr, 1978, Kerr, G. to Jeffrey R., June 16, 1977).

The PSJ's careful selection of consultation participants suggests that the PSJ's office wanted to control the content of the consultation. Kerr's references to political posturing and emotionalism were likely aimed at the "women's groups" to which he referred. By characterizing women's contributions in this way, he was able to rationalize restricting

the number of activists at the Consultation and dismiss the value and relevance of their expertise.

The Consultation on Rape represented one of the first provincial efforts to formulate expert medicolegal knowledge and practices on rape. Much of the discussion revolved around developing a more coordinated, standardized medicolegal response to rape. The panel entitled the Initial needs of the victim centered on the problems for survivors/victims seeking medical treatment in emergency wards (Provincial Secretariat for Justice, 1978). Physicians' reluctance to treat survivors/victims, their lack of training in medical forensic evidence collection, and their "judgmental attitudes" (Provincial Secretariat for Justice, 1978, p. 4) in rape cases were problematized by the panel's participants. Most significantly, participants highlighted the lack of standardized protocols for medical forensic evidence collection as a serious concern. Out of this discussion arose the following two recommendations: "standardized protocol and procedure for hospital staff be established for victims of rape...[and] the development and use of a standardized Rape Kit for all hospitals in the province is needed" (Provincial Secretariat for Justice, 1978, p. 5).

At the Consultation's closing remarks, Don Sinclair, the Deputy Provincial Secretary for Justice, applauded the efforts of the participants (Provincial Secretariat for Justice, 1978). He stressed the need for a coordinated medicolegal response and more professionalized knowledge on rape. Responding to what may have been some adamant

critiques by the eight anti-rape activists present at the Consultation,[27] Sinclair spoke about the dangers of criticism,

> The need for cooperation has been evidenced throughout the Consultation and to meet that need it is incumbent upon each of us to acknowledge that we are not the only players in the game and that others' roles are just as important as ours. We shall make no progress by criticizing the other players, the other agencies, the other government departments. Let us be self critical by all means but I think we lose our effectiveness and our credibility when, by direct accusation or by implication, we leave the impression that we (whoever "we" are) are doing the 'right' things while others fumble or bumble or just don't care. *Nobody has a monopoly of expertise or of good will in this area* [emphasis added] (Provincial Secretariat for Justice, 1978, p. 10).

Sinclair's remarks leveled the expertise in the room. His claim that "nobody has a monopoly of expertise" diminished rape crisis centre activists' claim to expertise and the wealth of knowledge on rape that rape crisis activists had gained. In so doing, Sinclair opened the opportunity for professional groups, who had, up until that point, largely ignored the problem of rape, to claim their own expertise on rape. Sitting on the cusp of what would be a rise in specialized knowledge on rape and sexual violence in the 1980s

[27] The available records on the Consultation present the views expressed as largely homogenized. However, from the tone and content of many other texts written by rape crisis activists at the time, it is likely that the activists at the Consultation forcefully advocated for survivors/victims through pointed critiques of medical and legal practice. I was unable to find any records on the Consultation that were written by anti-rape activists. The one box at the University of Ottawa Archives and Special Collections where these records are most likely to be is currently being processed and is not publically available.

and 1990s, Sinclair's claim laid the foundation for a surge in medicolegal expertise in sexual violence.

Following the Consultation, an Implementation Committee, consisting of 10 Consultation participants, two of whom were rape crisis staff, worked to implement the recommendations from the Consultation (Unknown, ca. 1978a). Importantly, this committee, drawing on what had been designed in Niagara, set in place a standardized sexual assault evidence kit for the province of Ontario.

Ontario's First Sexual Assault Evidence Kit

The first provincial Sexual Assault Evidence Kit was assembled by rape crisis centre volunteers and staff. The Niagara rape crisis centre received a contract from the PSJ to prepare and pack 3,000 SAEKs for the province. One activist recalled, "I remember sitting with 3,000 boxes and just putting together all these kits, which then would have been distributed to the hospitals in the province" (RCC12). Despite the hesitations that some rape crisis centre workers had with the SAEK and their complicated role as marginalized experts in medical practice, anti-rape activists became the designated actors to physically assemble the SAEK.[28]

The provincial government introduced the SAEK to Ontario on Friday, January 16, 1981.[29] In the press release announcing its arrival, the Minister for Justice Policy, Gord Walker stated,

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[28] This changed several years later, when the PSJ switched to a private contractor for SAEK preparation (FSM).

[29] The SAEK had been in use since 1979 (Provincial Secretariat for Justice, 1979a), but was formally introduced in 1981. Why the announcement of the SAEK was delayed by two years is not clear in the historical records.

> Standardization of a sexual assault evidence kit is one further step in our efforts to help the victims of crime...The extent of the consultation among practitioners in the health and justice fields demonstrates the seriousness we attach to finding better ways of helping the victims of sexual assault....This new kit should shift the responsibility for identifying evidence onto the *experts* in health and forensic science and thus alleviate some of the pressure on the victim, at a time of great emotional distress, to *produce evidence* of a criminal attack...and provide the police with evidence necessary for a thorough criminal investigation [emphasis added] (Provincial Secretariat for Justice, 1981, p. 1).

Walker used the development of the SAEK to claim that government and medicolegal actors had an active interest in survivors/victims, despite what had been the noticeable absence of this interest throughout much of the 1970s. His claim that the SAEK would "shift responsibility onto the experts" (p. 1) foreshadowed the growth in expert knowledge and practice on sexual violence in the 1980s and 1990s. Most significantly, his statement conveyed the promise of the new technoscientific witness to produce objective, credible evidence of rape.

The announcement of the SAEK expressed high hopes for the new medicolegal tool. The SAEK was described as "a significant breakthrough in helping women prove sexual assault" (p. 2). Given the histories that were inscribed in the SAEK– the distrust of women reporting rape, the prevailing view of forensic science as objective and credible, and the evidentiary requirement for corroborative medical evidence – the extent to which the SAEK would prove to be a "significant breakthrough" for women is debatable. In the

following chapters, I examine how the SAEK worked for and on women within medicolegal practice throughout the SAEK's 34-year history in Ontario. In the next chapter, I explore how the SAEK and its meaning as the technoscientific witness gained stability in the Ontario medicolegal network.

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NEWS RELEASE

Friday, January 16, 1981

ONTARIO INTRODUCES STANDARDIZED FORENSIC EVIDENCE KIT TO HELP VICTIMS OF SEXUAL ASSAULT

A standardized forensic evidence kit has been developed in Ontario for use by doctors and nurses to improve the collection of evidence in sexual assault cases, Gord Walker, Minister responsible for Justice Policy in Ontario announced today.

"The standardization of a sexual assault evidence kit is one further step in our efforts to help the victims of crime and sustain public confidence in the justice system," Mr. Walker, a staunch advocate of extending victim rights, commented.

Archives of Ontario, RG 64
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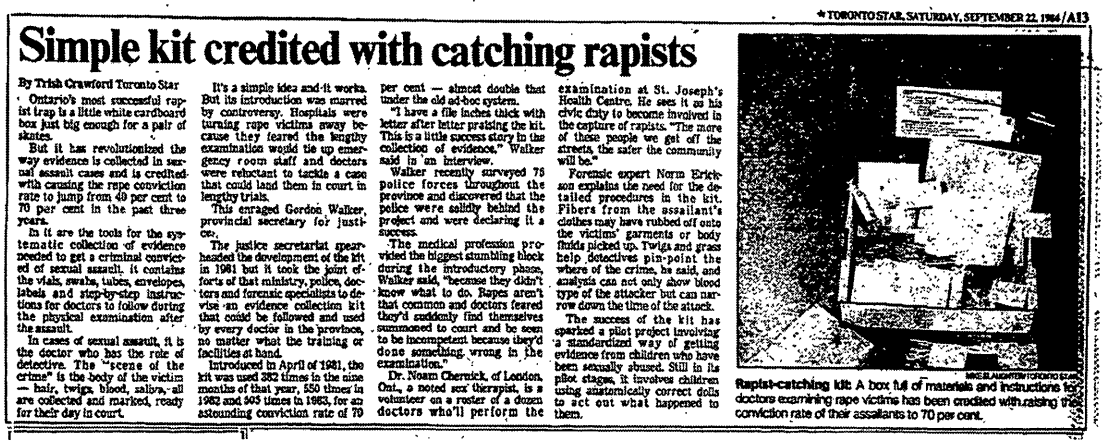
Press Release Announcing the first SAEK in Ontario, 1981

CHAPTER 4
Stabilizing the Sexual Assault Evidence Kit in its Medicolegal Network

"You could hear the gears of specialization grinding, the carving up of victim-populations, the negotiations of turf, the vying for funding, for prestige, for place. Never having heard it before, I did not then identify the hum and buzz as the sound of persons professionalizing"
(Toronto Rape Crisis Centre/Multicultural Women Against Rape, n. d.).

In just a few years after the first provincial Sexual Assault Evidence Kit (SAEK) was introduced to Ontario, the media were proclaiming the new tool to be "Ontario's most successful rapist trap" (Crawford, 1984, A13).[1] Media reports suggested that the SAEK had "revolutionized the way evidence [was] collected in sexual assault cases" (A13). In 1984, the Minister for Justice Policy who had announced the SAEK three years earlier stated, "I have files inches thick with letter after letter praising the kit. This is a little success story in the collection of evidence" (A13). These reports portrayed the SAEK as an already accepted technoscientific object that medicolegal actors trusted to



★TORONTO STAR, SATURDAY, SEPTEMBER 22, 1984/A13

Simple kit credited with catching rapists

By Trish Crawford Toronto Star

Ontario's most successful rapist trap is a little white cardboard box just big enough for a pair of skates.

But it has revolutionized the way evidence is collected in sexual assault cases and is credited with causing the rape conviction rate to jump from 40 per cent to 70 per cent in the past three years.

In it are the tools for the systematic collection of evidence needed to get a criminal conviction of sexual assault. It contains the vials, swabs, tubes, envelopes, labels and step-by-step instructions for doctors to follow during the physical examination after the assault.

In cases of sexual assault, it is the doctor who has the role of detective. The "scene of the crime" is the body of the victim — hair, twigs, blood, saliva, all are collected and marked, ready for their day in court.

It's a simple idea and it works. But its introduction was marred by controversy. Hospitals were turning rape victims away because they feared the lengthy examination would tie up emergency room staff and doctors were reluctant to tackle a case that could land them in court in lengthy trials.

This enraged Gordon Walker, provincial secretary for justice.

The justice secretariat spearheaded the development of the kit in 1981 but it took the joint efforts of that ministry, police, doctors and forensic specialists to devise an evidence collection kit that could be followed and used by every doctor in the province, no matter what the training or facilities at hand.

Introduced in April of 1981, the kit was used 382 times in the nine months of that year, 550 times in 1982 and 905 times in 1983, for an astounding conviction rate of 70 per cent — almost double that under the old ad-hoc system.

"I have a file inches thick with letter after letter praising the kit. This is a little success story in the collection of evidence," Walker said in an interview.

Walker recently surveyed 76 police forces throughout the province and discovered that the police were solidly behind the project and were declaring it a success.

The medical profession provided the biggest stumbling block during the introductory phase, Walker said, "because they didn't know what to do. Rapes aren't that common and doctors feared they'd suddenly find themselves summoned to court and be seen to be incompetent because they'd done something wrong in the examination."

Dr. Noam Chernick, of London, Ont., a noted sex therapist, is a volunteer on a roster of a dozen doctors who'll perform the examination at St. Joseph's Health Centre. He sees it as his civic duty to become involved in the capture of rapists. "The more of these people we get off the streets, the safer the community will be."

Forensic expert Norm Erickson explains the need for the detailed procedures in the kit. Fibers from the assailant's clothes may have rubbed off onto the victims' garments or body fluids picked up. Twigs and grass help detectives pin-point the where of the crime, he said, and analysis can not only show blood type of the attacker but can narrow down the time of the attack.

The success of the kit has sparked a pilot project involving a standardized way of getting evidence from children who have been sexually abused. Still in its pilot stages, it involves children using anatomically correct dolls to act out what happened to them.

Rapist-catching kit: A box full of materials and instructions for doctors examining rape victims has been credited with raising the conviction rate of their assailants to 70 per cent.

Toronto Star, September 22, 1984
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[1] Other reports expressed similar sentiments, claiming that the SAEK would "catch more rapists" ("Kit will Catch," 1981, A24), "help prosecute offenders [and] avert dismissals" ("In brief," 1981, P5), and ensure "victims' rights" (Speirs, 1981, CL8).

give reliable, credible testimony of rape. However, in this chapter, I illustrate that in the 1980s, the SAEK was not immediately accepted by all actors in its network. Instead, the SAEK sparked many tensions and controversies between actors, which had to be overcome before the tool could be trusted and accepted in the medicolegal network.

This chapter explores medicolegal efforts in the 1980s to stabilize (Latour, 1987; Akrich, 1992) the SAEK and its meaning as the technoscientific witness of sexual assault. I argue that behind the "success stor[ies]" (Crawford, 1984, A13) of the SAEK in the media were a series of medicolegal controversies about expertise, advocacy, medicolegal practice, and the SAEK. Through these controversies, this chapter shows how medical, legal, and government actors fought to stabilize the SAEK as a trusted and accepted tool in medicolegal practice.

This is the point in my story about the SAEK where I begin to employ the term *medicolegal.* As I suggested in the previous chapter, the SAEK's design was one historical moment when medical and legal practices became bound in a single technological object. In this chapter, I sketch how this new medicolegal technoscience sparked new controversies and uncertainties within its shifting network.

The efforts to stabilize the SAEK occurred in the context of shifting dynamics within the anti-rape movement, evolving legal definitions of rape, and ongoing controversy amongst medicolegal actors. This chapter examines how medicolegal actors' sought to give the SAEK stability with new sexual assault expertise, experts, and expert spaces, and by marginalizing and displacing rape crisis centre workers in the SAEK exam

and enacting a forensic script for the SAEK.[2] I describe the shifting relations between rape crisis centre workers and medicolegal actors and trace the "expert-community boundary work" (Jasanoff, 1998, p. 733) that displaced rape crisis centre workers in the SAEK exam and situated them as non-users of the SAEK.[3] I investigate how medical and legal actors used the SAEK in medicolegal practice and how it enacted particular meanings of rape and sexually violated bodies. I adopt Akrich's (1992) term, "scripts" (p. 208) to describe the SAEK's forensic script that many medicolegal actors hoped would stabilize the SAEK in the medicolegal network and trace how the SAEK and its script were stabilized and destabilized in medicolegal controversy. These intersecting contexts, practices, and controversies, as this chapter illustrates, were all involved in stabilizing the SAEK in the medicolegal network.

This chapter illustrates stabilization as a process of building consensus amongst many actors by negotiating controversies, tensions, and new actor relations within a network. Here, stabilization is not an outcome of resolved controversies, but is instead, an ongoing effort. By exploring the work in stabilizing the SAEK, I do not suggest that stabilization was ever achieved; that controversy ended or that design work stopped. Instead, as I show in later chapters, despite the efforts to stabilize the SAEK in the 1980s,

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[2] Here, I am not suggesting that *all* medicolegal actors wanted to or were part of stabilizing the SAEK. Instead, I am pointing to what was a rush of activity amongst *many* medicolegal actors to stabilize the new tool in medicolegal practice.

[3] By exploring these tensions, I do not mean to suggest that these groups were mutually exclusive. In the 1980s, some feminist (anti-rape) activists were active in law, as lawyers and judges, and in medicine, as physicians and nurses (Prentice, Bourne, Brandt, Light, Mitchinson, & Black, 1996). However, in this chapter, I am interested in the tensions between anti-rape activists working in rape crisis centres and medicolegal actors involved in the SAEK exam. Although there may have been some overlaps between these groups, in this chapter, I trace the tensions between them.

it continued to be *de*stabilized and *re*stabilized in medicolegal practice throughout the 1990s and 2000s.

I use the terms rape and sexual assault interchangeably in this chapter to reflect the shifting language of 1980s. As I discuss, rape was eliminated from the Criminal Code of Canada in 1983 and replaced with a three-tiered sexual assault offence. I use the term sexual assault to reflect this shift and the term rape to illustrate the political potency that the term rape maintained for many activists in the anti-rape movement.

I begin this chapter by briefly sketching the medicolegal network that formed around the first SAEK.[4] I then examine some of the shifts in the anti-rape movement in the 1980s as a way of sketching a backdrop for medicolegal efforts to marginalize and displace rape crisis centre workers in the SAEK exam. I then turn to the SAEK, and discuss how the SAEK's forensic script enacted new meanings of sexual assault and victims'/survivors' bodies in medicolegal practice. I conclude by exploring how the newly formed expert space for SAEK exams, the Sexual Assault Treatment Centre, and the newly formed expert for SAEK exams, the Sexual Assault Nurse Examiner, contributed to marginalizing rape crisis centre workers in the SAEK exam and to stabilizing the SAEK in its medicolegal network.

A New Medicolegal Network

The new SAEK quickly became part of medicolegal practice. By 1983, 82% of the hospitals surveyed by the Ontario Hospital Association had at least one SAEK in their

[4] Many of the actors who made up the SAEK's network were already related and acting around medical forensic evidence collection when the SAEK arrived in 1981, as my detailing in the last chapter showed. However, in this chapter I argue that the SAEK shook up those relations and in doing so, contributed to transforming them.

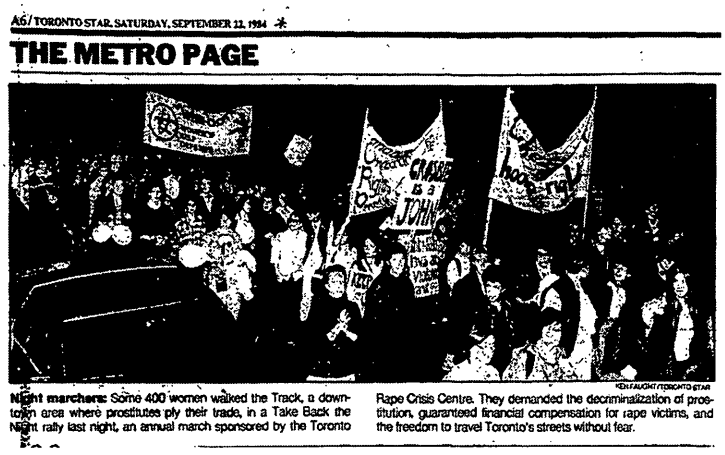
emergency ward ("A Report," 1983). In a handbook on the new SAEK, the Provincial Secretariat for Justice (1979a) anticipated that the SAEK's design would standardize and coordinate forensic evidence collection and preservation and in so doing, eliminate some of the uncertainties in medicolegal practice. The SAEK's detailed protocol guided emergency physicians collecting evidence from survivor's/victim's bodies (Provincial Secretariat for Justice, 1979a). When a SAEK exam was completed, the SAEK's protocol instructed police to transfer the kit to the Centre of Forensic Science, where forensic scientists would analyze its contents and write a report detailing the analysis results (Provincial Secretariat for Justice, 1979a). Following this, SAEK reports were sent to investigating officers, and if the case proceeded to trail, the prosecuting lawyer and defence attorney. In some cases, lawyers used the laboratory results of the SAEK exam as technoscientific evidence of rape.

The SAEK's travels through the medical exam room, police station, forensic laboratory, and courtroom sketched a path through what I am calling the SAEK's medicolegal network. The SAEK's network in the early 1980s was made up of physicians, police, forensic scientists, lawyers, the SAEK, other tools and texts, and to varying degrees, rape crisis centre workers and survivors/victims. It is this network and its constellation of actors that shifted significantly in the 1980s through medicolegal controversy, changing practices, legal reform, and the development of medicolegal expertise, experts, and expert spaces for sexual assault.

These changes in the network reshaped the SAEK and the relations between its fellow actors. Survivors/victims became situated as the implicated users of the SAEK:

their bodies were implicated in the SAEK's work, but in ways that afforded them little control. Rape crisis centre workers' positioning in medical practice changed through controversies and developing medicolegal expertise around sexual assault: they became situated as marginal non-users of the SAEK. This change in rape crisis centre workers' level and type of involvement with the SAEK occurred against a backdrop of shifting dynamics within the anti-rape movement. I turn to this now.

Shifts in the Anti-Rape Movement


A6/ TORONTO STAR, SATURDAY, SEPTEMBER 22, 1984

THE METRO PAGE

Night marchers: Some 400 women walked the Track, a downtown area where prostitutes ply their trade, in a Take Back the Night rally last night, an annual march sponsored by the Toronto Rape Crisis Centre. They demanded the decriminalization of prostitution, guaranteed financial compensation for rape victims, and the freedom to travel Toronto's streets without fear.

Toronto Star, September 22, 1984
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The 1980s was a vibrant and transformative decade for the anti-rape movement. In the context of government pressures to professionalize and credentialize rape crisis advocacy, the movement was reshaping its politics and identity and growing in strength and visibility. Outside of the rape crisis centres, some feminist lawyers were actively lobbying for legal change (Prentice et al., 1996). Inside rape crisis centres, new modes of organizing and resisting rape were being devised such as Take Back the Night marches, rape confrontations, and letters to rapists (Neigh, 2012). These developments were accompanied by internal tensions around the movement's identity and its relationship to medicolegal practice (Pierson, 1993). One activist described these changes by saying, "we ourselves were transforming and being transformed" (RCC14).

The shifts in the anti-rape movement in the 1980s occurred in the context of larger pressures to professionalize and credentialize women's organizations, advocacy, and care (Masson, 1998; Morgan, 2002). Medical professional and regulatory organizations were pressuring non-professional health care providers in the women's health movement, the lay midwifery movement, and some forms of alternative medicine to professionalize. These groups used medical licensing, regulations, and funding requirements to force professionalization (Morgan, 2002). Similarly, feminist peer advocacy within the anti-violence movement[5] was under attack from professionals in psychiatry and psychology, who were attempting to regulate and medicalize counseling services for women (Marriner, 2012). These pressures to professionalize were often solidified in funding negotiations, where funders could explicitly limit their funds to professionalized services (Cohen, 1993; Ng, 1996; Masson, 1998).

This context set up the conditions in which rape crisis centre workers' expertise on rape – which for many, was based on peer advocacy, feminist politics, and for some, personal experience – became increasingly marginalized in medicolegal practice. It laid the ground for the rise of medicolegal expertise, experts, and expert spaces for sexual assault and set the context in which rape crisis centre workers were marginalized and displaced in the SAEK exam. In this section, I sketch some of the shifts in the anti-rape movement in the 1980s and the changing relations between rape crisis centre workers and government and medicolegal actors. To do so, I focus on two aspects of the movement: a) government funding requirements and how they shaped some of the practices in rape

[5] This term includes both the anti-rape movement and the movement around battered women (later termed domestic violence).

crisis centres, and b) some of the internal conflicts within the movement over its politics, identity, and relationship to medicolegal practice.

Rape crisis centre funding.

The government funding that the Ontario Coalition of Rape Crisis Centres (OCRCC) won in 1980 was accompanied by a range of conditions and requirements (Sinclair, 1980, D. Sinclair to S. Sahli, June 26, 1980).[6] These conditions reshaped the organizational structures and practices within many rape crisis centres in Ontario, and in so doing, redefined how rape crisis centre workers and government and medicolegal actors were related.

To receive $150,000 of yearly funding from the Provincial Secretariat for Justice (PSJ), the OCRCC had to agree to transform its structure and open rape crisis centres to government surveillance (Sinclair, 1980, D. Sinclair to S. Sahli, June 26, 1980). The funding agreement stated that the OCRCC had to immediately transform its collective organizational structure to a hierarchical one, which included a head office, an office manager, a full time fund-raiser, and a contracted "firm of chartered accountants and legal counsel to assist in conforming to all corporate requirements" (Campling, 1980, C. Campling to G. Walker, March 25, 1980). The OCRCC also had to agree to submit quarterly and yearly reports on the rape crisis centres' activities and finances (Sinclair, 1980, D. Sinclair to S. Sahli, June 26, 1980).

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[6] The funding conditions and requirements that the PSJ imposed were similar to those that other government funding agencies imposed on other women's organizations and services (for more discussion, see Cohen, 1993; Ng, 1996).

The PSJ's funding requirements generated many uncertainties within the OCRCC. Some anti-rape activists argued that the collective spirit of the OCRCC was being lost with the newly imposed hierarchical order, which situated the OCRCC as a formalized body that individual rape crisis centres had to appeal to for funds (RCC11). Others argued that the OCRCC had no choice but to accept the PSJ's funding requirements because rape crisis centres were on the verge of closing due to lack of funds (RCC10). In response, some rape crisis centres retained their collective structure, while others moved to hierarchical models (RCC4).

Another set of tensions arose from the PSJ's requirement that the OCRCC work cooperatively with medicolegal actors. The 1980 funding agreement stated that the OCRCC had to "explore mutually with the Secretariat the possibility of joining forces with other centres and/or agencies delivering services on a "crisis" basis [and] continue the Centre's efforts to develop closer liaison with hospitals" (Sinclair, 1980, D. Sinclair to S. Sahli, June 26, 1980). This funding requirement imposed expectations on anti-rape activists to develop cooperative and collaborative relationships with medicolegal actors. For some anti-rape activists, this expectation was naive and impractical. The Toronto Rape Crisis Centre/Multicultural Women Against Rape (n.d.) explained,

> This was often an unrealistic expectation since many hospitals and police forces...wanted nothing to do with rape crisis centres. Rape crisis workers were often perceived as unprofessional, improperly trained, and threatening. The idea was that doctors, psychiatrists, and policemen knew far more than any woman off the street possibly could and should, therefore, be left alone to do their jobs (p. 5).

According to some of the anti-rape activists, the resistance to collaborative relations between anti-rape activists and medicolegal actors went both ways. Some anti-rape activists saw their work as oppositional to medical and legal systems, and therefore viewed the requirement to liaise with medicolegal actors as a government effort to depoliticize anti-rape activism and institutionalize anti-rape advocacy (RCC4; RCC11).

The pressures on rape crisis centres to adopt government imposed models continued through the 1980s and 1990s, as many centres continued to struggle and appeal for funds (Pierson, 1993). Through various funding requirements, government agencies placed increasing demands on rape crisis centres to professionalize their advocacy and peer counseling services with psychologists and social workers. While some centres adopted this model, others did not (Marriner, 2012). Reflecting on why her centre refused to professionalize their services, one staff member said,

> We never required of each other that you have a degree. You don't have to be a social worker to do good work, to be an effective counselor or advocate...[professionalized services] take advocacy out of the community ...and puts it in the hands of someone who is a trained professional (RCC4).

In addition to the tensions government funding inspired within the anti-movement, other tensions arose among anti-rape activists around the movement's politics and identity. These debates reshaped the movement and its relation to medicolegal practice.

Recognizing difference.

In the late 1970s and early 1980s, there were growing tensions within the anti-rape movement around the recognition of differences between women on the basis of race, class, and disability (Pierson, 1993).[7] Women of colour, disabled women, and working class and poor women challenged radical feminists' theorizing on rape as being hinged on a false universalism, which assumed sexism was a shared experience amongst women (Rowland & Klein, 1996). According to Michelle Landsberg (2011), a Canadian journalist who often wrote on women's issues, many white feminists resisted these politics. Pierson (1993) described this resistance when she said, "the dominant women's movement has been slow to come to terms fully with the implications of the fact that some women, by virtue, of class and race and able-bodiness, are more privileged and have more power than others" (p. 186).

Some women of colour challenged the radical feminist analysis of rape as a tool of sexism by arguing that racism could not be disconnected from sexism in analyses of rape and sexual violence (Davis, 1983; Harris, 1990; Monture-Okanee, 1992). Some explicitly challenged white anti-rape activists for ignoring and silencing women of colour's experiences of rape (Davis, 1983). As Makeda Silvera said in a published conversation about racism and sisterhood,

> I'm sick of some of these white feminists when they talk about rape. It's always from *their* perspective – being knocked down somewhere in a dark alley or a park

[7] This is not to suggest that these tensions around difference were not present before the late 1970s or 1980s. Women of colour, disabled women, and working class and poor women were always active in the anti-rape movement (Neigh, 2012). However, during this time period, tensions around the radical feminist position on rape as a shared experience were acutely visible.

> and being raped. They never mention other kinds of rape, other abuse that women of colour and immigrant women experience (Bannerji, Brand, Khosla, & Silvera, 1983, p. 8).

In response, some white anti-rape radical feminists argued that feminist theories built from women's experiences were not racist or homogenous, but were instead, meant to include the diversity of women's experiences (MacKinnon, 2005). These debates waged not only in the pages of feminist literature, but also in the practices of the Ontario Coalition of Rape Crisis Centres.

According to some rape crisis centre activists, in the OCRCC, women of colour often had to fight for representation in staff positions and at the Coalition's board meeting tables (RCC7; RCC11). One activist and woman of colour described her experience in the OCRCC by saying, "it was an ever struggling battle to have those discussions that moved from just a talk to action" (RCC11). As a result of some of these struggles, the OCRCC reported in 1991 that rape crisis centres in Ontario were beginning to offer more services that accommodated some of the differences amongst women (OCRCC, 1991). However, according to several anti-rape activists, these tensions continued, as women of colour, disabled women, and working class and poor women continued to struggle for representation and a voice in the anti-rape movement (RCC11). These conflicts had a role in shifting the OCRCC's politics towards a focus on how women experience rape and the threat of rape differently (Cahill, 2001). Amidst these shifts were other tensions, in which the movement's identity, particularly in relation to medicolegal practice, was being questioned.

Conflicted relations and strategies for resistance.

In the late 1970s and 1980s, debates were intensifying in the anti-rape movement about rape crisis advocacy and its relation to medicolegal practice (Neigh, 2012; Pierson, 1993). In particular, rape crisis centre workers were debating appropriate strategies for resisting male violence, and in so doing, were questioning the necessity of the medicolegal system and activists' relationship to it (Neigh, 2012).

While some rape crisis centre volunteers and staff worked with medicolegal actors to reform medicolegal practice amongst nurses, doctors, police, and lawyers, others refused to do this work, arguing that it represented an over reliance on institutionalized solutions to male violence (Zook, 1980). According to archival records, some Ontario rape crisis centres were growing increasingly frustrated with the inadequacies of medicolegal practice and began devising alternative, non-medicolegal strategies for resisting male violence. The Toronto Rape Crisis Centre was one of these centres, and by 1986, they were offering survivors/victims several alternatives to reporting to the police and going to the hospital. In a brochure introducing these options, the centre wrote,

> As rape crisis workers and as women, we all know that the 'legal justice' system does not work for us...taking control and taking action in ways that a woman determines to be best for her are essential parts of women's liberation. Part of our work in Rape Crisis Centres is to take knowledge and information gained from women's experience and put it together so we can offer as many options as possible to assaulted women (p. 1).

With this brochure, the TRCC offered women seeking alternatives to the medicolegal system three options: i) a personalized letter from the TRCC to a rapist to "let the rapist know that women will not be silent about rape, that what he had done is wrong, and [to] suggest that he seek counseling" (TRCC, 1986, p. 1), ii) a community postering initiative to warn a neighbourhood about a rape and "make the issue of violence against women public" (p. 2), and iii) a rape confrontation to allow a survivor/victim, along with a number of TRCC women, to confront her rapist to express how the rape had affected her. According to the TRCC, these alternatives "show we do not need men or institutions to 'act on our behalf'; we know the experience of rape, we tell the truth and we are strong" (p. 2).

University of Ottawa Archives, X10-1
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Poster, ca. 1986

Not all rape crisis centre workers agreed that the TRCC's strategies for resistance had a place in rape crisis centres and, according to some reports, many debates in the OCRCC ensued ("Agencies split," 1984). Some rape crisis centre workers insisted that the strategies were dangerous and misplaced in the rape crisis centre (RCC10). Others claimed that they were "wonderfully human" (Lakeman as cited in Neigh, 2012). In these debates, activists were actively questioning their relation to medicolegal practice and in some cases, resisting government pressures to create

collaborative relations with medicolegal actors. In so doing, rape crisis centre workers were questioning the movement's identity and its relation to medicolegal practice.

In this context, advocates of the SAEK were continuing efforts to stabilize the SAEK in medicolegal practice with the SAEK's forensic script and medicolegal expertise, experts, and expert spaces for the SAEK. As I show, through these efforts, rape crisis centre workers were increasingly displaced in the SAEK exam.

Tools Standardizing Practice: The Sexual Assault Evidence Kit

When the SAEK was first introduced to medicolegal practice in 1981, many government agencies and medicolegal actors anticipated that it would ease tensions amongst medicolegal actors and enhance the efficiency of medicolegal practice in sexual assault cases (Provincial Secretariat for Justice, 1978; Ontario Hospital Association, 1983b). The Ontario Hospital Association (1983b) described the SAEK as a tool that would fill the void of expert knowledge on forensic evidence collection in cases of sexual assault. The Provincial Secretariat for Justice (1978) described the SAEK as a tool that would give forensic evidence greater value in cases of rape and reduce the pressures on physicians to give testimony on medical evidence collection. However, these hopes for the SAEK were not so easily realized. Stabilizing the SAEK in the medicolegal network required the work of many.

In this section, I describe the first provincial SAEK and trace aspects of its forensic script that some hoped would stabilize the SAEK in the medicolegal network. I describe ways that the SAEK was used in practice and how it helped to enact particular meanings of rape, sexually violated bodies, and survivors/victims in medicolegal practice

that were often in contrast to those articulated within in the anti-rape movement. Following this, I describe the controversies, shifting practices, and changing laws that stabilized and destabilized the SAEK in the medicolegal network.

Forensic scripts.

Akrich (1992) argues that technological objects are embedded with "scripts" (p. 208) that stipulate rules for action and meanings of use. Scripts, she states, emerge out of technological design where, as the previous chapter illustrated, particular "visions...of the world" (p. 208) are inscribed in an object's material form. Timmermans and Berg (1997) build on Akrich's (1992) notion of scripts to describe medical protocols as "technoscientific scripts" (p. 275), which, they suggest, define a protocol's "actions, settings, and actors" (p. 275) and the relations between them. Technoscientific scripts, for Timmermans and Berg (1997), include not only prescriptions for action in medical protocols, but also the prescriptions for who performs the protocol, where, on whom, and with what purpose. I suggest that the SAEK was inscribed with a particular type of technoscientific script: a *forensic* script that specified and in so doing, shaped medicolegal action and the actors involved in it.

Akrich (1992) suggests that when scripts are "acted out" (p. 222), a "network of technical objects and actors is stabilized" (p. 222). In the case of the SAEK, it was not as simple. The following reveals that the SAEK's forensic script was a dynamic set of prescriptions for action that were routinely challenged and reformulated through the SAEK's use. Many of these controversies over the SAEK's script had the effect of destabilizing the SAEK in medicolegal practice.

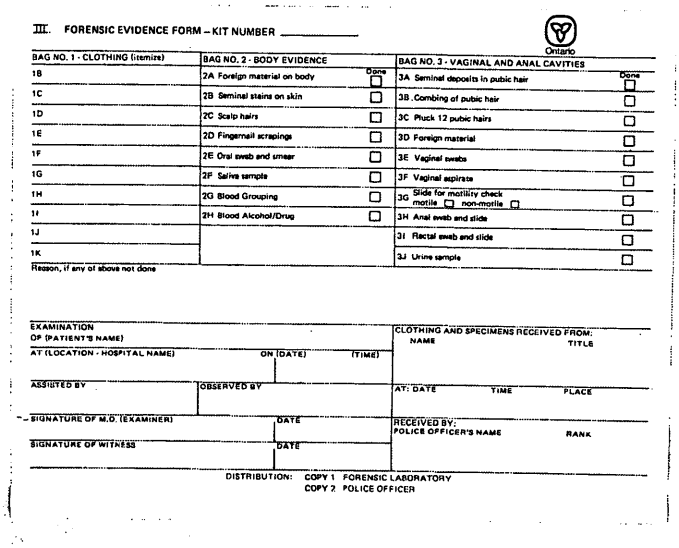
The SAEK and its forensic script.

"My number was called and I'm wheeled into a medium-sized room where three women in white lab coats are waiting. They speak softly, tell me their nurse and doctor names, [and] what they will do... Like an annual physical, they light my eyes, touch me, bend, tap, prod and weigh me. They ask if I take medication, have attempted suicide, been admitted to a psychiatric hospital. If I have had children, abortions, recent consensual sex.... Then they ask me to tell my rape. They write everything down, record the data on forms with numbers and codes that have been waiting for me to be raped. All of this is standard procedure. The women who treat me explain everything in apologetic tones, whisper commands in powdered voices - things better not spoken too loud. They are efficient and distant as they spread a circular plastic sheet on the floor and ask me to stand on it and remove my robe. They brush the hair on my head and between my legs pluck[ing] fifteen pubic hairs by the root...stirrups, gloves, stainless steel inside me, entering, expanding. From a nearby microscope a woman's voice says, "We've got sperm here, one's still alive." I tell her to kill it and she looks at me and smiles. Everything is collected in vials and plastic or under glass, labeled with my name. All these pieces of me are placed in a kit to be touched and examined, probed and considered some more, somewhere, by someone, for something" (Doe, 2003, p. 13).

The first provincial SAEK in 1981 contained many tools and texts for documenting and collecting traces of rape: physical injuries, sperm, and foreign bodily fluids. The SAEK contained tools for evidence storage (bags for clothing, envelopes for hair and debris, and containers for urine samples), and tools for evidence collection (a hair comb, toothpicks for fingernail scrapings, swabs for vaginal, anal, and rectal samples, and a syringe and tubing plastic container for the vaginal wash) ("Contents of the SAEK," ca. 1981). The kit also included many texts for coordinating the SAEK's use: a consent form for the survivor/victim, a sexual assault history form for the assault details and the survivor's/victim's sexual history, a procedures form that described the SAEK guidelines, a forensic evidence form to document the samples collected, and a procedural booklet that described the SAEK in detail.

The texts that accompanied the SAEK outlined prescriptions for how the tool was to be used, by whom, where, and under what circumstances (Provincial Secretariat for Justice, 1981). They detailed the SAEK's forensic script. The texts stressed the

importance of closely following the script, as this would, the texts claimed, ensure greater efficiency and effectiveness of medicolegal action in sexual assault cases. The SAEK's procedural booklet stated, "if prescribed procedures are followed, it will be less likely that the acceptability of the evidence will be questioned in court" (Provincial Secretariat for Justice, 1978, p. 20). By providing rigid prescriptions for action, the PSJ and other medicolegal actors hoped that the SAEK's forensic script would give forensic evidence greater value in rape cases.



III. FORENSIC EVIDENCE FORM – KIT NUMBER _____

Ontario

BAG NO. 1 - CLOTHING (itemize)	BAG NO. 2 - BODY EVIDENCE	Done	BAG NO. 3 - VAGINAL AND ANAL CAVITIES	Done
1B	2A Foreign material on body	☐	3A Seminal deposits in pubic hair	☐
1C	2B Seminal stains on skin	☐	3B Combing of pubic hair	☐
1D	2C Scalp hairs	☐	3C Pluck 12 pubic hairs	☐
1E	2D Fingernail scrapings	☐	3D Foreign material	☐
1F	2E Oral swab and smear	☐	3E Vaginal swabs	☐
1G	2F Saliva sample	☐	3F Vaginal aspirate	☐
1H	2G Blood Grouping	☐	3G Slide for motility check motile ☐ non-motile ☐	☐
1I	2H Blood Alcohol/Drug	☐	3H Anal swab and slide	☐
1J			3I Rectal swab and slide	☐
1K			3J Urine sample	☐

Reason, if any of above not done

EXAMINATION OF (PATIENT'S NAME)

AT (LOCATION - HOSPITAL NAME) ON (DATE) (TIME)

ASSISTED BY OBSERVED BY

SIGNATURE OF M.D. (EXAMINER) DATE

SIGNATURE OF WITNESS DATE

CLOTHING AND SPECIMENS RECEIVED FROM: NAME TITLE

AT: DATE TIME PLACE

RECEIVED BY: POLICE OFFICER'S NAME RANK

DISTRIBUTION: COPY 1 FORENSIC LABORATORY
COPY 2 POLICE OFFICER

Archives of Ontario, RG 64-10
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SAEK Forensic Evidence Form, ca. 1981

The SAEK's protocol instructed physicians[8] to follow the SAEK's forensic script regardless of a survivor's/victim's description of rape or physicians' judgment of its truthfulness ("Procedures Form," ca. 1981).[9] A sexual assault nurse recalled, "once you opened that kit, you were completing every single step in it. You were taking all your patients' clothes, you were plucking head hair. You were doing everything to that patient…it was horrendous, it really was" (SANE4). The SAEK and its script dictated the

[8] As I describe later, in the early years of the SAEK, physicians were primarily responsible for the SAEK exam, with nurses acting as assistants. This was an aspect of the SAEK's forensic script that was later was a subject of controversy.

[9] Omission of SAEK steps was permitted; however, this could only be done if an investigating officer and physician agreed to its necessity and a detailed rational for the omission was provided in the SAEK documents ("Taking Care," 1990).

action in the SAEK exam room. The script simultaneously positioned the survivor/victim as the implicated user of the SAEK. By signing the SAEK consent form, she expressed her willingness, coerced or otherwise, to use the SAEK, or to have it used on her.[10] However, upon signing the consent form, the SAEK's script denied her any control over the SAEK's work and situated her as a subject of medicolegal practice who was simultaneously on the margins.[11]

The SAEK's script reduced medical forensic exams to a series of standardized steps. Many hoped that stripping medical forensic evidence of any signs of medical actors' subjectivity would increase the likelihood that in the courtroom, it would appear objective, and therefore be more likely to be admissible (Provincial Secretariat for Justice, 1978). For many, the SAEK's script held the promise of stabilizing the SAEK's as the reliable and credible technoscientific witness of sexual assault. While there has been no historical analysis of whether the SAEK's forensic script did indeed increase the admissibility of medical forensic evidence in rape cases (Du Mont & Parnis, 2003), anecdotally, one crown prosecutor who practiced in the 1970s and 1980s suggested that after the SAEK was developed, medical forensic evidence was rarely challenged in court and was commonly deemed admissible.

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[10] I write this with the acknowledgement that for many survivor's/victim's, consenting to the SAEK exam is complicated by police pressures and lack of information (see chapter 6 for further discussion). From the original SAEK consent form, it is unclear whether survivors/victims had the right to consent to a SAEK exam without immediately reporting a rape to the police. Although the consent form suggests that the decision to report and to have the exam were separate, the form provided no way for her to specify to which of the two options she was consenting to ("Consent Form," ca. 1981). The consent section on the Sexual History Form (ca. 1981) created further confusion by combining the consent to the SAEK exam with consent for medical personnel to report the rape to the police. From this, it can be assumed that in most cases, consent to the SAEK exam was tied to consent to police involvement.

[11] She was *on the margins* to the extent that she had little influence in or on practice, but she (or her body) was simultaneously the *subject* of medicolegal practice. I describe this contradictory positioning in more detail below.

The SAEK's forensic script did not, however, immediately stabilize the SAEK in medicolegal practice. It was instead often the subject of controversy. Here, I trace three aspects of the script and some of the controversies that arose around them.

Seeing identity in bodily traces.

Part of the SAEK exam involved collecting foreign bodily traces from a survivor's/victim's body – blood, skin, hair, and semen – for the purposes of identifying a perpetrator of rape ("Forensic Evidence Form," ca. 1981). This component of the SAEK reflected the common evidentiary requirement in 1970s rape cases for corroborative evidence that explicitly identified the perpetrator. As I illustrated in the last chapter, this legal requirement had been inscribed in the SAEK's material design, most particularly in its detailed instructions for collecting identifying corroborative evidence.

The practice of collecting bodily traces for forensic identification was propelled by common beliefs in forensic science that "it is almost impossible to commit a crime without leaving any physical evidence" (Krishnan, 1978, p. 12) and that physical evidence contained "clues to the circumstances of the crime and the identity of the offender" (p.12). Individuality, it was assumed, was reflected in the body, and therefore, could be seen in the bodily traces (Cole, 2001). These beliefs were visible in the SAEK's prescribed steps for combing the survivor's/victim's body for traces that could help identify a sexual assault perpetrator.

In the early 1980s, the forensic identification methods in sexual assault cases were mainly blood, semen, and hair analysis (FSM; FS1). These analyses were predominantly comparative and involved matching samples obtained in the SAEK to those collected

from the suspect or from where the rape occurred (FS1). Through comparison, identity was surmised from visible similarities in hair types and/or matching blood types and groupings within blood and semen samples.[12] These techniques could not identify an individual but instead, identified a group of individuals that shared similar blood or hair types. This drastically changed with the introduction of DNA analysis in the late 1980s, which I describe in chapter 5. However, in the early 1980s, the forensic methods for hair comparison and blood typing and grouping were those that the SAEK's forensic script aimed to serve.

"Painless" hair plucking.

The SAEK's forensic script included a series of steps that involved combing and plucking a survivors'/victims' head and pubic hair. Physicians and nurses were to collect 50 head hairs by either combing a survivors'/victims' hair, "rub[bing her] scalp vigorously" (Provincial Secretariat for Justice, 1978, p. 26), or plucking individual head hairs. Pubic hairs (a minimum of 12) were also plucked (Provincial Secretariat for Justice, 1978). Forensic scientists used the 62 plucked or gathered hairs to identify and differentiate foreign hairs found on the survivors'/victims' body (Krishnan, 1978). This part of the SAEK's forensic script was a subject of much debate.

Controversies among physicians, forensic scientists, and some anti-rape activists over the efficacy of plucking pubic hairs began early in the SAEK's history (Martin, DiNitto, Maxwell & Norton, 1985; "Meeting Notes," 1983). These controversies featured opposing assertions about the levels of pain the procedure caused and its forensic

[12] I describe these methods in greater detail in chapter 5.

necessity. In 1982, at a meeting of physicians, forensic scientists, and government officials in Toronto, one physician asserted that the pain of plucking pubic hairs was excessive and should justify the removal of the step in the SAEK ("Meeting Notes," 1983). The forensic scientist in attendance opposed this omission and argued that it was necessary to forensic hair comparison as it was a process that required "a total sample" (p. 5) including the plucked hair root. In this debate, forensic necessity prevailed and the step was not removed from the SAEK's forensic script.

In the years following, some physicians attempted to recast the practice of plucking pubic hairs as not only necessary, but also relatively painless for survivors/victims (Hargot, 1985a). In 1985, Dr. Len Hargot described the ease with which pubic hairs could be plucked,

> This can be done very easily by grabbing the pubic hair with the fingers, telling the patient that this will be somewhat uncomfortable, and giving a very quick tug. This may not be as painful as it sounds. Local anesthetic may be administered at the discretion of the physician. However, we have found that this is not necessary when adequate explanation is given (p. 778).

These claims were similarly made in the first training video for physicians and nurses on the SAEK, where a doctor was featured as saying to the survivor/victim, "this won't hurt" before he began plucking her pubic hairs (Slater, D., 1981, Slater to R. Cornish, February 12, 1981).[13]

[13] The training video was titled *Helping Victims* and was released around 1984. I could find no copy of the video in provincial, municipal, or hospital archives. What I cite here is a letter from the Ontario Coalition of Rape Crisis Centres to the Provincial Secretariat of Justice, which describes the video in detail.

Some anti-rape activists challenged medical actors' assertions about painless plucking by arguing that not all survivors/victims felt plucking in the same way. In a letter to the PSJ, one activist wrote, "while the doctor may feel confident that plucking pubic hairs won't hurt, it is the victim who will experience any pain and it is her feeling that should be respected" (p. 1). Other feminist scholars asserted that the pain associated with hair plucking was "unnecessary suffering" (Martin, DiNitto, Maxwell & Norton, 1985, p. 240) for the survivor/victim. Despite these contestations, medical claims of painless plucking and forensic claims of the necessity of total hair samples supported the inclusion of hair plucking in the SAEK's script for two decades until 2002, when it was finally removed from the SAEK's script (FS1).

Seeing motility.

In addition to the techniques for collecting hair, the SAEK's forensic script also included steps for collecting motile sperm. To collect sperm, physicians and nurses were instructed to use a vaginal aspirate, which involved filling and then removing 10ml of distilled water in a survivor's/victim's vaginal cavity (Provincial Secretariat for Justice, 1978). Using the water from the vaginal wash, physicians and nurses would prepare a microscope slide, which they observed under a microscope in the exam room to determine if motile sperm were present in the vaginal cavity. Evidence of motile sperm could be used in court to indicate when sexual intercourse had taken place and to identify the time the rape had occurred. The SAEK procedures stated, "sperm motility is not usually present after 12 hours" ("Procedures Form," ca. 1981); if motile sperm were seen, it was assumed that a rape had occurred in the past 12 hours (Krishnan, 1978).

The scientific claims about sperm life in the vagina embedded in the SAEK's forensic script shaped the tool's usability. The SAEK procedures form stated,

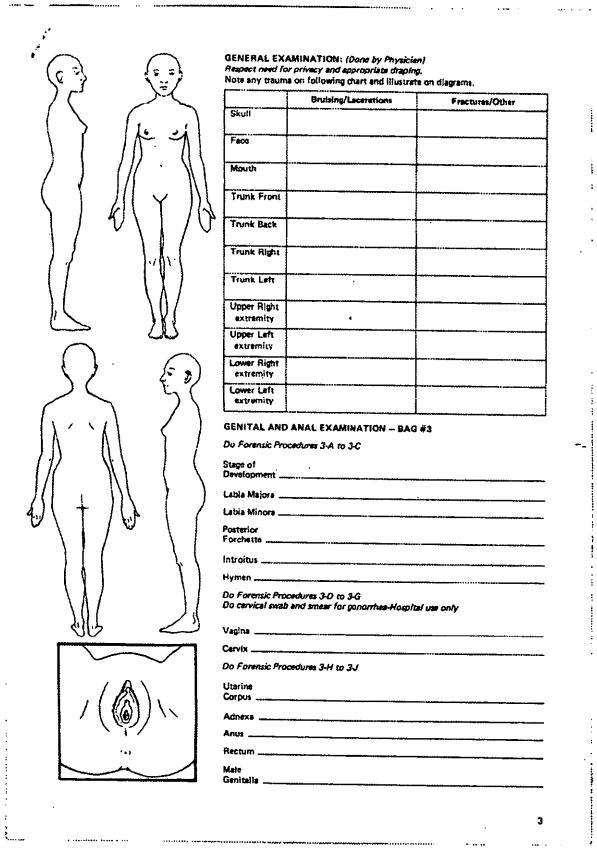
> The most useful evidence is collected within 24 hours of the assault...When 48 hours or more have elapsed between the time of the assault and the examination, the collection of specimens from body orifices will not generally yield useful information for court purposes ("Procedures Form," ca. 1981, p. 1).

According to the SAEK's script, physicians were not to use the SAEK to take a vaginal aspirate, or oral, anal, and rectal swabs after 48 hours ("Procedures Form," ca. 1981). The SAEK's instructions suggested that there was scientific consensus over motile sperm life; however, medical and forensic science literature suggested otherwise (Astrup, Thomsen, Lauritsen, & Ravn, 2012). Some scientific reports claimed that motile sperm usually survived only eight hours in the vaginal cavity (Krishnan, 1978), whereas others claimed it could survive 72 hours (Hargot, 1982) and, still others, 96 hours (Evrard, 1971).

Additional controversy surrounded the tools that physicians' used to see motile sperm in the SAEK exam. Hargot (1985a) suggested that the low-powered microscope that physicians commonly used led to many false negatives in motile sperm tests. Hargot argued that higher-powered microscopes and staining procedures in forensic laboratories were far more successful in identifying motile sperm. With this argument, Hargot challenged the conclusions that many physicians' were making about motile sperm in SAEK exams. In addition to steps for collecting samples of foreign bodily traces, the SAEK script also called for a detailed physical examination of the survivor/victim.

The SAEK seeing violence

The physical exam component of the SAEK exam involved physicians producing visible representations of bodily violence. The SAEK procedures instructed physicians to "look for evidence of violence e.g. marks, bruises, lacerations, scratches, [and] fractures" (Provincial Secretariat for Justice, 1978, p. 26) and draw and describe what they observed on the body map detailing the "location, dimensions, tenderness, colour, and estimated age of the lesion" (p. 26). Inscribed in these instructions were the 1970s' evidentiary requirements for corroborative evidence of force in rape cases.



GENERAL EXAMINATION: *(Done by Physician)*
Respect need for privacy and appropriate draping.
Note any trauma on following chart and illustrate on diagrams.

	Bruising/Lacerations	Fractures/Other
Skull		
Face		
Mouth		
Trunk Front		
Trunk Back		
Trunk Right		
Trunk Left		
Upper Right extremity		
Upper Left extremity		
Lower Right extremity		
Lower Left extremity		

GENITAL AND ANAL EXAMINATION – BAG #3
Do Forensic Procedures 3-A to 3-C

Stage of Development _____
Labia Majora _____
Labia Minora _____
Posterior Forchette _____
Introitus _____
Hymen _____

Do Forensic Procedures 3-D to 3-G
Do cervical swab and smear for gonorrhea-Hospital use only

Vagina _____
Cervix _____

Do Forensic Procedures 3-H to 3-J

Uterine Corpus _____
Adnexa _____
Anus _____
Rectum _____
Male Genitalia _____

3

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Body Map, 1981

The body map reflected legal definitions of rape as forced vaginal penetration. In the first SAEK in 1981, the body map featured a simple line drawing of a female (abled) body, which was relatively young and thin and devoid of any racialized features ("General Examination," ca. 1981). The body in the map was the type that, according to the Criminal Code, could be raped. The body map depicted a narrow image of rape and rape

survivors/victims that was in stark contrast to the diverse images that some activists were making visible in the anti-rape movement.

Below the body diagram in the body map was a close up drawing of the perineum, which featured most prominently, the vaginal opening. By highlighting the vaginal area over the anal area, and excluding the oral and penile, the body map constrained physicians' drawings and descriptions of rape to the injuries caused by forced vaginal intercourse. Rape could only be seen in the body map as marks on or around the vagina or as less specified marks on the rest of the body. Other physical injuries, forms of rape (such as oral or anal), and the emotional and psychological marks that rape had left on the survivor/victim were obscured or unseen in the body map. In constraining visual depictions of rape, the body map enacted and reflected narrow constructions of rape and its survivors/victims.

SAEK in practice: Enacting meanings of rape, bodies, and survivors/victims.

When the SAEK was put to work in medicolegal practice, it enacted particular meanings of rape, sexually violated bodies, and survivors/victims. On the basis of these meanings, the SAEK's forensic script was extended to survivors/victims to define a set of expected evidence preserving actions for survivors/victims post-rape.

The SAEK enacted the survivor's/victim's body as, in the words of some contemporary medical actors, "a walking crime scene" (Price, Gifford, Summers, 2010,

p. 549).[14] With the SAEK's forensic script, her body became implicated in medicolegal practice and she became the subject of it when physicians and nurses combed her body for physical traces of rape. Rape, in the SAEK exam room, became defined as an act that was empirically observable on the body through visible physical injury, motile sperm, and foreign hairs. This was, according to some rape crisis centre workers, a glaring contrast to the understanding that many anti-rape activists had of rape as an act that rarely left visible marks (RCC4; RCC13).

The SAEK's script stipulated the technologies that physicians and nurses would use to see traces of rape. White and Du Mont (2008) describe how sexual assault is "visualized" (p. 1) in the contemporary SAEK exam through technical "optical technologies" (p. 1). Expanding their definition of technology to include not only technical technologies, but also "simple tools" (MacKenzie & Wajcman, 1999, p. 3), it could be said that the SAEK of the 1980s included a range of optical technologies for seeing rape: the microscope for viewing motile sperm, and the comb for gathering hair, the body map for illustrating violence, and the swabs, bags, toothpicks, and syringes for collecting blood, skin, hair, and semen. Physicians' use of these technologies enacted meanings of rape as an act that could be seen.

The SAEK's technologies worked to "freeze" (King, 1994, p. 90) rape so that it could be later observed and witnessed in the courtroom. As one forensic scientist said, describing the contemporary SAEK, "the kit is great because it captures the evidence at

[14] Understanding the sexually violated body as a crime scene in forensic examination is a common dictum reiterated in nursing and psychology literature (Price, et al., 2010; Johnson, Peterson, Sommers, Baskin, 2012; Campbell, Patterson, & Bybee, 2009). Feminist scholars have explored how this understanding disempowers women who experience rape (Doe, 2012), rearticulates notions of the domestic (Mulla, 2008), and fragments the body and reduces conceptions of rape to bodily violence (Bumiller, 2008).

the time the complainant comes forward and it is then locked down in time" (FS1). With the SAEK, visual signs of rape were "locked down" so that they could later be "virtual[ly] witnessed" (Shapin & Schaffer, 1985 p. 60) by lawyers, judges, and juries. In this way, the SAEK's testimony as the technoscientific witness allowed other actors in the courtroom to virtually witness sexual assault. Shapin and Schaffer describe virtual witnessing as a "literary technology" (p. 60) that early scientists used to "produc[e] in the reader's mind an image of the experimental scene in a way that obviates the necessity for either direct witness or replication" (p. 60). The SAEK's testimony worked in a similar way: it produced images of rape in lawyer's, judge's, and jurists' minds that removed the necessity for directly witnessing sexual assault.

In the contemporary courtroom, Bumiller (2008) suggests that, "sexual violence is made verifiable through the voyeuristic reimagining of the violation of women's bodies" (p. 32). Reports from the late 1970s and 1980s suggest a similar trend. If rape was virtually witnessed in the courtroom with physical injuries and foreign bodily traces, it was more likely to be believed (Clark & Lewis, 1977; Kinnon, 1978).

In addition to meanings of rape as empirically observable, the SAEK and medicolegal practices around it also enacted rape as a medical problem requiring medical intervention (Doe, 2003; Mulla, 2008; Doe, 2012). The survivor/victim in a SAEK exam was commonly named in training videos and medical literature as "the patient" ("Taking Care," 1990; Fahrney, 1974; Hargot, 1985a) who was being given medical treatment. This language likened the survivor/victim to other emergency ward patients, rape to a medical condition that could be treated, and the SAEK to other medical procedures.

As the survivor's/victim's body became enacted as a crime scene, she was positioned in practice as a risky medicolegal outsider who had the potential to unknowingly destroy valuable physical evidence at the scene of the crime. The SAEK's forensic script encouraged her to see her own body as a crime scene by stipulating a set of actions for her to take to preserve and protect bodily evidence until it could be collected with the SAEK. Many of the texts, information booklets and pamphlets for survivors/victims on the SAEK outlined strict instructions on preserving bodily evidence. The Provincial Secretariat of Justice (1978b) handbook for survivors/victims included instructions in capitalized letters that read, "DO NOT BATHE, SHOWER, OR DOUCHE. These actions can destroy evidence" (Provincial Secretariat for Justice, 1978b, p. 1).

The SAEK's forensic script configured an ideal implicated user of the SAEK.[15] This ideal implicated user was the survivor/victim who knew and followed the SAEK's forensic script and thus worked cooperatively with the SAEK. To fit this definition, a survivor/victim needed to have the capacity and desire to read the dense English SAEK instructions and the ability and wish to follow them immediately following their rape. For many women, these instructions were likely difficult to remember and to follow in the face of trauma and the long emergency room delays. Many rape crisis centres attempted to make these instructions more accessible to women, and in doing so, I argue that they became involved in stabilizing the SAEK, despite the fact that many were deeply critical of its use.

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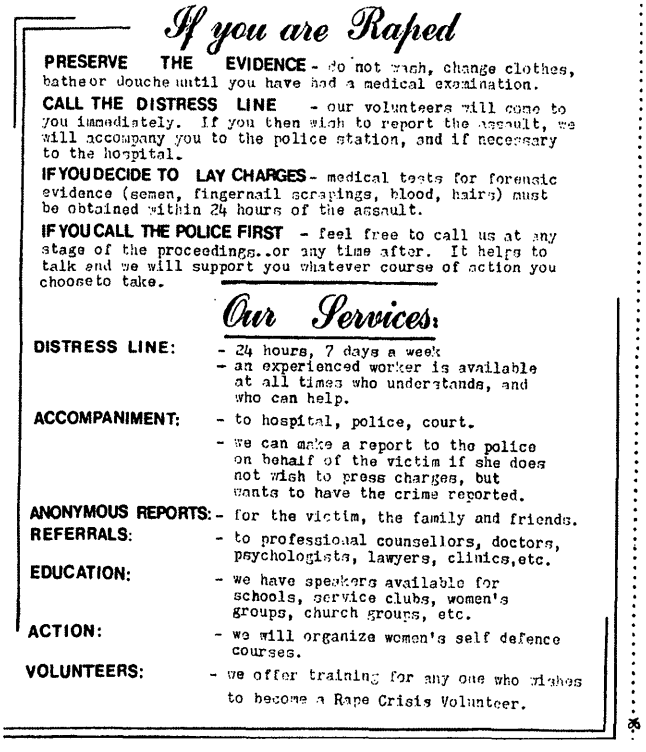
[15] I expand this idea further in chapter 6.

Conflicted relations: Rape crisis centre workers and the SAEK.

Although many anti-rape activists had advocated for the SAEK's development in the 1970s and some had participated in its early design, many anti-rape activists had what appeared to have a conflicted relationship with the SAEK. One rape crisis centre worker described this by saying, "we were never big believers in the evidence kit" (RCC4). According to her, many of the anti-rape activists thought that the SAEK gathered useless evidence that could easily be explained in court as traces of consensual sexual activity. Another activist recalled, "there was a lot of tension around what the kit did beyond prove that there may have been some kind of activity that might be labeled as sexual activity...there was a great deal of conversation [and] fretting" (RCC14).

While some claimed that the SAEK "lent some amount of credibility" to women's rape reports and "gave some women comfort" (RCC12), others argued that the SAEK symbolized "the medical system becoming...a gate keeper to the legal system" (RCC14), and falsely represented rape "as either a medical issue or a legal issue, as opposed to a social issue" (RCC14). Some argued that the kit was a tool that perpetuated the disbelief of women's testimonies of rape in the legal system, and as such "the kit couldn't be understood outside of the context of patriarchy" (RCC14). However, for many rape crisis centre workers, these tensions about what the SAEK did and what it symbolized were weighed against the knowledge that for some survivors/victims, although often very few, the SAEK provided the necessary evidentiary proof that their rape had occurred for a perpetrator to be convicted of rape (RCC12; RCC14). The SAEK was, according to some, "a necessary evil" (RCC14).

Despite the uncertainties about the SAEK amongst rape crisis centre workers, many rape crisis centres and the texts they produced participated in stabilizing the SAEK and its forensic script. Rape crisis centres' brochures often included instructions for preserving bodily evidence ("Sudbury Rape Crisis Centre," ca. 1980; "Sexual Assault Centre London," 1981; "Sexual Assault Crisis Centre Windsor," ca. 1984), and some volunteer training manuals described how volunteers should convey information about evidence preservation to survivors/victims ("Training Manual," 1977; Toronto Rape Crisis Centre, 1979). Many of these texts reiterated government and medical descriptions of how to preserve evidence and the importance of doing so for police reports. The doubts that many rape crisis centre workers had about the SAEK's value were erased in most of these texts. By erasing their own uncertainty within their texts, many rape crisis centres participated in advertising the SAEK and its forensic script to survivors/victims.



If you are Raped

PRESERVE THE EVIDENCE - do not wash, change clothes, bathe or douche until you have had a medical examination.

CALL THE DISTRESS LINE - our volunteers will come to you immediately. If you then wish to report the assault, we will accompany you to the police station, and if necessary to the hospital.

IF YOU DECIDE TO LAY CHARGES - medical tests for forensic evidence (semen, fingernail scrapings, blood, hairs) must be obtained within 24 hours of the assault.

IF YOU CALL THE POLICE FIRST - feel free to call us at any stage of the proceedings..or any time after. It helps to talk and we will support you whatever course of action you choose to take.

Our Services:

DISTRESS LINE:	- 24 hours, 7 days a week - an experienced worker is available at all times who understands, and who can help.
ACCOMPANIMENT:	- to hospital, police, court. - we can make a report to the police on behalf of the victim if she does not wish to press charges, but wants to have the crime reported.
ANONYMOUS REPORTS:	- for the victim, the family and friends.
REFERRALS:	- to professional counsellors, doctors, psychologists, lawyers, clinics, etc.
EDUCATION:	- we have speakers available for schools, service clubs, women's groups, church groups, etc.
ACTION:	- we will organize women's self defence courses.
VOLUNTEERS:	- we offer training for any one who wishes to become a Rape Crisis Volunteer.

University of Ottawa Archives, X10-1
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Sudbury Rape Crisis Centre Pamphlet ca. 1984

Rape crisis centres and their texts became involved in making the SAEK work in medicolegal practice when they disseminated medicolegal expectations for the implicated user of the SAEK. While the SAEK's forensic script for survivors'/victims' actions post-

rape gained stability, the script for medicolegal actors' actions did not, as legal reforms and medicolegal controversy threw parts of the SAEK's script into question.

Destabilizing the SAEK with Law and SAEK Users

Redefining Tools: Rape law reform.

In 1982, after more than six years of anti-rape and feminist lawyers and activists lobbying for legal reform, sections of the Criminal Code of Canada relating to rape were redrafted (Sheehy, 1999; Tang, 1998). When the reforms came into effect in early 1983, they eliminated the Criminal Code's narrow definition of rape as forced vaginal penetration and created a new section for sexual assault under the larger heading of physical assault (s. 246). Mirroring the structure for physical assault offences, sexual assault was defined as a three-tiered offence with graded levels of violence and penalty, which included: i) sexual assault, with a maximum penalty of 10 years (s. 246.1), ii) sexual assault with the use or threat of bodily harm (s. 246. 2), with a maximum penalty of 14 years, and iii) aggravated sexual assault, with the maximum penalty of life imprisonment (Bill C-127, 1982). With this reform, sexual assault was given a more expansive definition that included other forms of non-vaginal rape and sexual assault, as well as sexual assault against men. The reform also eliminated the immunity that husbands had under the previous Criminal Code to rape their wives.

In addition to the substantive changes in sexual assault law, there were several procedural reforms regarding the evidentiary requirements for sexual assault. Most important to the SAEK, the 1976 Criminal Code reforms on corroborative evidence were reinforced with a clearer mandate in 1982, a mandate that eliminated the need of

corroborative evidence for sexual assault conviction through the words: "no corroboration is required for a conviction and the judge shall not instruct the jury that it is unsafe to find the accused guilty in the absence of corroboration" (Bill C-127, 1982, s. 246.4).

When these reforms were being drafted in Bill C-127 (1982), many hoped that the new reform would eliminate the sexist biases previously embedded in rape law and increase the reporting and conviction rates for sexual offences (Parnis & Du Mont, 1999). Michelle Landsberg (2011) expressed this hopefulness when she described the anticipated reform in her column in 1981; "the new terminology happily washes away accumulated layers of sexism currently built right into the laws: that only a woman can be raped, only by men, and only when the penis penetrates the vagina" (p. 125). Despite the confidence with which many feminists and anti-rape activists welcomed the expected reform, Landsberg's (2011) columns suggest that some had hesitations and doubts about the reforms capacity to radically shift the legal handling of sexual violence and mourned the loss of the term rape, which had animated the anti-rape movement for the previous decade.

Bill C-127 (1982) had significance for the SAEK. By reshaping parts of the law that had been inscribed in the SAEK's design, the reforms had the potential to call the SAEK's design and meaning into question. The SAEK's purpose of capturing visual signs of forced vaginal penetration became unnecessarily narrow under the expanded definition of sexual assault. Also, the reform opened the possibility of challenging the SAEK's purpose of collecting identifying evidence of an offender, which some anti-rape

activists argued, stemmed from the belief that survivors/victims were raped by people they did not know (RCC4). By eliminating husbands' immunity to rape, many activists and medicolegal actors expected that more sexual assaults involving known offenders would come forward; as one crown attorney reportedly said in 1981, "a change like that could open the floodgates" (Landsberg, 2011, p. 127). In most cases involving known offenders, identifying information was not required as the case more commonly revolved around consent, not identity (DL6). By redrafting the legal basis upon which the SAEK was built, Bill C-127 had the potential to destabilize the forensic script of the SAEK.

In late 1982, just after Bill C-127 (1982) had been introduced in parliament, medical and legal actors were designing and distributing a new SAEK to Ontario hospitals (Cornish, 1982, R. Cornish to Emergency Room Physicians, Nurses, Police, Crown Attorneys, December 10, 1982). The redesigned SAEK reflected relatively minimal changes, which included two new forms (a French consent form and a new medical history form) and removed one forensic procedure of scraping a survivor's/victim's fingernails. The only evidence that the SAEK's forensic script had been redesigned to reflect the pending legal reforms was its inclusion of instructions for gathering forensic evidence from male survivors/victims of sexual assault.

The SAEK's body map, which had previously featured a distinctly female body, was redrawn to feature a seemingly unsexed body with a small jaw, similarly sized hips and shoulders, muscular legs, and a short hair cut. Below the close up diagram of the vaginal area, a diagram of the penile region was added. In these changes, the SAEK's

forensic script shifted slightly to accommodate the SAEK's new purpose of collecting forensic evidence of sexual assault from women, men, girls and boys.[16]

These relatively small changes to the SAEK did not reflect the elimination of the corroborative evidence requirement (Parnis & Du Mont, 1999). The SAEK still maintained its purpose of collecting evidence of bodily harm that could be used to substantiate or refute a survivor's/victim's experience of sexual assault. The SAEK retained its emphasis on collecting evidence that identified the perpetrator, despite what was expected to be a significant increase in cases involving known perpetrators. While the SAEK's forensic script was only slightly altered by the 1983 legal reforms, parts of the script were hotly contested in the medicolegal system in the years before and after.

Designated SAEK users.

In the 1980s, the SAEK's forensic script stipulated physicians as the SAEK's primary users (Ontario Hospital Association, 1983a). This instruction gave physicians a new expert claim over the new tool and the sexually violated bodies it worked on. As White and Du Mont (2008) have noted, with the SAEK, "physicians were integrated into a new form of expertise" (p. 2) on rape, violated bodies, and forensic evidence.

To use the words of Science and Technology Studies scholar, Sheila Jasanoff (1998), physicians in the 1980s had "authorized lines of sight" (p. 713) over sexually violated bodies. Their scope of practice, unlike nurses and many other medical personnel, gave them the authority to collect medical samples from body orifices (MacDonald,

[16] Despite these changes, I continue to use the female pronoun when I refer to survivors/victims, as women have been and continue to be the most likely survivors/victims of rape and sexual violence in Canada (Kong, Johnson, Beattie, Cardillo, 2002).

Wyman, & Addison, 1995, p. 1). The vaginal aspirate and speculum examination in the SAEK exam required a medical actor who had the authority and expertise to *see* inside women's bodies.[17]

In the 1980s, nurses were most often physicians' assistants in the SAEK exam, who could collect some forensic evidence, but only at the physician's discretion (Provincial Secretariat for Justice, 1978).[18] Nurses were often responsible for explaining the SAEK procedures to the survivor/victim and completing some of the documentation ("Taking Care," 1990) and with physician permission, they collected the survivor's/victim's clothes and some hair, mouth, and fingernail samples ("Procedures Form," ca. 1981). Although physician-nurse teams were often used for SAEK exams (Du Mont & Parnis, 2003), the procedure forms and training videos clearly stipulated the physician's authority over the SAEK and the procedures in the exam.

Not all physicians welcomed their new responsibility for the SAEK. While many medicolegal and government actors hoped that the SAEK would increase physicians' willingness to conduct forensic exams by simplifying the process (Ontario Hospital Association, 1983a), it did not prove to do so in practice ("A Report of the OHA," 1983). Some physicians felt uneasy about their new dual role as medical care providers and SAEK forensic evidence collectors (Martin et al., 1985). One doctor described this by saying, "I think anytime we are asked to move outside of a primarily medical role, there

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[17] Martin et al. (1985) describe two additional reasons why physicians were chosen to conduct the SAEK exam: the assumption that survivors/victims would be more likely disclose rape to a physician and the assumption that physicians were more likely to be seen as credible witnesses in rape cases.

[18] Despite not having the same degree of authority as physicians, from the historical reports, it appears as though nurses received more training on the SAEK than physicians: in the Ontario Hospital Association survey in 1983, only 65% of Ontario hospitals had trained physicians on the SAEK, where 78% had trained nurses ("A Report of the OHA," 1983).

is a certain discomfort" (D1). According to many of the historical records, this clash between medicine and law played out in physicians' responses and resistance to the SAEK and its forensic script that designated them as the tool's primary users. The controversies that the physicians had the effect of *destabilizing* the SAEK in medicolegal practice.

Thirty-five percent of hospitals surveyed by the Ontario Hospital Association in 1983 reported problems with the SAEK ("A Report of the OHA," 1983). Most notably, physicians reported frustration about the significant amount of time that the SAEK imposed on forensic exams. One nurse remembered the frustration the SAEK caused amongst many medical staff. "Everyone would do this big yawn if a sexual assault case came in…they would say 'oh god, who's ready to be in one room for five hours?'" (SANE2).

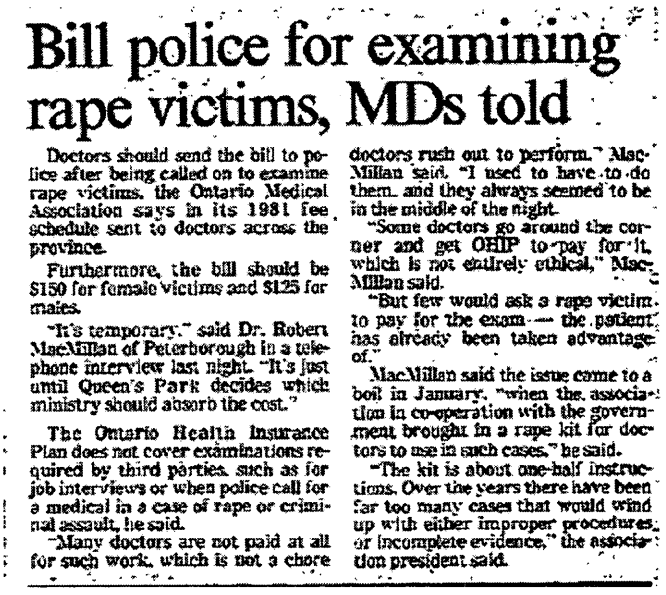
In medical journals, some physicians expressed concerns about the usability and design of the new tool and debates waged about its practicality. In response to one article that praised the SAEK (Hargot, 1985a), Herbert and Whynot (1985) wrote,

> It has been our experience that the Ontario kit, like most others…makes a simple examination unnecessarily complicated, time consuming, and expensive…one can take all appropriate evidence with a few swabs, test tubes, and slides – all available in any office or emergency department (p. 1453).

Hargot (1985b), an avid supporter of the SAEK, responded in a later article, "my fear in having a less defined protocol is that we would be taking a step backwards…the use of

the kit is meant to simplify the procedure, not to complicate it" (p. 1453). While Hargot saw the SAEK's benefits, many other physicians did not.

Physician dissatisfaction with the SAEK started early. In 1981, in response to increasing physician resistance to the SAEK, the Ontario Medical Association (OMA) announced that physicians would begin charging $150 for every SAEK exam ($125 for male survivors/victims) (Montgomery, 1981). The Ministry of the Attorney General refused to pay the fee. The OMA responded by stating that if the Ministry would not pay for SAEK exams, physicians would charge the "authorities requesting the service" (p. 1), which likely referred to individual police detachments. By 1983, however, the OMA and the Ministry had apparently reached a settlement that would grant physicians $185 for each SAEK exam, which would be paid by Ontario Health Insurance Plan (Ontario Hospital Association, 1983a). Despite secured payment, many physicians as well as other emergency room staff continued to resist accepting responsibility for administering the SAEK. Physicians and nurses often prioritized other medical emergencies over survivors/victims and as a result, long delays awaited many



Bill police for examining rape victims, MDs told

Doctors should send the bill to police after being called on to examine rape victims, the Ontario Medical Association says in its 1981 fee schedule sent to doctors across the province.

Furthermore, the bill should be $150 for female victims and $125 for males.

"It's temporary," said Dr. Robert MacMillan of Peterborough in a telephone interview last night. "It's just until Queen's Park decides which ministry should absorb the cost."

The Ontario Health Insurance Plan does not cover examinations required by third parties, such as for job interviews or when police call for a medical in a case of rape or criminal assault, he said.

"Many doctors are not paid at all for such work, which is not a chore doctors rush out to perform," MacMillan said. "I used to have to do them, and they always seemed to be in the middle of the night.

"Some doctors go around the corner and get OHIP to pay for it, which is not entirely ethical," MacMillan said.

"But few would ask a rape victim to pay for the exam — the patient has already been taken advantage of."

MacMillan said the issue came to a boil in January, "when the association in co-operation with the government brought in a rape kit for doctors to use in such cases," he said.

"The kit is about one-half instructions. Over the years there have been far too many cases that would wind up with either improper procedures or incomplete evidence," the association president said.

Toronto Star, April 9, 1981
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survivors/victims in Ontario hospital emergency wards (Women's College Hospital, 1983).

One survivor's/victim's wait in a Toronto emergency ward made front-page headlines in 1982. After waiting many hours in the emergency ward at Humber Memorial Hospital in Toronto, medical staff refused to treat the survivor/victim and she was reportedly forced to travel to Women's College Hospital for the SAEK exam (Stead, 1982). When the survivor/victim reported her story to the media, controversies sparked over who was to blame (D1). In the media reports, some criticized the physician involved and others, police officers and rape crisis centres, reported the systemic problem of delays in emergency wards (Stead, 1982).

According to some memos from the Ontario Hospital Association (1983b), these media reports put the emergency room delays "under close public scrutiny" (p. 1). In an effort to regain public confidence in medical responses to sexual assault, the Minister of Health stated in the media that he would be "writing to every hospital in the province to ensure that never again will a rape victim be turned away untreated" (Stead, 1982, p. 1). Likely, he sent out the following letter,

> Recent disturbing events surrounding the care and treatment of rape victims in the emergency department of some hospitals is causing some concern. I would like to stress that the *first priority* is to ensure that appropriate medical treatment is provided and that the necessary forensic process is carried out with the *utmost urgency* and sympathy. The rape evidence kits have been designed to provide a standardized means of collecting forensic information and evidence. Although I

> appreciate that it takes time to complete the requirements within the kit, this aspect should not be allowed to delay or alter the provision of adequate care and attention given to the patient...It is the duty of everyone involved to treat these unfortunate victims with utmost sensitivity [emphasis added] (Ontario Ministry of Health, 1982, p. 1).

In the media, the Ministry claimed that the government had done its part in supporting survivors/victims by educating physicians on the SAEK and financing rape crisis centres (Stead, 1982). Despite the government's efforts, however, public relations battles between government parties ensued in the media and Ontario Liberal and NDP leaders reportedly challenged the Conservative government's for being disinterested in survivors/victims and their needs (Stead, 1982).

As a result of the mounting public pressure, government agencies proposed to move the SAEK out of emergency wards in Toronto and into a regional sexual assault treatment centre ("Meeting Notes," 1983). The centre would be staffed by specially trained physicians and nurses and would be responsible for treating all survivors/victims in the Toronto area (Women's College Hospital Public Relations, 1982). These proposals sparked a restabilizing of the SAEK with a new expert space for the SAEK exam.

Stabilizing with New Expert Spaces

Sexual Assault Care and Treatment Centres (SACTC) were built as new medicolegal spaces for the SAEK. For many medical, legal, and government actors, these centres held promise of diminishing the controversies around the SAEK by providing a new institutional home for the SAEK where it could be reclaimed by willing medical

actors. In addition to the survivor's/victim's experience at Humber Memorial Hospital, many other things fuelled the development of the first SACTC in Toronto.

Imagining a SACTC.

The idea for a hospital-based SACTC was in existence long before it was realized in Toronto. Hospital-based SACTCs had been running in the United States since 1972 (Burgess & Holmstrom, 1973). In Ontario, a regional rape treatment centre was opened in Hamilton in 1979 (Hargot, 1982). When the steps were undertaken to design and build a SACTC in Toronto, these centres were used as a model ("Rape Treatment Centre," 1982).[19]

Many supporters of the proposed Toronto SACTC described the centre as the only solution to physicians' reluctance to the SAEK and to emergency room delays ("Meeting Notes," 1983; Women's College Hospital, 1983). One proposal stated,

> Although revisions to the Sexual Assault Kit have made it easier to use and procedures have been somewhat standardized, there is still a feeling that police cases of this nature are not truly a part of emergency medicine. Feelings cannot be legislated and problems will continue to occur unless centres providing necessary care are doing so (Women's College Hospital, 1983, p. 4).

[19] This history is somewhat unclear. In many public relations documents, Women's College Hospital (WCH) claims to be the *first* sexual assault care and treatment centre in Canada (Sunnybrooke and Women's College Health Sciences Centre, n.d.; Ontario Network of Sexual Assault/Domestic Violence Treatment Centres, n.d.). However, the WCH proposal for the centre (WCH Public Relations, 1982) as well as some internal memos on the development of the centre ("Rape Treatment Centre," 1982), clearly suggest that WCH's plan was to "utilize/modify the step-by-step plan already in existence at McMaster" (p. 1). While it is not clear if Hamilton had a physical centre in 1979, which the WCH had in 1984, one Hamilton physician did describe the Hamilton sexual assault treatment program as a centre, which suggests that it might have been a dedicated physical space for sexual assault treatment (Hargot, 1982).

According to this argument, "problems" around the SAEK would only be diminished and "feelings" resisting the SAEK subdued if a new expert space was developed that housed voluntary trained physicians willing to take responsibility for the SAEK.

The Ontario government framed the proposed SACTC as having even broader appeal (Ontario Ministry of Health, ca. 1984). SACTCs seemingly meshed well with the government's push in the 1980s to lower costs of health care, increase efficiency, and centralize health services (Murray, Jick, & Bradshaw, 1984). Keith Norton, the Ontario Minister of Health, expressed this clearly in a news release announcing SACTCs in Ontario:

> In an era of limited fiscal resources, new money must be generated by trade-offs and economies within the health care system itself...it is imperative to use every health care dollar as effectively as possible...in the hospital sector, tough times means co-operative times (Ontario Ministry of Health, ca. 1984).

In many reports, centralizing health care services for sexual assault and eliminating the delays the SAEK caused in emergency wards with a SACTC was cast as a necessary step for reducing the health care costs of sexual assault treatment (Women's College Hospital, 1983).

In addition to government arguments for SACTCs, one municipal report, written in 1983, gave the idea of SACTCs in Toronto some of its greatest publicity. Following a series of rape-murders in Toronto in 1982, a task force was initiated to investigate the criminal justice system's response to public violence ("Task Force on Public Violence," 1983). The Task Force, headed by a member of the Board of Police Commissioners for

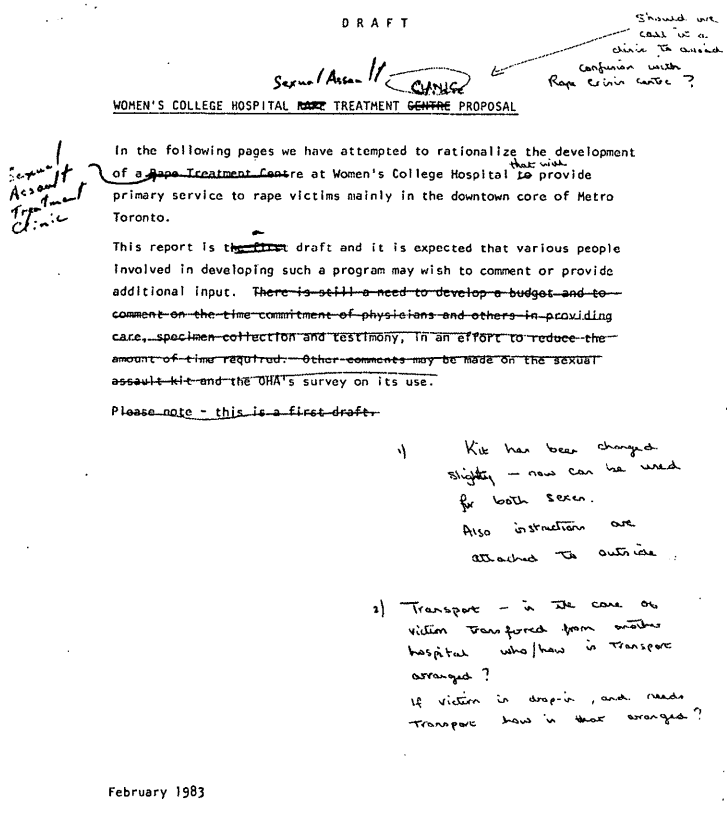
Toronto (Baker, 1983), included six working groups with over 80 volunteers ("Task Force on Public Violence," 1983), some of whom were anti-rape activists from the Toronto Rape Crisis Centre (Watt, S., 1982, S. Watt to Members, December 13, 1982). The Task Force recommended many changes, ranging from specialized police rape investigation squads to public education campaigns on the criminal justice system ("Task Force on Public Violence," 1983). Most notable was their recommendation to develop five regional sexual assault centres in Toronto. The Task Force's report was covered extensively in the media (Baker, 1983; Lipovenko, 1984).

The Task Force report marked another moment when anti-rape activists and rape crisis centre workers became involved in the action around the SAEK. Ironically, it would be the sexual assault centres that some medical actors would use to displace rape crisis centre workers from medicolegal practice involving the SAEK.

Women's College Hospital's SACC.

Women's College Hospital was the first hospital in Toronto to propose to house a regional SACTC (WCH Public Relations, 1982). The hospital argued that its established expertise in women's health and history of "demonstrated social awareness" (Women's College Hospital, 1983, p. 4) made it an ideal home for the SACTC. Despite some initial concerns about funding (Haslehurst, 1983, J. Haslehurst to D. Psutka, September 6, 1983) and designating adequate staff and space for the centre ("Executive Committee Minutes," 1983), the hospital began its preparations to open the SACTC by April 1984 (Anderson, 1984).

Naming expert spaces.



DRAFT

Should we call it a clinic to avoid confusion with Rape crisis centre?

Sexual Assault Care Centre

WOMEN'S COLLEGE HOSPITAL ~~RAPE~~ TREATMENT ~~CENTRE~~ PROPOSAL

Sexual Assault Treatment Clinic

In the following pages we have attempted to rationalize the development of a ~~Rape Treatment Centre~~ at Women's College Hospital that will provide primary service to rape victims mainly in the downtown core of Metro Toronto.

This report is ~~the first~~ draft and it is expected that various people involved in developing such a program may wish to comment or provide additional input. ~~There is still a need to develop a budget and to comment on the time commitment of physicians and others in providing care, specimen collection and testimony, in an effort to reduce the amount of time required. Other comments may be made on the sexual assault kit and the OHA's survey on its use.~~

~~Please note - this is a first draft.~~

1) Kit has been changed slightly - now can be used for both sexes. Also instructions are attached to outside

2) Transport - in the case of victim transferred from another hospital who/how is transport arranged?
If victim is drop-in, and needs transport how is that arranged?

February 1983

The Miss Margaret Robins Archives of Women's College Hospital, HAS 73-34
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Memo, 1983

In the year before the centre opened, there was some controversy about what the centre should be called. An early report in 1982 used the name, "Rape Treatment Centre" (Women's College Hospital Public Relations, 1982, p. 1). However, less than a year later, in an internal memo, an unidentified author scribbled over the name with notes about the drawbacks of using the word centre. She or he questioned, "should we call it a clinic to avoid confusion with rape crisis centre[s]?" ("Draft," 1983). Possibly, this question was sparked by hesitations that the Ministry was expressing about treatment centres duplicating the services in rape crisis/sexual assault centres (Watt, 1984, S. Watt to J. Pepino, May 4, 1984).

Despite their apparent concern with being confused with rape crisis/sexual assault centres, hospital administrators eventually chose the name, "Sexual Assault Care Centre

(SACC)" (Sunnybrooke and Women's College Health Sciences Centre, n.d.). Feminist scholar Marjorie Cohen (1993) notes that governments have often "co-opted" (p. 21) organizational names from the women's movement and have as a result, created much confusion about organizational structures. Along similar lines, it could be said that the SACC chose a name that co-opted organizational titles from the anti-rape movement and in so doing created confusion amongst victims/survivors seeking support and police investigators about where the SAEK exam was done.[20]

On April 12, 1984, the Women's College SACC opened its doors (Lipovenko, 1984). The centre was located in the hospital near the emergency ward and had its own examination room for SAEK exams and a seating area for medical consultations (Women's College Hospital, 1983). It was staffed by several nurses and 14 physicians who had agreed to be associated with the centre (Anderson, 1984). In some articles announcing the centre, medicolegal actors reported the benefits of institutionalized sexual assault care over rape crisis advocacy. In one

ONTARIO MEDICINE APRIL 2, 1984

ONTARIO HAPPENINGS

Staffed mostly by GPs

Sexual assault centre to open

TORONTO — Almost two years after a rape victim was refused treatment at one of this city's hospitals, a sexual assault centre is being opened at Women's College Hospital with an initial roster of 14 doctors, all but one of whom are family physicians.

It will be the first such organized effort in metropolitan Toronto. Other physician teams operate similar facilities at McMaster Medical Centre in Hamilton, St Joseph's Hospital in London and Mississauga General Hospital.

The idea for the centre came during the summer of 1982 when a series of sexual assaults and murders had local women clamouring for increased protection and more services.

One of the physicians involved at the Women's College centre, Dr. Yvonne Verbeeten, says she volunteered for the rostery "because this is a social problem and someone has to do it."

Operating 24 hours a day, seven days a week, the centre will be located in or near the emergency department, although it will be considered a separate entity, something which distinguishes it from other centres in the province, says coordinator Ann Kurdyak.

Estimated patient load will be from 150 to 300 women a year.

Sexual assault victims prefer to be treated in a hospital rather than a rape centre because they find "a certain comfort in institutions", says Marlaine Sachs Sniderman, a social worker who lectures on the sexual assault problem to health care professionals and police.

During the medical examination, physicians are advised to tell the victim exactly what they are doing. Gaining the patient's consent also helps to distinguish the examination of the vaginal area from the rape itself.

If the victim requests a female staff member, "every attempt should be made to accommodate her," says Sachs Sniderman. However, she adds that women are not necessarily more empathetic than men and sometimes "distance themselves" from the situation.

The majority of physicians at the centre are women.

Pauline Anderson

Dr. Yvonne Verbeeten

APR 17 1984

The Miss Margaret Robins Archives of Women's College Hospital, HAS 73-9
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Announcement of Women's College SACC,

[20] In many of my interviews, the respondents and I had to take extra steps to clarify which type of centre we were talking about: SACTCs or rape crisis/sexual assault centres (which many of them are now called). As I discuss more in chapter 6, this confusion has supported the efforts to redefine sexual assault care and advocacy.

article, a social worker stated, "sexual assault victims prefer to be treated in a hospital rather that a rape centre because they find a certain comfort in institutions" (Anderson, 1984). These claims, in retrospect, foreshadowed what would be a more organized effort to displace rape crisis centre workers in the SAEK exam.

A (dis)comforting expert space.

Not long after the SACC opened at Women's College, other SACTCs began opening across the province. By 1987, there were 15 SACTCs in Ontario (Brodie, 1987) and by 2000, there were 27 (Saltmarche & Cherrie, 2000). In 1993, a provincial network of SACTCs had formed. In 1998, many centres' mandates expanded to include survivors/victims of domestic violence (KPMG Consulting, 1999) and this change was reflected in the network's name.[21] By providing a new expert space for the SAEK, the SACTCs silenced some of the controversies about SAEK's in emergency wards, and in so doing, gave the SAEK some renewed stability in medicolegal practice. Many medicolegal actors heralded the Ontario SACTCs as a significant advancement in the medicolegal response to sexual assault (Lipovenko, 1984; Baker, 1983); however, as I will argue, their introduction had more nuanced effects.

According to many rape crisis centre workers, for many survivors/victims the SACTCs provided a welcomed alternative to emergency wards (RCC4; RCC13; SANE1; SANE2). Many nurses I interviewed reiterated this by saying that the trained staff at the SACTCs and the separate location from the emergency ward created "a more caring and supportive environment" (SANE1) for survivors/victims. However, there were many

[21] For simplicity, I use the name Sexual Assault Care and Treatment Centre (SACTC) for the remaining chapters.

survivors/victims who did not directly benefit from the SACTCs, such as those survivors/victims who did not wish to go to the hospital after experiencing a sexual assault or those whose access to the SACTC was limited or prevented by language, lack of information, geography, limited transportation or for other reasons.

In the initial years of the Women's College SACC, the centre's mandate was, according its coordinator Dianne Nannarone,

> Two fold...to present an approach to comprehensive *management* which is responsive to the emotional, physical, and medical/legal needs of victims of sexual assault, and to present a '*networking' model* for nurses and physicians and other health care professionals integrating medical and emotional treatment with the criminal justice system as part of the therapeutic process [emphasis added] (Unknown, 1986, p. 1).

By fostering a "networking model" (p. 1) for medical professionals, the SACCs became the physical location where expertise on sexual assault was developed and supported. By seeking to "manage" (p. 1) sexual assault as an "emotional, physical, and medical/legal" (p. 1) problem, practices in the SACC enacted meanings of sexual assault as an individual trauma and sexual assault treatment as a medical/legal intervention. Sexual assault treatment became tied to the SAEK as the tool became a central part of medicolegal practice.

The physical layout of the Women's College SACC reflected the meanings of sexual assault, survivors/victims, and sexual assault treatment that were inscribed in the SAEK and mirrored in the SACC's mandate. One video that was filmed at the SACC

captures the small space that was reserved for consultation, which seemingly could only comfortably accommodate one physician, one nurse, and the survivor/victim.[22] The restrictive capacity of the room reinforced meanings of sexual assault treatment as an individualized exchange between medical personnel and survivors/victims. The room's central feature, the large examining table, and the other medical and forensic tools surrounding it, defined sexual assault treatment as a medical/forensic intervention, which included the SAEK exam. Sexual assault, within this physical arrangement, became an individual, medical problem, or as Doe (2003) says, "a personal tragedy rather than a social evil and a crime" (p. 307). In 2000, the SACC opened an interview suite for police interviewing survivors/victims (Public Affairs, 2000). This structural addition solidified the connection between sexual assault treatment and the law that the SAEK forged.

The SACC's physical location reinforced medicolegal definitions of the ideal implicated user of the SAEK. To access the SACC services and therefore the SAEK, a survivor/victim had to have transportation to the centre, health care coverage, the ability to speak English,[23] the willingness to go to a hospital, a degree of comfort in institutionalized spaces that were predominantly white and English speaking, and the physical mobility to lie on the examining table that did not accommodate mobility impairments.[24] These restrictions on SACC access defined the narrow bounds of the SAEK's ideal implicated user.[25]

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[22] I draw the contents of this description of the SACC from the SAEK training video, *Taking Care* (1990), which was filmed at the Women's College Hospital SACC.

[23] Sexual assault treatment centres in Ontario introduced French services in 1994 (Ontario Women's Directorate, 1994). I found no evidence of other language services being offered before this date.

[24] In the 1980s, lack of accommodation for individuals with physical impairments was not unique the SACTCs and characterized many institutional and public spaces (Ringaert, 2003). In the SACTCs,

Boundary work: Expert spaces displacing rape crisis centre workers.

The SACTC's physical space allowed medical actors to control rape crisis centre workers involvement in the SAEK exam. Many medicolegal actors used the SACTCs to do what Jasanoff (1998) has called "expert-community boundary work" (p. 733), where they drew and policed new lines between the SAEK experts and rape crisis centre volunteers and staff. Whereas a decade earlier, rape crisis centre workers were commonly situated as *experts* on the margins of medical practice, now, with the development of the SAEK, medicolegal expertise, and expert spaces, they were becoming increasingly displaced in the SAEK's work. Medicolegal actors' boundary work attempted to situate rape crisis centre workers as non-users of the SAEK who were on the margins of the SAEK's work and who had limited influence over its use. These efforts sparked much controversy.

Within the first month of the WCH SACC opening, the Toronto Rape Crisis Centre and the hospital were in negotiations over whether volunteers had the right to accompany survivors/victims into the SAEK exam (Lipovenko, 1984). As two activists remembered, "we had to insist that we remain[ed] in the process" (RCC13) because "our role was not seen as a critical one" (RCC14). Hospital administrators expressed concerns about the lack of hospital based "controls" ("Women's College Hospital Memo," 1982b, p. 2) over rape crisis volunteers. The hospital proposed,

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accessible examining tables that accommodated mobility impairments caused by disability and severe injury were introduced in 1998 (Barnhouse, D., 1998, D. Barnhouse to P. Campbell, March 2, 1998).

[25] I discuss this further in chapter 6.

> ...that those volunteers selected to service this Centre be carefully screened, as it would be most damaging to individual victims as well as Women's College Hospital, if volunteers were to use to the program to press personal beliefs regarding reporting and prosecution of rapists (Women's College Hospital, 1983, p. 11).

Reports suggest that the hospital would only permit advocates from rape crisis centres in the SAEK exam if they promoted the SACC and the SAEK to survivors/victims. The hospital wrote in the SACC proposal, "it is hoped that staff of the rape crisis centre would *recommend/convince* victims, who had not yet obtained care, to seek out the assistance of Women's College Hospital's Sexual Assault Treatment Centre" [emphasis added] (p. 12). Hospital administrators were situating rape crisis centre workers as non-users of the SAEK who could only be marginally involved in the SAEK's work if they promoted and supported it.

According to some anti-rape activists, the tensions between the hospital and rape crisis centre made anti-rape advocacy difficult in the SACC, particularly for those without professional training of some kind (RCC14). One activist explained,

> Some of our volunteers were not highly professionalized individuals who could show a card and talk the appropriate professional language. We were women helping other women....the tension was based on the rape crisis centre's political analysis of rape intersecting with the hospital hierarchy and insistence on credentials (RCC14).

The Toronto Rape Crisis Centre collective stated that, "rape crisis workers were often perceived as unprofessional, improperly trained, and threatening" (TRCC, n.d.). In this context of expert boundary drawing, many activists claimed that the expectation on rape crisis centres to "liaise" (Sinclair, 1980, D. Sinclair to S. Sahli, June 26, 1980, p. 1) with hospitals in the government funding requirements was difficult if not impossible to fulfill (TRCC, n.d.).

"The Ultimate Co-Optation"

Many anti-rape activists questioned the rise of expert knowledge and practice around sexual assault and saw the SACTCs as an effort to undermine and co-opt sexual assault services and advocacy in the anti-rape movement (RCC4; RCC7; Doe, 2003; Doe, 2012). When the Women's College SACC opened, Deb Parent, from the Toronto Rape Crisis Centre, was quoted in the media as saying "I don't want to see mini rape crisis centres set up at hospitals" (as cited in Lipovenko, 1974). A similar sentiment was expressed when a third generation anti-rape activist that I interviewed recalled her grandmother's descriptions of the SACTC's opening in her Northern Ontario community. She said, "I remember what my grandmother said when the SACTC came in…'this is the death now for women's groups. This is *the ultimate co-optation*'" [emphasis added] (RCC7).

The growth of SACTCs in Ontario in the late 1980s and 1990s was accompanied by an expanded mandate for many centres, which included advocacy, public education, and research on sexual assault ("Annual Report," 1988). Some SACTCs adopted self-

descriptions that resonated some of the same language rape crisis centres' had used to define themselves (e.g. Winner, 1977; "Why Invest," 1979). One in particular read,

> Our role is to help women regain control, power and choice in their lives. We also play an advocacy role by influencing policy and requesting funding for new programs to meet the need of our clients. We are committed to practical and theoretical research designed to...facilitate the understanding and prevention of sexual assault ("Interviews," 1999).

By building a physical space for the SAEK exam, the medical actors in the SACTCs claimed a new medicolegal expertise over not only the SAEK, but sexual assault as well. The expertise in the SACTCs fit well within the climate of increasing government pressures to professionalize sexual assault advocacy and services. This claim to expertise was further solidified with the development of a new expert for the SAEK exam.

Stabilizing with New Expert Users

As the numbers of SACTCs grew across the province, centre coordinators increasingly struggled to find willing physicians to staff the centres (SANE2). These difficulties inspired initiatives to devise alternatives to the physician-nurse model for the SAEK exam (Du Mont & Parnis, 2003). Centre coordinators identified nurses as cheaper and more accessible source of labours for the SAEK exam (D1). Out of this, a new expert user of the SAEK arose in the medicolegal network: the Sexual Assault Nurse Examiner (SANE). This new actor expanded the SAEK's network and as a result, some of the controversies around the SAEK's use diminished and the SAEK became further stabilized in medicolegal practice.

Sexual assault nursing first appeared in the United States, almost twenty years before it was developed in Canada (Ledray & Simmelink, 1997). In the early 1970s, some medical clinicians were arguing for a new occupational group of nurses responsible for the forensic exam (Williams & Williams, 1973; Donadio & White, 1973). These clinicians suggested that nurses were uniquely poised to become the primary professionals for sexual assault treatment because of their extensive experience supporting survivors/victims through the forensic exam and because most nurses were women. Not long after, in 1976, the first Sexual Assault Nurse Examiner (SANE) program was developed in the United States (Ledray & Simmelink, 1997). SANE programs in the US grew steadily in the years that followed, with their numbers dramatically increasing with the 1994 Violence Against Women Act (Fitzpatrick, Ta, Lenchus, Arheart, Rosen, Birnback, 2012). Although SANE programs in Canada developed more slowly, when they began to appear, they relied heavily on the model that had been established in the United States (SANE5).

In 1992 in Ontario, nurses at a Ministry of Health conference expressed an interest in establishing a SANE program in Ontario (Macdonald, Wyman, & Addison, 1995). By this time, the Regulated Health Professions Act had expanded Ontario nurses' scope of practice to include the authority to insert instruments and/or hands "beyond the opening of body orifices" (Macdonald, Wyman, & Addison, 1995, p. 1-A).[26] This change gave nurses the authority to *see* inside a woman's body using a speculum or other

[26] This change coincided with many other expansions in nurses' scope of practice (Worster, Sarco, Thrasher, Fernandes, & Chemeris, 2005).

medical tools, or in other words, an "authorized line of sight" (Jasanoff, 1998, p. 713) over sexually violated bodies.

In the few years that followed, several Ontario nurses obtained SANE training in the US, and in 1995, a SANE program was introduced to the SACC at Women' College Hospital (Macdonald, Wyman, & Addison, 1995). In this program, nurses could conduct SAEK exams without physicians if the survivor/victim did not meet any of the criteria for physician referral, which included things such as, vaginal bleeding, pregnancy, and histories of psychosis and suicide attempts, among other things (Macdonald, Wyman, & Addison, 1995). According to Du Mont & Parnis (2003), the objective of SANE program at WCH, as with the programs in the US and the others that later developed in Ontario, was to "increase efficiency, consistency, and quality of health care and evidence collection by using a single well-trained professional" (p. 173).

Ontario SANEs built their professional status by claiming expert knowledge over the SAEK, and through that, sexual assault and medical forensic science. In 1995, a SANE training program was introduced to Ontario, which included 40 training hours on the SAEK and other forensic and medical tools such as speculums and pregnancy and tests, and on general themes of forensic science relating to sexual assault and the techniques and skills for "maintaining professionalism and objectivity in medical documentation and courtroom presentation" (Du Mont & Parnis, 2003, p. 175). Through these training programs, SANEs solidified an expertise over the SAEK, other tools of forensic evidence collection, and sexual assault that other emergency room nurses and physicians did not have. SANEs supported their claims to expertise with a wealth of

empirical research, largely conducted by SANEs, on the benefits of SANE programs on forensic evidence collection (Ledray & Simmelink, 1997; Sievers, Murphy, & Miller, 2003), efficiency and quality of sexual assault treatment (Stermac & Stirpe, 2002), quality of sexual assault care (Dandion-Abbott, 1999), and prosecution rates in sexual assault cases (Aiken & Speck, 1995; Cornell, 1998; Little, 2001; Hutson, 2002). In 2007, Canadian SANEs formalized their professional status with a Forensic Nurses Society of Canada (Forensic Nurses' Society of Canada, 2012). Through these moves to professionalize and credentialize SANEs, the SAEK became the domain of a new expert.

According to some reports, many physicians resisted the development of SANE programs in their hospitals (SANE2). As one sexual assault nurse recalled, "they did not want to let go" of the expert status that the SAEK exam had afforded them (SANE2). Maier (2012) found that some physicians "did not understand SANEs' role and resisted SANEs' presence in 'their territory'" (p. 1326). Other physicians, however, reportedly worked cooperatively with SANEs and welcomed the reprieve that reduced responsibility for the SAEK had offered them (Martin et al. 1985).

By taking responsibility for the SAEK exam, SANEs were, and continue to be, called on to testify in sexual assault cases, sometimes as lay witnesses, where they testify on their practices in the SAEK exam, and sometimes as expert witnesses, where they express opinions on whether a survivor's/victim's injuries could have resulted from consensual sexual activity (DL3; DL5). In Canadian law, expert evidence is only considered admissible if it is given by a "properly qualified expert" (R. v. Mohan,

1994).[27] In some sexual assault cases, defence lawyers have successfully argued that SANEs are not qualified experts as they have relatively limited training, compared to physicians (R.v. Radcliff, 2009), and they have a lack of experience examining non-sexually assaulted anatomy (R.v. Thomas, 2006). One defence lawyer outlined his approach for challenging SANEs expertise;

> I say things like, you've got no particular training in that area, you haven't been to medical school, you are not a physician, you are not an expert, you haven't conducted any studies, you are doing a sexual assault kit on people who are all coming in essentially indicating that there has been forced sexual activity in some way, so what kind of comparator is that? (DL2).

Despite these attacks on SANE's expertise, several nurses reported that SANEs are commonly deemed properly qualified experts and have given expert testimony (SANE2; SANE5; SANE1).

SANEs' introduction to the medicolegal network redefined the SAEK's forensic script as SANEs became the SAEK's designated users.[28] This shift was accomplished in practice. As SANEs did more SAEK exams across the province, testified in more sexual assault cases, and SACTCs came to be known as the institutional homes for SANEs, the SAEK's forensic script shifted to accommodate the new expert.

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[27] R. v. Mohan sets out four criteria for expert evidence, of which this is one. The other three criteria are: the evidence must be "relevant"; "necessary to assist the trier of fact"; and "there must be no exclusionary rule otherwise prohibiting the receipt of the evidence."

[28] Not all hospitals in Ontario have SANE programs and as such, there are hospitals where physicians or nurses without SANE designations use the SAEK. I describe this further in chapter 6.

Much of the clinical research on SANEs has claimed that they are more likely to adhere to SAEK protocols than emergency physicians (Ledray & Simmelink, 1997; Dandion-Abbott, 1999; Sievers, Murphy, & Millers, 2003; Campbell, Patterson, & Lichty, 2005; Campbell, Patterson, & Bybee, 2009) and more likely to collect the stipulated amounts and different types of evidence the SAEK requires and store and label the evidence according to the SAEK's requirements (Ledray & Simmelink, 1997; Dandion-Abbott, 1999; Sievers, Murphy, & Millers, 2003). SANEs' adherence to the SAEK's script has been linked in the literature to increased rates of sexual assault prosecution (Ledray & Simmelink, 1997; Campbell, Patterson, & Bybee, 2009). SANEs' work of ensuring that the SAEK's script was closely followed was thus part of and contributed to the bustle of medicolegal activity attempting to stabilize the SAEK in the medicolegal network.

Concluding Thoughts

Through the medicolegal efforts to stabilize the SAEK, medicolegal actors claimed a new interest and expertise in sexual assault with new experts and expert spaces for the SAEK exam. With this shift, anti-rape activists from rape crisis centres became largely displaced in the SAEK exam. While the SACTCs and SANEs appeared to successfully stabilize the SAEK in the medicolegal network, and silence most of the controversies surrounding it, the SAEK would destabilize again through new scientific controversies, technological developments, and legal uncertainties. In the following chapter, I explore the introduction of DNA analysis to forensic evidence collection in

sexual assault cases, a development that would radically shift the SAEK's meaning and material form once again.

Chapter 5
Assembling the Genetic Technoscientific Witness of Sexual Assault

When forensic DNA typing[1] was introduced to sexual assault investigation in Canada in 1989, it redefined the technologies that forensic scientists were using to analyze the Sexual Assault Evidence Kit (SAEK). In so doing, DNA typing redefined the SAEK and the evidence it produced. In this chapter, I examine the rise of forensic DNA typing in Canada and explore the technoscientific and legal controversies around DNA that *destabilized* the SAEK. I show how with DNA technology, the SAEK's material form was redesigned and its meaning in medicolegal practice was reassembled and *stabilized* as the new *genetic* technoscientific witness of sexual assault.[2] Through the history of controversy around DNA typing, I show how medicolegal trust in the SAEK as the new genetic technoscientific witness of sexual assault was accomplished in practice.[3]

Sheila Jasanoff (2006) argues that in forensic practice, "physical traces remain silent...unless they are made to speak with the aid of specialized laboratory techniques" (p. 330). Following this argument, I suggest that physical traces collected with the SAEK remain largely silent until they are analyzed by forensic scientists and interpreted by

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[1] DNA is an abbreviation for deoxyribonucleic acid, a type of molecule that is found in cell nuclei and mitochondria that forensic scientists now understand to reflect an individual's unique genetic make-up. Forensic DNA typing, DNA profiling or DNA analysis, are abbreviations that all refer to a family of techniques for analyzing genetic material in trace evidence. In sexual assault cases, DNA typing technologies are used to identify perpetrators of crime from trace evidence gathered at a crime scene and/or with the SAEK.

[2] Other scholars and forensic scientists have described DNA as a genetic witness of crime (Federico, 1991; National DNA Databank, 2003). Here, I build on this metaphor, to show how the advent of DNA typing led to the SAEK being redefined in medicolegal practice as the genetic technoscientific witness of sexual assault.

[3] Forensic DNA typing is not limited to sexual assault investigation. It was and continues to be used in a variety of criminal investigations where there are traces of bodily tissues or fluids, such as murder, manslaughter, assault, and robbery. In this chapter, I focus on the history of DNA typing as it relates to sexual assault investigation.

medical and legal actors. Only by making the SAEK speak can the SAEK act as the technoscientific witness of sexual assault. In this chapter, I focus on the techniques for making the SAEK speak about the identity of sexual assault perpetrators.[4] I argue that DNA typing contributed to destabilizing the SAEK by calling into question the techniques that medicolegal actors used in the 1980s to make the SAEK speak and redefining and *stabilizing* new techniques for making the SAEK speak in sexual assault cases.

As I stated in chapter 1, some Science and Technology scholars have proposed that stabilized technologies are those "in which the conflict and heterogeneity inherent in technology building is overcome...and the social relations which lie behind the technology are made either invisible or unquestionable" (Halfon, 1998, p. 802). Adopting a similar perspective, Akrich (1992) argues that once stabilized, technologies act in networks as "instruments of knowledge" (p. 221). These perspectives frame stabilization as an outcome of controversies that have been resolved and made invisible. I argue that the SAEK's entangled histories demand an alternative framing.

As I will show in this chapter, despite the efforts to stabilize the SAEK in medicolegal practice in the 1980s, and its continued use throughout the 1990s, there were vibrant controversies around its meaning and material form. In the 1990s, medicolegal actors were using the SAEK as an "instrument of knowledge" (Akrich, 1992, p. 221) in sexual assault cases, but were also debating and redefining the technologies for analyzing

[4] As I illustrated in the previous chapter, there are other components of the SAEK, such as the body map and sexual and medical history form, which are also made to speak through medical and legal interpretation. I discuss this further in chapter 6.

the SAEK's contents. Here, I adopt Singleton's (1998) understanding of stabilization, which proposes that instability can exist within stability to show how controversies over the technologies for analyzing the SAEK coexisted with the SAEK's continued use in medicolegal practice.

This chapter illustrates a crucial shift in the SAEK's terrain. In chapter 3, I illustrated how action around the SAEK and sexual assault in the 1970s was on the street, in community rape crisis centres, and consultations between anti-rape activists and government, medical, and legal actors. In chapter 4, I showed how action around the SAEK shifted to hospital emergency wards and Sexual Assault Care and Treatment Centres (SACTCs). In this chapter, the action shifts location again. Here, I show how the activity around the SAEK and sexual assault moved to scientific laboratories, legal courtrooms, and government boardrooms.[5] With this shift, I argue that the flurry of action around the SAEK moved even further from its origins in the anti-rape movement.

This chapter illustrates how DNA analysis shifted the focus of many discussions around the SAEK from protocols, services, and treatment to bodily substances and identity. I show how material things – blood, semen, DNA profiles, laboratory tools, etc. – formed new practices and relations between actors in the SAEK's network. In doing so, I explicitly illustrate how non-human actors were central to reassembling the SAEK in meaning and in material form.

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[5] Here, I am *not* suggesting that action in other locations ceased. Instead, I proposing that there were different historical locations where there were flurries of activity around the SAEK and sexual assault. The result was that over the course of this history, different actors became central to the SAEK's assembly and reassembly.

I show how DNA analysis brought scientists, lawyers, and government actors into the centre of action around the SAEK and pushed rape crisis centre workers further to the margins. Following the medicolegal efforts to displace rape crisis centre workers in the SAEK exam in the 1980s, few rape crisis centre workers were involved in the controversies around DNA technology and the SAEK in the 1990s. During this time, as I show in this chapter, there were many anti-rape activists involved in legal reforms for sexual assault law and some who voiced contentions around the rise of DNA evidence. However, with the development of medicolegal expertise, experts, and expert spaces for sexual assault and the rise of DNA, rape crisis centre workers were increasingly left out of the medicolegal controversies and consultations around the SAEK. As a result, many of the traceable controversies[6] around DNA and the SAEK feature medicolegal actors who used the SAEK as the technoscientific witness, such as forensic scientists, lawyers, physicians, and nurses. The content of this chapter reflects this shift.

I begin this chapter by briefly sketching some of the context into which forensic DNA typing in sexual assault cases entered in the late 1980s. I then describe the development of DNA typing and some of the legal and technoscientific controversies that surrounded its introduction in medicolegal practice. I track how, through these controversies, forensic scientists, government agencies, and the media used violence against women to propel a rapid acceptance of forensic DNA typing by framing it as a technology that would enhance public safety and protect the public from violent crime. I

[6] There are few historical records on rape crisis centre workers' explicit involvement in controversies around DNA evidence in sexual assault cases. This does not mean that advocates were not involved, but instead reflects the fact that they left few accessible traces in public archives and libraries.

then turn to sketch how DNA typing led medicolegal actors to redesign the SAEK's material form and reassemble its meaning into the *genetic technoscientific witness* in medicolegal practice. I show how in practice, the revised SAEK enacted new meanings of survivors'/victims' and their bodies. I conclude by examining how DNA and the SAEK has seemingly been stabilized in medicolegal practice and question whether the controversies around DNA typing have in fact come to a close.

Setting the Stage

Forensic DNA typing emerged within a particular historical context that enabled its rapid acceptance as an objective set of techniques for analyzing SAEKs. In what follows, I briefly sketch the political, legal, and forensic scientific contexts within which DNA typing emerged.

Rebick (2005) describes the 1990s as a decade that featured pervasive and powerful conservative politics, media declarations that the feminist movement was over, and severe federal and provincial funding cuts for women's organizations. Many of the rape crisis centre workers that I interviewed echoed this description by saying that during the 1990s, funding pressures on rape crisis centres became more acute, collectives diminished, and pressures to professionalize intensified (RCC4; RCC13; RCC14). In this context, lawyers and forensic scientists were developing new medicolegal practices for sexual assault cases and anti-rape activists were actively organizing to transform sexual assault law.

Survivors'/victims' credibility on trial.

Rape victims still very much on trial

Once again, recent headlines remind us that an old wrong has yet to be righted: Rape victims are still on trial, almost as much as they were under the old law before Bill C-127 was passed in 1983.

Ten years ago only 3 per cent of all rapists ended up in jail. Only six out of every 100 rapists were even brought to trial. Half the cases were dismissed by the police. Most of the rest never got to court because crown attorneys believed they would never get a conviction.

It wasn't that they didn't believe a rape hadn't occurred. The problem was putting the victim on the witness stand, where she would be raped verbally as every detail of her sexual history was paraded before the court and her community. To get a conviction back then, a woman had to have lived an absolutely blameless life, untouched by human hands — unless they belonged to her husband — before her assailant would be sent to jail.

With Bill C-127 a woman's sexual history was not supposed to be flaunted before the court unless it had some special significance to that particular case.

Today defence lawyers don't pry into every detail of a woman's sexual past. They go about winning their cases, as one lawyer said, "by discrediting her with kid gloves." They grill the woman

on every aspect of the crime. While she faces the man who raped and threatened her, she has to recount the brutal act in minute detail. And she better not stumble over any item.

The Metro Action Committee on Public Violence Against Women and Children has detailed the kind of qualities a woman must have to make a rape case stick.

First, you have to be chaste or celibate or be married for years to the same man. If you have been married before and divorced, or have lived common-law, or are pregnant, you are in trouble.

You must have had no alcohol or drugs within 24 hours of the assault. You should be pleasant looking and conservatively dressed. You must be an immaculate housekeeper and have a photographic memory because you will be grilled on every detail of the crime: what your assailant wore, the color of his eyes, the position of articles in the room when the act occurred, exactly what you were wearing, what was said, and so on.

It also helps if your English is impeccable, and you have no visible handicap. You must never hesitate or look confused. On the other hand, if you are too controlled or assertive, that will go against you because obviously the assault did you no "lasting harm." If you are too emotional you will be discredited as being excitable and unstable. (One young woman who was taking therapy to help her overcome the trauma of being raped had that fact held against her at her assailant's trial as an indication that she was basically unstable.)

Above all, don't have the misfortune to be raped by a friend, ex-lover, lover, neighbor, co-worker or boss. Often women don't even report such cases and the prosecution won't go ahead with the case because they are convinced they won't win.

Of course, if you have been hitchhiking, or were in a bar alone, or were wearing a light skirt or jeans or not wearing a bra or were wearing too much makeup, you'll be discredited.

Every 17 minutes in Canada a woman is raped. That amounts to 31,000 Canadian women who are raped every year. A survey of U.S. college students estimated one in every five woman at college is raped.

Yet rape is the most unreported crime in Canada, and has one of the lowest conviction rates.

Rape is a violent, brutal crime. As one police officer said, it's the worst experience a woman will have in her life. A rape victim wrote: "Men seem incapable of understanding what rape means to women. It is the most physically painful ordeal you can have and live afterward. I felt I was being repeatedly stabbed with a knife and being ripped and torn in one of the most sensitive areas of my body for 15 minutes. There is no sex in rape. I think this confusion between sex and rape is largely responsible for the male fantasies of it being pleasurable for the victim, for its glorification in the movies, and the relatively light sentences imposed by judges on convicted rapists."

A mother wrote me about her 15-year-old daughter who had been raped. The girl had nightmares for a year afterward. To try to put the experience behind her, she had to go to school in another province. The mother ended her letter: "Rape is rape and my daughter will never get over the horror of it."

Because no weapon had been used the judge decided there had been no lasting harm. The man got two years less a day. The woman's daughter got a life sentence.

Toronto Star, January 30, 1988
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The 1990s was a tumultuous decade for sexual assault law. While many feminist lawyers, scholars, and activists were organizing to implement legal reforms, defence lawyers were devising and solidifying new defence strategies for challenging survivors'/victims' credibility in court. This context opened the doors to DNA analysis being used in sexual assault cases as an apparently objective technology for analyzing the SAEK.

According to some feminist scholars, despite the protections survivors/victims gained with the 1983 rape law reform, sexual assault courtrooms in the 1990s were "a minefield for female sexual assault victims" (Lee, 2000, p. 8), where their credibility was put on trial with new means and a new fervor. In contrast to these assertions, some defence lawyers argued that the accused were disadvantaged by the 1983 sexual assault law reforms, which according to some, provided "a blue print for convicting people of sexual assault" (Schmitz, 1988, p. 43). Some lawyers argued that in this climate, new aggressive defence strategies were needed to challenge the survivor's/victim's credibility. One such

defence strategy was proposed by Michael Edelson at an Ottawa criminal bar meeting in 1988, where he asserted that the defence should "whack the complainant hard at the preliminary…if you destroy the complainant in a prosecution, you cut off the head of the Crown's case, and the case is dead" (p. 44). "Destroying" the complainant, according to Edelson, involved collecting discrediting evidence in survivor's/victim's psychiatric, hospital, and criminal records, establishing a survivor's/victim's drug use, and hiring a private investigator to "beat the bushes and interview some of the principle Crown witnesses" (p. 45). According to one of Michele Landsberg's (2011) columns, rape crisis staff and volunteers reported that Edelson's tactics were widely followed in the 1990s, particularly after two additional legal reforms that were designed to minimize defence interrogation into survivors'/victims' sexual histories and personal records.

In 1991, the Supreme Court ruled that the existing restrictions on the admissibility of sexual history in sexual assault cases violated the constitutional rights of an accused under the Charter of Rights and Freedoms (R. v. Seaboyer, R. v. Gayme, 1991). According to Johnson and Dawson (2011), many feminist advocates, scholars, and lawyers contested the ruling and argued that it would discourage women from reporting sexual assault. In response to this pressure, the Minister of Justice, Kim Campbell, organized a consultation that included 60 women's groups, which contributed to drafting new legislation for the use of sexual history in sexual assault cases (Stuart & Delisle, 2004). Landsberg recalled,

> It was an unprecedented, almost incomprehensible event: Conservative prime minister Brian Mulroney was in power, and here was his minister of justice, Kim

> Campbell, summoning grassroots and front-line women's groups…I was among the startled invitees. Never before had a justice minister asked the advice of women in reforming the rape laws (p. 128).[7]

Bill C-49 arose from these consultations and when it was passed in 1992, it added section 276 to the Criminal Code, which defined stricter rules around the admissibility of a survivor's/victim's sexual history. While this reform clarified the laws around the admissibility of sexual history, it did not preclude the use of sexual history and gave judges the authority to rule that evidence of sexual history was relevant in sexual assault cases. A Department of Justice study in 1997 found that in most sexual assault cases, judges continued to admit evidence of sexual history, often on the basis of vague defence arguments about relevance (Meredith, Mohr, & Carins Way, 1997).

In response to the new legislation limiting the use of sexual history, some defence lawyers turned to survivors'/victims' personal records as a means of challenging their credibility and discrediting their testimony (Johnson & Dawson, 2011). In 1995, the Supreme Court ruled that personal records could be used if defence counsel proved that the records were relevant to the case (R. v. O'Conner, 1995). In 1997, Bill C-46 was passed, adding Section 278 to the Criminal Code, which established a firmer set of requirements for judges determining the relevance of personal records and included a recognition of the survivor's/victim's right to privacy. The reform was challenged shortly after as a Charter violation; however, the Supreme Court ruled in R. v. Mills (1999) that

[7] This is perhaps somewhat overstated. As I described in chapter 3, in 1976, anti-rape activists drafted recommendations for rape law reform for the Law Reform Commission (Vance, 1978). The extent to which the government solicited activists' recommendations in 1976 is unclear from the historical records.

it did not infringe on the Charter rights of the accused. Although some activists initially considered the Supreme Court ruling to be a victory, it did not stop many defence lawyers from continuing to argue that personal records were in fact relevant (Johnson & Dawson, 2011).

Despite some of the advancements in legal protections for survivors/victims gained in the 1990s,[8] many feminist scholars and activists argued that survivors'/victims' credibility in the courts was continually undermined and challenged. In 1999, Penni Mitchell reflected back on the decade of legal reform and wrote "no means no, but the war against sexism in the courts is far from over" (Mitchell, 1999). Within this context, forensic DNA typing emerged as a new technology that promised to provide objective, credible evidence of sexual assault. As survivors'/victims' credibility was being challenged in the courts, the credibility of the new genetic technoscientific witness of sexual assault was being assembled. This assembly involved not only developing new laboratory techniques and technologies for analyzing the SAEK, but also displacing old ones.

Making the SAEK speak in the 1980s.

In the late 1970s and 1980s, the Sexual Assault Evidence Kit (SAEK) samples of hair, blood, and semen were "made to speak" (Jasanoff, 2006, p. 330) with analysis that forensic scientists and police used to exclude possible suspects of sexual assault. These techniques did not identify individual perpetrators, but could exclude them if the scientist

[8] Another significant legal development in the 1990s was what has come to be known as the "no means no legislation," where the Supreme Court ruled that implied consent is not a valid defence for sexual assault (R. v. Ewanchuk, 1999).

could show that the suspect's physical characteristics did not match those they saw in the sample (Stone & Stone, 1978). As I show in this chapter, DNA analysis displaced these techniques, and in so doing, destabilized the SAEK of the 1980s.

In the 1980s, forensic scientists visually compared hairs in the SAEK and hairs collected from a suspect to demonstrate a match, which could be used in court to indicate a suspect's guilt ("Scientific Evidence," 1980).[9] According to one forensic science manager, matches were, however, very rare, as hair similarity was difficult to determine with any certainty (FSM). To put this in Latour's terms (2005), hairs *resisted* being analyzed and categorized in this way. As a result, forensic scientists more commonly used other techniques to analyze the SAEK (FSM).

Forensic scientists used blood typing to analyze blood and bodily fluid in the SAEK (Eckert, 1978). The Landsteiner-Berstien classification system was most commonly used, which involved identifying one of four blood types (A, B, AB, and O) in a sample. In this system, forensic scientists would associated each blood type with estimated frequencies of their occurrence in North American populations: Type A characterizes 41% of the population, Type B, 10%, Type AB, 4%, and Type O, 45% ("Scientific Evidence," 1980). To specificity the analysis, some scientists used protein and blood grouping systems, in which they used particular combinations of blood types to formulate smaller population frequencies (Krishnan, 1978). Forensic scientists could use the blood type or grouping that they identified in a SAEK sample to exclude all suspects with that blood type (Krishnan, 1978). Like hair, however, blood was not easily

[9] Chemical analysis was also used, however, most forensic scientists considered it to be complex and unfruitful because chemical compositions of hairs varied across the body (Krishnan, 1978).

categorized and according to Gill, Jeffreys, & Werrett (1985), these techniques "left a large degree of uncertainty" (p. 578), which often played out in the courtroom.

One crown prosecutor asserted that, in the 1980s, forensic hair and blood analysis was rarely useful in sexual assault cases (CA5). He explained that "it was almost impossible to get a conviction...because you didn't have the scientific evidence linking the accused to the victim" (CA5). With the available forensic techniques, the analyzed SAEK could only reveal a possible link between an accused and a survivor/victim ("Scientific Evidence," 1980). The crown prosecutor described blood grouping by saying, "it was very very very weak evidence...that evidence was so weak because of the vast number of people who are in blood groups. It was almost um, the evidence was negligible" (CA5). According to this prosecutor, the SAEK of the 1980s had little value in the sexual assault courtroom beyond illustrating injuries. The perceived limitations of the SAEK and forensic hair and blood analysis helped set the stage for the rise of DNA analysis.[10]

When forensic DNA analysis emerged in the late 1980s, forensic scientists vowed that it would displace and surpass the older techniques of forensic hair and blood analysis (Gill, Jeffreys, & Werrett, 1985). They promised that it would outshine previous forensic methods and provide objective identifying evidence in sexual assault cases. In these reports, DNA typing held the potential to redefine the techniques and technologies for analyzing the SAEK, and therefore to *destabilize* the SAEK of the 1980s.

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[10] Others have argued that DNA analysis was also sparked by growing discontent with other forensic methods, such as forensic fingerprinting. For a detailed history of the controversies surrounding forensic fingerprinting, see Cole (2001).

Displacing Old Techniques: The Discovery of DNA Typing

In the early 1980s, Alec Jeffreys, a geneticist at the University of Leicester, England, and his colleagues were devising a new forensic technique of extracting identifying codes from bodily fluids, which they claimed, could identify individuals. In 1985, Jeffreys and his colleagues announced their discovery of what they called "DNA fingerprinting" (Jeffreys, Wilson, & Thein, 1985; Gill, Jeffreys, & Werrett, 1985).[11] They claimed that DNA fingerprinting would be a powerful new method that would replace earlier forensic methods and in so doing, "revolutionize forensic biology" (Gill, Jeffreys, & Werrett, 1985, p. 577).

The method that Jeffreys and his colleagues proposed was multi-staged and involved extracting DNA strands from a sample, cutting them into fragments, and illuminating DNA fragment variations, or Restriction Fragment Length Polymorphisms (RFLP) (Curran, 1997). RFLPs were, according to Jeffreys and his co-researchers, specific to individuals on the basis of their varying length and amounts of repetitive nucleotide sequences (Gill, Jeffreys, & Werrett, 1985, p. 577). Through this method, these researchers produced a "DNA fingerprint" (p. 577), which illustrated variations in DNA fragments with an image that appeared almost like a supermarket bar code (Gerlach, 2004). Jeffreys proposed that an unknown "DNA fingerprint" from a suspect

[11] This term was later rejected by forensic scientists and geneticists because it was thought to obscure a crucial difference between forensic fingerprinting and DNA profiling: a DNA profile's uniqueness is determined through statistical probabilities of a DNA profile's rarity within a population, whereas a fingerprint's uniqueness is assumed (Cole, 2001). While fingerprints were thought to be a unique mark of individuality, DNA profiles are seen as rare genetic sequences (Cole, 2001). The terms "DNA profiling," "DNA typing" and "DNA analysis" were adopted as alternatives to Jeffreys' original "DNA fingerprinting." In accordance with this turn, I use these three terms interchangeably.

could be compared to a known "DNA fingerprint" from a victim or a crime scene to determine if there was a match (Jeffreys, Wilson, & Thein, 1985).

Not long after Jeffreys and his colleagues had publically described their new technique, DNA typing became a central feature in a 1986 sexual assault murder investigation in Leicester, England (Gerlach, 2004). Two young women, Lynda Mann and Dawn Ashworth, had been sexually assaulted and murdered by an unknown perpetrator or perpetrators ("Jail term cut," 2009). The police sought thousands of blood samples from men in surrounding communities for DNA testing (Wambaugh, 1989). Colin Pitchfork was eventually identified as the perpetrator and he became the first person to be convicted of a crime based on forensic DNA evidence ("Jail term cut," 2009).

How genetic fingerprinting can aid forensic science

A new method of identifying rapists or other criminals who leave a bit of their own blood, semen or other body tissue on their victim or at the scene of the crime has forensic scientists quite excited.

It's called genetic fingerprinting.

"It gives us the opportunity to be much more specific in sexual assault cases," said Douglas Lucas, director of the Ontario Centre for Forensic Science.

Previously it was often difficult to determine which cells belonged to the victim and which to the assailant in a sample taken from the vagina of a woman who had been raped, Lucas said.

The new technology allows scientists to examine the genes inside body cells in a bit of dried blood, for example, or in semen. Each person's genetic "signature" is unique. Even identical twins have slight differences.

Earlier this month in England, for the first time a court granted permission for such a test to be submitted as evidence in a criminal case.

In the United States, the first two cases in which genetic testing will be submitted as evidence are expected to be heard within the next six weeks, according to Dr. Robert Shaler, director of forensic science of Lifecodes Inc., a New York state company that has developed and performs such tests. Both are rape cases, Shaler said in a telephone interview.

MARILYN DUNLOP

Medicine

In Ontario, Lucas predicts, it will be another two years before such evidence is offered in court.

"We (at the centre) have people prepared to go elsewhere to study the techniques and the RCMP in Ottawa is at about the same stage," Lucas said.

One of the key people in Canada conducting research into genetic material, DNA, taken from dried blood stains is Dr. Rex Ferris, British Columbia's chief pathologist.

Obtaining dried blood is common in criminal cases, Lucas said. It could be damning evidence (when genetic examination proves it came from a suspect). But, he said, researchers such as Ferris are seeking to determine how big a stain is needed to extract sufficient DNA — the material genes are made of — to make an identification and how long after a crime the testing would still be valid.

Shaler said his company's scientists have been able to identify genes in blood stains more than five years after the blood was shed and in semen obtained from vaginal swabs from victims of sexual attacks two years later. "DNA is extremely stable," Shaler said. "DNA has even been isolated from mummies."

Genetic fingerprinting can help clear suspects as well as helping to prove guilt. Shaler said a test got a New York man accused of rape released from jail. "The man had never been arrested before. He insisted he was innocent. He wanted the test although it was explained to him that he would be putting nails in his own coffin if his genes matched those in the semen." Sperm had been obtained by means of a swab from the vagina of the victim. "The test proved the sperm that had been found was not his," Shaler said.

However, he added, that did not prove conclusively the man was not the rapist. The wrong man's sperm might have been collected in the sample. The semen found in the woman could have come from another man with whom she had voluntarily had sexual relations about the same time as the rape occurred and not from the rapist, whoever he might be.

"We don't know yet if the prosecution will challenge the decision to release the man," Shaler said.

In Britain, genetic testing is being used in a search for the murderer of two schoolgirls.

Among 2,000 people whose blood type matched that of the murderer, 400 volunteered to undergo genetic testing. None of them was the man the police sought. In particular, it cleared a heavy cloud of suspicion from one 17-year-old youth.

But, said Shaler, the testing isn't likely to catch the murderer because a killer isn't apt to volunteer to be tested.

Lucas said if the test does come into widespread use in Canada it may raise ethical issues concerning testing of suspects.

Suppose police had found hair follicle cells or blood cells clearly belonging to an unknown murderer or rapist and arrest a suspect. How would a blood sample be obtained from the suspect to see if genes matched?

Lucas said in the U.S. a court may order a suspect to give a blood sample but that is unlikely in Canada.

The gene test has already been used to determine paternity. Because half of an individual's genes are inherited from the father, blood cells of a baby or of an aborted fetus can be compared with those of a man who might be the father to prove whether he sired the child.

Similarly in cases of abandoned babies, gene testing could tell whether a particular woman was the child's mother. In Britain, the testing has been used in immigration cases to establish whether a newcomer's claim to be related to a person living in England is true.

Toronto Star, August 16, 1987
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Destabilizing the SAEK with a revolutionary technology.

Jeffreys and his co-researchers had foreshadowed Colin Pitchfork's conviction several years earlier when they claimed that DNA typing would revolutionize violent crime investigation, most "particularly with regard to the identification of rape suspects"

(Gill, Jeffreys, & Werrett, 1985, p. 577). In one article, Gill, Jeffreys, and Werrett asserted that DNA typing would overcome common forensic challenges in sexual assault cases and would, for the first time in forensic biology, "enabl[e] positive identification of the male donor/suspect" (p. 577) of a sexual assault.[12] With these claims, the SAEK of the 1980s that had been "made to speak" (Jasanoff, 2006, p. 330) with hair and blood analysis, lost value in the eyes of many forensic scientists and police investigators.

Only a few years after Gill, Jeffreys, and Werrett's (1985) article was published, Canadian and American forensic scientists began echoing the claims of DNA's potential for transforming sexual assault investigation and the SAEK. In 1987, John Wilker, the president of an American private lab, asserted DNA's potential by saying, "in rape cases in which sperm can be recovered, there is just no way that could be analyzed until now" (Hilts, 1987, C16). In the same year, Douglas Lucas, the director of the Ontario Centre of Forensic Science, claimed that DNA fingerprinting's "greatest application would be in sexual assault cases" (Strauss, 1987, D4).

DNA's anticipated usability in sexual assault investigations was situated in a rush of media coverage in the late 1980s about DNA's potential to revolutionize forensic science. Canadian and American media were quick to cast DNA typing as a radically new, infallible technique for identifying perpetrators of crime (Lynch et al., 2008). Canadian newspaper headlines described DNA as the "hot new crime buster" (MacCharles, 1988, A1) that "points at the guilty" (Strauss, 1987, D4) and "makes criminal identification certain" (Hilts, 1987, C16). DNA analysis was proclaimed to be

[12] The scientists rested the technique's revolutionary potential in rape cases on a narrow understanding of rape as an act of penile-vaginal penetration perpetrated by an unknown offender.

the "biggest advance in the science of crime detection in a century" (Lohr, 1987, G8). In some reports, DNA analysis was likened to a divine intervention for crime detection. One detective in Calgary was reported as saying "it's like God opened up the clouds and said to offenders, 'Stand by, I've got a new process for the police to use'" ("DNA Prints," 1987, H8). These reports cast older forensic techniques for analyzing SAEK contents as outdated and largely incapable of producing useful evidence. DNA was thus gaining credence by *destabilizing* the SAEK of the 1980s and the techniques for *making it speak.*

By 1988, the Centre of Forensic Science was, according to one media report, receiving dozens of DNA typing requests from police and procurators across the country (MacCharles, 1988, A1). The Royal Canadian Mounted Police Forensic Laboratory was given a $3 million dollar budget to begin the preparations for a DNA typing laboratory, and the Ontario Centre of Forensic Science, an allocated $100,000 for DNA typing research (MacCharles, 1988, A1). In the face of this funding and the growing anticipation of the technology's arrival in Canada, some forensic scientists and lawyers expressed hesitancy about how the courts would receive the new technology. The director of the CFS was reported in the media as saying that despite the growing excitement about DNA typing, "forensic scientists were laying low...nobody wants to rush before a judge and jury until the method is known to be foolproof" (MacCharles, 1988, A1). Some lawyers reportedly questioned the feasibility and ethics of obtaining DNA samples from unwilling suspects (Dunlop, 1987, C1).

Despite any hesitations there may have been, in the fall of 1989, the RCMP laboratory in Ottawa began accepting DNA samples (Counsell, 2007), and in July 1990,

the Centre of Forensic Science followed suit (Campbell, 1996). In the five years that followed, DNA typing was used in over 1,000 criminal trials in Canada (R. v. S.F., 1997). With the increasing use of DNA typing in medicolegal practice, the SAEK was on the verge of being redefined as a tool for collecting DNA evidence. While the sheer numbers of cases using DNA typing conveyed a general acceptance of the technology in medicolegal practice, the first few years of forensic DNA typing were filled with many legal and technoscientific controversies and changing scientific practices. As I show, these tensions and shifts in practice were part of the process of *stabilizing* the new SAEK and its meaning as the genetic technoscientific witness of sexual assault in medicolegal practice.

Destabilizing through Shifting Practice and Controversy

DNA typing technologies began to change not long after they were introduced to forensic work. In the late 1980s and 1990s, some forensic scientists argued that RFLP DNA analysis was difficult to use in sexual assault cases, because it required a significant amount of time and large non-decayed samples of blood or semen (Reynolds & Blake, 1991).[13] According to a media report in 1987, some molecular biologists were arguing that with RFLP DNA testing, sexual assault kits from the 1980s were inadequate (Bass, 1987, A1). One argued that kits from the 1980s were designed for older techniques that required only small amounts of semen to confirm that sperm was present. In contrast, he stated, the large amounts of sperm that RFLP DNA testing required was often not being collected with the existing kits. Others blamed the difficulties in collecting adequate

[13] A complete RFLP DNA analysis required approximately 10-12 weeks and approximately 10ml of sperm or a bloodstain the size of a quarter (Campbell, 1996).

amounts of DNA for RFLP DNA analysis not on sexual assault kits, but on the fact that adequate samples were rarely available in sexual assault kit exams (Reynolds & Blake, 1991). In response to these perceived limitations, scientific practices began to shift in the mid-1980s with the development Polymerase Chain Reaction (PCR) and Short Tandem Repeat (STR) analysis, two new techniques for DNA typing.

PCR is a technique currently used to increase amounts of DNA in a sample through a series of heating and cooling cycles that duplicate the DNA. With this technique, millions of copies of a DNA molecule can be produced within a few hours, which reduces the size of sample required for DNA profiling from that of a quarter to 0.3-0.5 nanograms (a billionth of a gram) (Lynch et al., 2008). When PCR was first introduced to Canada in the early 1990s, media reported scientists saying that it was a "huge leap for the science" (Kozicki, 2007, p. 42) that would expand the capacity of forensic DNA typing and significantly reduce the time it required.[14] The introduction of PCR was accompanied by the development of Short Tandem Repeat (STR) analysis, which involved analyzing shorter lengths of DNA. When STR and PCR techniques were used together, scientists could analyze small-degraded samples collected with the SAEK to develop DNA profiles (Curran, 1997).

According to one forensic scientist, these changes in scientific practice enhanced the usability of the SAEK (FS1). With the combined STR and PCR technique, it became more likely that scientists could devise a DNA profile from the SAEK contents and *make it speak* in medicolegal practice. While these developments seemingly *stabilized* the new

[14] For a detailed anthropological study of PCR's development, see Paul Rabinow's (1996) *Making PCR.*

SAEK, other legal and technoscientific controversies were arising that would *destabilize* the SAEK and the new techniques for analyzing it.

Controversy in the courts: The "DNA wars."

In the 1990s, legal and technoscientific controversies were erupting over the reliability of DNA evidence. What would come to be called the "DNA wars" (Thompson, 1993, p. 22) characterized much of the early to mid-1990s in the United States. The American DNA wars centered on the reliability of DNA collection and analysis and the accuracy of DNA profile interpretation (Lynch, 1998). While some prosecutors and forensic scientists avidly advocated for admitting DNA evidence in criminal trials, others argued that the flood of excitement around DNA had led courts to prematurely rush to introduce DNA evidence before the scientific community had deemed it to be reliable (Lander, 1989; Hoeffel, 1990). Hoeffel, a legal scholar, argued in 1990 that DNA had been "steamrolled...through the courts" (p. 466) and that restraint must be exercised "on the acceptance of unproven novel scientific techniques that turn courtrooms into laboratories and defendants into guinea pigs" (p. 467). The debates were aired in US courtrooms and in published articles in science and legal journals (Lynch et al., 2008).

In Canada, the so-called DNA wars were far less animated. According to Gerlach (2004), Canadian courts were less concerned with the technical reliability of DNA analysis than their American counterparts and focused instead on interpreting DNA profiles with probabilities of identification. By challenging DNA, these controversies simultaneously challenged the SAEK's capacity to act as a genetic technoscientific witness that accurately identified perpetrators of sexual assault.

Forensic scientists interpreted DNA profiles with statistical estimates that another individual, other than the suspect, matched the DNA profile in the SAEK or at the crime scene. The estimates were based on databases of DNA that were intended to represent the genetic variability within a population but were at the time, loosely compiled from blood banks, police volunteers, and other nonrandom samples and divided into roughly defined racial subgroups (Lynch et al., 2008). Some population geneticists challenged the validity of statistical estimates based on the early databases and raised "the subpopulation problem" (Cohen, 1990, p. 358), which highlighted the possibility that DNA profile frequencies might differ between sub-populations and laboratory DNA databases.

In Canada, questions around the subpopulation problem first appeared in a sexual assault murder case in British Columbia in 1991 (R. v. Baptiste, 1991). The defense argued that the DNA evidence derived from the vaginal swab and a bloodstain on the accused's pants had been based on insufficient sub-population data on the small Aboriginal community in British Columbia where the suspect was from. Defence lawyers asserted that as a result, there was "no scientific basis" to the scientist's interpretation of the DNA evidence, which was that the possibility the DNA came from someone other than the suspect was extremely remote. In this case, DNA's capacity to reveal identities of sexual assault perpetrators was in question. Despite the controversy in court, the trial judge, and the subsequent Court of Appeal, ruled that the DNA evidence was in fact admissible. The subpopulation problem was featured in several subsequent Canadian

cases, most involving Aboriginal defendants, until the late 1990s,[15] when the debates had largely subsided with developments in technologies and population data (Frederiksen, 2011).

By the mid 1990s, many forensic scientists were proclaiming that, "the DNA fingerprinting wars [were] over" (Lander & Budowle, 1994, p. 735). According to Lynch et al. (2008), the controversies had largely subsided with the release of the National Research Council report on forensic DNA evidence in 1996, numerous consultations and working groups on DNA evidence that occurred in the early 1990s and the series of standards and protocols that had been developed as a result. In 1994, two opposing participants in the DNA controversies, Eric Lander, a key critic of forensic DNA typing and Bruce Budowle, a proponent of DNA typing, asserted together that there was "no remaining problem that should prevent the full use of DNA evidence in any court" (Lander & Budowle, 1994, p. 735). They called for a wide-spread acceptance of DNA evidence, "the public needs to understand that the DNA fingerprinting controversy has been resolved. There is no scientific reason to doubt the accuracy of forensic DNA typing results...Now, it is time to move on" (Lander & Budowle, 1994, p. 738).

Lander and Budowle's assertions reverberated in Canadian and American courtrooms. In 1997, one Ontario Supreme Court judge clearly depicted DNA's new uncontroversial status in a statement he made during a sexual assault trial. He declared,

> There is no real controversy in scientific and legal communities that DNA analysis is currently the most advanced tool for human identification since the

[15] By this point, a threshold of admissibility for novel scientific evidence had been established through R. v. Mohan (1994), which was used to determine the admissibility of DNA in subsequent cases.

> advent of fingerprinting. As such, there is no necessity in this case for a lengthy explanation into the underlying scientific principles of DNA analysis. The science is capable of eliminating coincidence (R. v. S.F., 1997).

The SAEK of the 1980s and the techniques for making it speak had been relegated into the past. Now, with declarations that the DNA wars were over, the new technique for analyzing the SAEK was being defined in medicolegal practice as reliable, objective, and "the most advanced tool for human identification" (R.v. S.F., 1997). With this, the SAEK was being stabilized as a tool that could objectively identify perpetrators of sexual assault. This change in the SAEK's value was made public through one particular serial sexual assault investigation in Ontario.

Situating DNA and the SAEK as the objective protectors.

In 1996, Justice Archie Campbell released a report that documented the multiple failings of Ontario police and forensic scientists who had worked on the highly publicized sexual assault murder investigation of Paul Bernardo. This report, I argue, contributed to the efforts to destabilize the SAEK of the 1980s and stabilize the new SAEK with DNA analysis as an objective tool for identifying perpetrators of violent crime and protecting women from sexual perpetrators.

According to Campbell (1996), between the years 1987 and 1992, Paul Bernardo sexually assaulted and raped at least 18 women and murdered three others in Ontario. For much of this time, police knew Bernardo only as "the Scarborough rapist" (Ibbotson & Irish, 1988, A6; Mascoll & O'Neill, 1990, A1). Campbell's inquiry revealed that Bernardo remained unidentified for years because of delayed forensic analysis and a

series of disjointed, uncoordinated, and often disinterested police investigations. Campbell's report documented many dimensions of failed medicolegal practice, however, what is most significant here, is his analysis of what occurred at the Centre of Forensic Science.

Campbell (1996) described how police submitted multiple SAEKs from women Bernardo had raped in 1987 and 1988 for blood grouping analysis. He documented how, after a few failed attempts, the forensic results led police to reduce the suspect pool to 20% of the male population and later, to 13% of the male population. Campbell was clear to note that "conventional" (p. 43) blood-grouping tests were inadequate for identifying assailants with any precision. He reported that the CFS had ignored the police request to analyze Bernardo's DNA when it was resubmitted with 92 other samples from possible suspects. He noted that it was not until 1992, two years after the first SAEKs were submitted, when the police resubmitted the samples for DNA testing that the analysis was actually completed and Bernardo was identified and arrested. According to Campbell, during the time Bernardo's DNA was sitting at CFS unanalyzed, Bernardo raped four woman and tortured and murdered two others.

Campbell (1996) stressed that if Bernardo's DNA samples had been analyzed from the SAEKs that were first submitted in 1990, the rapes and murders between 1990 and 1992 would not have occurred. DNA analysis of SAEK contents, in this report, was framed as an objective technology that, if used in a timely way, could prevent violence against women, unlike the "conventional" (p. 43) techniques for analyzing SAEKs.

Delays in DNA analysis were described as a risk to public safety and he pressed for more funding for DNA analysis. He wrote,

> The Bernardo case demonstrates that delays in DNA testing can imperil personal safety and cost lives. Any reluctance to continue to spend the public funds necessary to maintain a reasonable turnaround time for DNA tests must give way to a consideration of the financial and human cost of failing to do so (p. 9).

Campbell's simple formula for ensuring public safety with SAEKs and DNA analysis was reiterated by the media, where DNA typing was described as the tool that could have protected some of the women Bernardo raped and murdered ("Bernardo DNA," 1996, A4; Kirk, 1995, A1). One of Bernardo's own lawyers was quoted as saying, "if they took samples...and done the proper tests, I think none of this would have happened" (Kirk, 1995, A1).

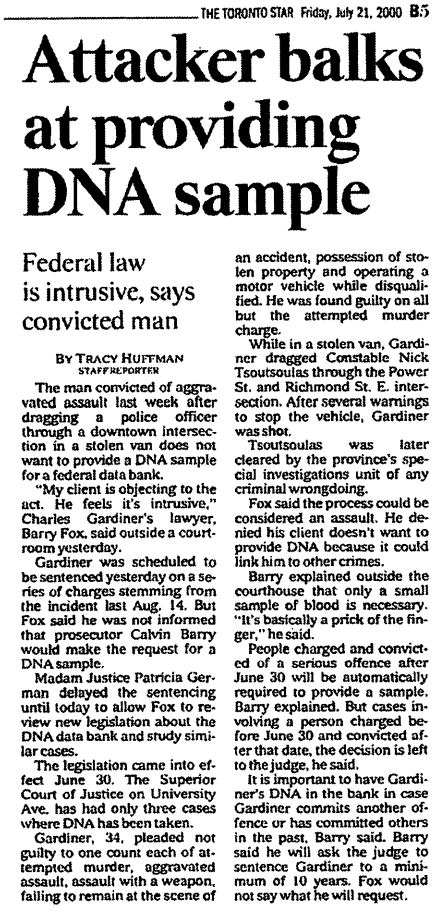
In response to the rush of media on Campbell's (1996) report, some feminist writers challenged Campbell's message by arguing that his simplistic conclusions arose from his blindness to the sexism embedded in police handling of violence against women (Dionne, 1997; Landsberg, 2011). Dionne (1997) argued that "he would have us believe that technology is the policing cure" (p. 3) for failed investigative techniques and violence against women.

Despite these critiques, the Campbell report helped to situate the SAEK with DNA analysis as necessary, objective technologies for protecting women and preventing violence. This contributed to laying the ground for two significant developments in law

around DNA typing, both of which redefined how DNA analysis was used in sexual assault investigations.

Redefining DNA Typing Practices in Law

Obtaining DNA.



THE TORONTO STAR Friday, July 21, 2000 B5

Attacker balks at providing DNA sample

Federal law is intrusive, says convicted man

BY TRACY HUFFMAN
STAFF REPORTER

The man convicted of aggravated assault last week after dragging a police officer through a downtown intersection in a stolen van does not want to provide a DNA sample for a federal data bank.

"My client is objecting to the act. He feels it's intrusive," Charles Gardiner's lawyer, Barry Fox, said outside a courtroom yesterday.

Gardiner was scheduled to be sentenced yesterday on a series of charges stemming from the incident last Aug. 14. But Fox said he was not informed that prosecutor Calvin Barry would make the request for a DNA sample.

Madam Justice Patricia German delayed the sentencing until today to allow Fox to review new legislation about the DNA data bank and study similar cases.

The legislation came into effect June 30. The Superior Court of Justice on University Ave. has had only three cases where DNA has been taken.

Gardiner, 34, pleaded not guilty to one count each of attempted murder, aggravated assault, assault with a weapon, failing to remain at the scene of an accident, possession of stolen property and operating a motor vehicle while disqualified. He was found guilty on all but the attempted murder charge.

While in a stolen van, Gardiner dragged Constable Nick Tsoutsoulas through the Power St. and Richmond St. E. intersection. After several warnings to stop the vehicle, Gardiner was shot.

Tsoutsoulas was later cleared by the province's special investigations unit of any criminal wrongdoing.

Fox said the process could be considered an assault. He denied his client doesn't want to provide DNA because it could link him to other crimes.

Barry explained outside the courthouse that only a small sample of blood is necessary. "It's basically a prick of the finger," he said.

People charged and convicted of a serious offence after June 30 will be automatically required to provide a sample. Barry explained. But cases involving a person charged before June 30 and convicted after that date, the decision is left to the judge, he said.

It is important to have Gardiner's DNA in the bank in case Gardiner commits another offence or has committed others in the past, Barry said. Barry said he will ask the judge to sentence Gardiner to a minimum of 10 years. Fox would not say what he will request.

Toronto Star, July 21, 2000
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In sexual assault cases, DNA profiles derived from SAEK contents were compared to DNA profiles derived from samples collected from suspects. In the early 1990s, police could only legally acquire suspects' DNA with their consent or from buildings, receptacles, and/or places (R. v. Prevost, 2011). According to some forensic scientists, these legal restrictions greatly limited the SAEK's capacities to identify perpetrators of sexual assault (FS1, FS2).[16] Shortly after DNA analysis made its entrance into Canadian courtrooms, legal questions began to arise about the constitutionality of police seizing DNA samples from suspects without their consent.[17]

[16] If the police did not have a DNA sample from a suspect, forensic scientists had nothing to compare to the DNA in the SAEK. The result, in these cases, was that the suspect was not identified.

[17] To my knowledge, these debates did not discuss the constitutionality of collecting DNA samples from survivors/victims, as it was assumed that survivors/victims had consented to the SAEK exam. Interestingly, however, many of these courtroom debates featured discussions about the threats that DNA sampling presents to an individual's bodily integrity, regardless of whether they have consented to it (R.v. Alexis, 1994; R.v. S.F., 1997; R.v. Stillman, 1997). I explore some of these debates in the context of the SAEK exam in chapter 6.

Courts debated whether seizing biological samples violated suspects' rights under the Canadian Charter of Rights and Freedoms (Gerlach, 2004).[18] In 1994, the Supreme Court ruled that police did not have the right to seize biological samples without valid and informed consent (R.v. Borden, 1994). However, this precedent quickly changed with the passing of Bill C-104 in 1995, which permitted police to seize biological samples for forensic testing with a warrant. The bill outlined a range of designated offences for which warrants could be obtained, which included sexual assault among many others (Solicitor General, 1996). Government officials cited Bill C-104 as the first phase of the Government of Canada's strategy to expand the use of DNA analysis (Curran, 1997).

The Solicitor General (1996) publicized Bill C-104 as one that would enhance the power of DNA to improve public safety and diminish violent crime. The Bill was, however, not without its critics. In the courtroom, there were several unsuccessful challenges to the new bill as a violation of the Charter. In one such challenge, which reached the Ontario Supreme Court, the judge asserted the Bill's importance to public safety by saying,

> The important government justifications of fostering effective crime control, protecting the innocent, enforcing society's criminal laws, and substantially improving *the search for truth* in the criminal trial process *warrant the court authorized intrusion upon bodily integrity*...the DNA warrant legislation is a

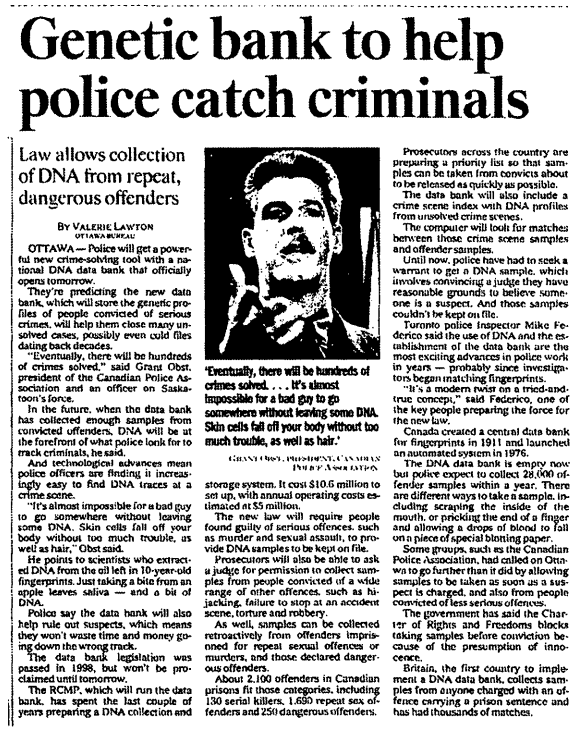
[18] Most notably, these challenges focused on the Charter rights to be "secure from unreasonable search and seizure" (Canadian Charter of Rights and Freedoms, 1982, s. 8) and have "security of the person" (s. 7).

rational and proportionate response designed to meet these objectives [emphasis added] (R.v. S.F., 1997, 143).

With this development, police could legally seize DNA samples from suspects to compare them to those obtained with the SAEK. This change in law set the stage for the second phase of the government's DNA Strategy, the development of the National DNA Databank.

Banking DNA.

Not long after Bill C-104 had passed, the Solicitor General of Canada (1996) initiated a nation-wide consultation on the prospect of a National DNA Databank that would house DNA profiles of convicted offenders. The proposed databank received substantial support from the Canadian Association of Chiefs of Police and various other victims' rights organizations, who had been lobbying for a National DNA Databank for several years (National DNA Databank, 2006). Many women's groups, and some rape crisis centre workers among them, voiced strong contestations about the proposed databank, arguing that it was a waste of valuable public resources (Kubanek & Miller, n.d.). Despite this resistance, Bill



Genetic bank to help police catch criminals

Law allows collection of DNA from repeat, dangerous offenders

BY VALERIE LAWTON
OTTAWA BUREAU

OTTAWA — Police will get a powerful new crime-solving tool with a national DNA data bank that officially opens tomorrow.

They're predicting the new data bank, which will store the genetic profiles of people convicted of serious crimes, will help them close many unsolved cases, possibly even cold files dating back decades.

"Eventually, there will be hundreds of crimes solved," said Grant Obst, president of the Canadian Police Association and an officer on Saskatoon's force.

In the future, when the data bank has collected enough samples from convicted offenders, DNA will be at the forefront of what police look for to track criminals, he said.

And technological advances mean police officers are finding it increasingly easy to find DNA traces at a crime scene.

"It's almost impossible for a bad guy to go somewhere without leaving some DNA. Skin cells fall off your body without too much trouble, as well as hair," Obst said.

He points to scientists who extracted DNA from the oil left in 10-year-old fingerprints. Just taking a bite from an apple leaves saliva — and a bit of DNA.

Police say the data bank will also help rule out suspects, which means they won't waste time and money going down the wrong track.

The data bank legislation was passed in 1998, but won't be proclaimed until tomorrow.

The RCMP, which will run the data bank, has spent the last couple of years preparing a DNA collection and storage system. It cost $10.6 million to set up, with annual operating costs estimated at $5 million.

The new law will require people found guilty of serious offences, such as murder and sexual assault, to provide DNA samples to be kept on file.

Prosecutors will also be able to ask a judge for permission to collect samples from people convicted of a wide range of other offences, such as hijacking, failure to stop at an accident scene, torture and robbery.

As well, samples can be collected retroactively from offenders imprisoned for repeat sexual offences or murders, and those declared dangerous offenders.

About 2,100 offenders in Canadian prisons fit those categories, including 130 serial killers, 1,650 repeat sex offenders and 250 dangerous offenders.

'Eventually, there will be hundreds of crimes solved. . . . It's almost impossible for a bad guy to go somewhere without leaving some DNA. Skin cells fall off your body without too much trouble, as well as hair.'

GRANT OBST, PRESIDENT, CANADIAN POLICE ASSOCIATION

Prosecutors across the country are preparing a priority list so that samples can be taken from convicts about to be released as quickly as possible.

The data bank will also include a crime scene index with DNA profiles from unsolved crime scenes.

The computer will look for matches between those crime scene samples and offender samples.

Until now, police have had to seek a warrant to get a DNA sample, which involves convincing a judge they have reasonable grounds to believe someone is a suspect. And those samples couldn't be kept on file.

Toronto police Inspector Mike Federico said the use of DNA and the establishment of the data bank are the most exciting advances in police work in years — probably since investigators began matching fingerprints.

"It's a modern twist on a tried-and-true concept," said Federico, one of the key people preparing the force for the new law.

Canada created a central data bank for fingerprints in 1911 and launched an automated system in 1976.

The DNA data bank is empty now but police expect to collect 28,000 offender samples within a year. There are different ways to take a sample, including scraping the inside of the mouth, or pricking the end of a finger and allowing a drops of blood to fall on a piece of special blotting paper.

Some groups, such as the Canadian Police Association, had called on Ottawa to go further than it did by allowing samples to be taken as soon as a suspect is charged, and also from people convicted of less serious offences.

The government has said the Charter of Rights and Freedoms blocks taking samples before conviction because of the presumption of innocence.

Britain, the first country to implement a DNA data bank, collects samples from anyone charged with an offence carrying a prison sentence and has had thousands of matches.

Toronto Star, June 29, 2000
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C-3, the DNA Identification Act (1998), was drafted and in December 1998, the bill authorizing the construction of the new databank was passed in the House of Commons.

Preparations to build the databank began shortly after Bill C-3's passing and within 18 months, with a $10.9 million dollar start up budget, the National DNA Databank opened on June 30, 2000 (National DNA Databank, 2003). The databank was to be situated in Ottawa, run by the Royal Canadian Mounted Police, and consist of two indices: a convicted offender index, which would store DNA profiles from convicted offenders obtained with warrants, and a crime scene index, which would store unknown DNA profiles collected from crime scenes and SAEKs (National DNA Databank, 2006). Police investigators would use the databank to identify unknown perpetrators and/or serial perpetrators by searching for matches between banked DNA profiles and known or unknown DNA profiles collected during police investigations. Within two years of being in operation, the databank had amassed 10, 261 DNA profiles (National DNA Databank, 2003), a number that has since swelled to 350,159, as of March 2013 (Royal Canadian Mounted Police, 2013).[19]

The DNA Databank was heralded as a development that would ensure public safety. Like the way scientists and government actors first described DNA, the media described the databank as the "revolutionary tool" (van Wageningen, 2000, A1) that would ensure the timely apprehension of violent offenders and protect the public from repeat offenses.

[19] As of March 2013, the databank included 266, 355 convicted offender profiles and 83, 804 crime scene DNA profiles (Royal Canadian Mounted Police, 2013). These statistics are continually increasing, as the databank receives an estimated 600 to 700 samples per week.

In a government press release introducing the databank, the Solicitor General stated, "this will give us a powerful investigative tool that will protect Canadians from violent criminals. It will help ensure that those guilty of serious crimes, such as repeat sex offenders and violent criminals, are identified and apprehended more quickly" (as cited in Curran, 1997, p. 24). In the first annual report for the databank, RCMP Commissioner Zaccardelli asserted the databank's value by saying, "for Canadians, it means safe homes and safe communities" (National DNA Databank, 2002, p. 2). By describing the databank as a tool that would ensure safety, these claims reinforced notions that DNA and the SAEKs that collected it had the power to protect the public from violent crime.

Not all people in Canada welcomed the introduction of the DNA databank. Some criminal lawyers expressed concerns that the bank "put too much personal information in the hands of the state" (van Wageningen, 2000, A1). The Privacy Commissioner of Canada (1995) voiced concerns about the breadth of the offenses captured in the databank. It was, however, women's groups who voiced the strongest opposition.

According to Kubanek and Miller (n.d.), the 670 member groups of the National Action Committee on the Status of Women and the 60 women's groups that responded to the Solicitor General of Canada (1996) consultation document opposed the development of a National DNA Databank. Kubanek and Miller argued that banking offenders DNA did not serve women's interests and that the databank was being "falsely romanticized as a 'quick fix' for the systemic problems that women face in dealing with the criminal justice system" (p. 3). They also argued that the databank would reflect the disproportionately high conviction rates for men of colour, Aboriginal men, and poor

men and would therefore reinforce existing inequalities. They attacked the databank's hefty budget and questioned how it was that women's survivor and advocacy organizations were so poorly funded when there were available funds for enhancing the strength of forensic DNA analysis.

Feminist critiques of the databank were, according to Gerlach's (2004), met with little interest from government agencies. In one speech, the Solicitor General briefly noted the women's groups concerns but quickly dismissed them by reinforcing DNA as a necessary tool for public safety;

> There are those who believe that resources earmarked for a DNA data bank would be better spent on family violence programs or women's shelters. In response, I would agree that spending in those areas is important...but at the same time, there is no doubt in my mind that a national DNA databank will add to the safety of all Canadians (as cited in Gerlach, 2004, p. 88).

This response was one of the few in which government actors publically responded to feminist critiques.

The development of the National DNA Databank, along with the legal provisions for DNA warrants, redefined how DNA typing was used in sexual assault investigations. With these changes, DNA samples obtained from the SAEK could be compared to those seized from a suspect or banked in the databank. These changes, according to some medicolegal actors, strengthened the SAEK's capacities to objectively and accurately identify sexual assault perpetrators (FS1; P1; CA5). However, not all agreed.

Continued Controversy

Almost as quickly as it was developed, forensic scientists were touting forensic DNA analysis as a technology that would revolutionize the investigation of violent crime and in so doing, protect the "innocent" (National DNA Databank, 2010, p. 3) victims of violence. In the late 1980s and 1990s, most of the cases that brought forensic DNA analysis into the public eye, such as the Paul Bernardo investigation, concerned sexual violence against women. As I have shown, many media articles, public inquiry reports, and government documents reiterated how DNA evidence had been and could be used to identify sexual offenders and protect women and girls from further victimization. In these accounts, women's and girl's experiences of sexual violence were used to advertise the power of forensic DNA analysis and propel its rapid acceptance in medicolegal practice. This strategy, however, did not go unchallenged.

Helen Holmes, an academic feminist, posed the question in 1994: "who benefits from the development and use of DNA typing?" (p. 232). She argued that police and crown attorneys were given a newfound credibility when they used the latest technology to fight crime and apparently protect the public from violence. Forensic laboratories, she contended, gained legitimacy, secured employment, and funding. Women, in Holmes' analysis, did not benefit from the rise of DNA typing. This was an argument that several other Canadian feminists reiterated (Kubanek & Miller, n.d.; Lee, 2000).

Kubanek & Miller (n.d.) outlined a fervent critique of the rise of DNA analysis in the Canadian legal system. They argued that despite the fact that DNA was being promoted in women's interests, forensic DNA technology rarely proved itself useful in

cases of sexual assault and rape. Most sexual violence cases, they asserted, involve perpetrators whom a survivor/victim knows, such as a father, brother, uncle, friend, boyfriend, or husband. In these cases, they stated, the legal question is one of consent, not identity, and therefore a technology for identifying the perpetrator of the attack is superfluous. They accused the media of sensationalizing rare occurrences of stranger rapes on women and girls who could most easily be portrayed as innocent and defenseless and the federal government, for "pander[ing] to the myth of the dangerous stranger" (p. 2).

Kubanek and Miller (n.d.) also raised a concern that if DNA evidence was used in sexual assault cases, it would devalue and displace other forms of evidence, including women's testimony. They wrote,

> Increasing the weight given to scientific evidence subtly alters the notion of reasonable doubt...DNA evidence provides such a high level of statistical reliability that other types of evidence pale in comparison....in cases where DNA evidence is not available....the usual evidence accumulated against the accused may look weak. In the eyes of the judge and jurors, the verbal testimony of witnesses, especially that of the victim, cannot carry the statistical reliability of scientific evidence, a bias which can only work against women in the majority of cases (p. 2).

With this argument, Kubanek and Miller described how the SAEK with DNA analysis could act as technoscientific witness in the courtroom, which would silence the women's testimonies of sexual assault.

Holmes (1994), Lee (2000), and Kubanek & Miller (n.d.), challenged the claim that DNA typing could protect women and girls from sexual violence. Holmes argued that the rise of DNA evidence would be unlikely to deter men from raping women and would be more likely to inspire new strategies amongst rapists to obscure or eliminate traces of rape, such as wearing a condom during a rape or participating in a gang rape. She expressed concern that forensic DNA evidence could lead government agencies to falsely believe that the problem of sexual assault had been solved. Kubanek & Miller (n.d.) asserted these sentiments more strongly when they wrote, "these interventions cannot be defended in the interests of women subjected to male violence...we will not have these actions taken in our name" (p. 4). Despite the many feminist critiques of DNA evidence, efforts were underway to redesign the SAEK's material form to suit the needs of forensic DNA typing.

Reassembling the SAEK

At the end of the 1990s, when the SAEK with DNA evidence had gained stability in medicolegal practice as a tool for identifying perpetrators of sexual assault, forensic scientists began efforts to redesign the SAEK's material form to suit the needs of DNA typing. Up until that point, the SAEK's material form had remained relatively constant, despite the many controversies and changing practices around it. In what follows, I describe how the SAEK was reassembled to serve its new purpose as a DNA evidence collector. I show how these changes in the SAEK led to new enacted meanings of sexually violated bodies in medicolegal practice.

Redesigning the SAEK's material form.

With the rise of medicolegal expertise in sexual assault, expert criticisms began to emerge about the intrusiveness of the SAEK (Griffiths, 1999). In an audit on sexual assault investigation in Toronto, Jeffrey Griffiths described the growing recognition amongst medicolegal actors in the late 1990s that for many women, the SAEK exam was "long, humiliating, and almost as traumatic as the sexual assault itself" (p. 96). In response, the Ministry of the Solicitor General organized a SAEK Working Group, which was charged with the task of reviewing the SAEK and its impact on survivors/victims of sexual assault.[20]

Alongside the SAEK Working Group, in 2001, the Centre of Forensic Science was conducting its own review of the SAEK "in light of current DNA technology."[21] Drawing on the findings from the CFS review and the SAEK Working Group, a new SAEK was designed. The CFS claimed that the new SAEK would be a "less intrusive procedure for [the] victim," would ensure "faster analysis within the lab [and] facilitate storage," and have an "optimal design for DNA analysis," which would create "more DNA-ready samples."[22] In 2001, the CFS held educationals on the new SAEK in five communities across Ontario where police, sexual assault nurses, physicians, and rape

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[20] Despite submitting multiple ATIP requests and conducting many archival searches, I have found very few records on this working group, who it included, how they functioned, for how long, to what end. The records that I have found include only short summaries of what was decided and do not include the list of attendees. However, around this time, the provincial coordinator of the sexual assault treatment centres became the primary contact for CFS forensic scientists who were redesigning the SAEK (FS1). This marked a divergence from the beginnings of the SAEK, when rape crisis centre workers were a central part of SAEK design meetings (chapter 3). From the change in practice, it could be assumed that SANEs took a central role in the SAEK Working Group, perhaps more than rape crisis centre workers.

[21] CFS, "Sexual Assaults and Forensic Evidence: SAEK Consultation," (May 29, 2001), obtained through FOI request to the Centre of Forensic Science, no. CSCS-A-2012-01825.

[22] Ibid.

crisis centre staff met to learn about the new SAEK. Following this, the new SAEK was released in hospital SACTCs.

The redesigned SAEK was not radically different from its previous iteration. However, the changes that were made are worth noting, as they offer insight into some of the past practices with the SAEK. Often it is in times of technological change that previous technological practice becomes most visible.

The new SAEK added and eliminated several evidence collection steps and included several new technologies for storing biological evidence. To allow forensic scientists to distinguish between a perpetrator's DNA and a survivor's/victim's, the new SAEK included a DNA sample from the survivor/victim, which was obtained with a buccal swab on the survivor's/victim's cheeks, tongue, and gums.[23] In response to the decreasing use of hair and blood typing analyses, CFS removed several steps from the SAEK.[24] Plucking pubic hairs, which had a decade earlier caused heated controversy amongst scientists, physicians and anti-rape activists, was completely removed from the SAEK exam. A forensic scientist reflected on this decision and said, "it was used so infrequently that the pain and the trauma [was] not worth it for those rare cases where you m[ight] find something" (FS1). The CFS also removed the vaginal aspirate for similar reasons. One sexual assault nurse explained that forensic scientists had found that swabs were just as effective for collecting seminal fluid in a woman's vaginal cavity as was a vaginal aspirate. She described the process by saying that it was "messy. Didn't

[23] CFS, "Hospital Instructions," (2012), obtained through FOI request to the Centre of Forensic Science, no. CSCS-A-2012-03930.

[24] CFS, "Sexual Assaults and Forensic Evidence: SAEK Consultation," (May 29, 2001), obtained through FOI request to the Centre of Forensic Science, no. CSCS-A-2012-01825.

really give us a whole lot of evidence. Therefore they decided it wasn't worth it, with nurses, and I know, patients rejoicing [laughs]" (SANE5).

Most significantly, the new SAEK was designed to be stored at room temperature (FS1). Previously, all SAEKs had been frozen; however, according to one forensic scientist, transportating frozen SAEKs from hospitals to police evidence units to the CFS often resulted in samples being spoiled, leaked, decayed, or damaged (FS1). The "RT swab box"[25] was introduced to the SAEK, which allowed moist swabs to breathe and dry. Some SAEK evidence that did not dry easily was still frozen, such as sanitary napkins, condoms, and wet diapers. The shift to a self-drying SAEK made it possible for hospitals to store SAEKs while a survivor/victim decided if she wanted to report to the police. A new policy was introduced to the SACTCs that stated that if a survivor/victim wanted to postpone the decision to report her assault, a SAEK could be held for 6 months (FS1). This development was identified by many SANEs I interviewed as a significant advancement for survivors/victims (SANE2, SANE5).

According to many medicolegal actors interviewed in this study, the reassembled SAEK gained a new credibility from DNA analysis techniques that *made it speak.* One officer remarked, "the introduction of DNA has been the biggest advancement in terms of catching a perpetrator...the value of the kit has changed because of DNA...[it] becomes more valuable because it contains DNA" (FIU2). With this new value in medicolegal practice, the reassembled SAEK worked in different ways and enacted different meanings.

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[25] Ibid.

The reassembled SAEK in practice.

Forensic DNA typing solidified a new purpose for the SAEK: it became the tool for identifying perpetrators of sexual assault. Many sexual assault police investigators I interviewed equated DNA testing with the SAEK, as if in the past decade, the two have become synonymous. The SAEK before DNA analysis had been understood as a tool that could, at best, eliminate suspects, whereas the SAEK after DNA analysis became a tool for the identification of suspects. With DNA testing, legal evidence of identity became the central concern of the SAEK exam, despite the contrary crime statistics that suggested that over half of sexual assaults involved perpetrators that a survivor/victim knew (Kong, Johnson, Beattie, & Cardillo, 2003).[26] The SAEK's new focus on identity did not reflect known trends in sexual assault, but rather reflected and reinforced an understanding of sexual assault as an act perpetrated by strangers. Forensic DNA typing gave the SAEK its new purpose of identifying "the dangerous stranger" (Kubanek & Miller, n.d., p. 2), and in so doing, shifted the meaning of the technology itself.

The genetic technoscientific witness.

Forensic DNA evidence was and is often dubbed as the "silent but credible witness" (National DNA Databank, 2003, p. 26) or the "genetic witness" (Frederico, 1991, p. 204). As two Canadian forensic scientists wrote, DNA evidence "speaks for itself. It doesn't lie, it has no bias, it doesn't forget and it doesn't change" (Hepworth & McLeod, 2005, p. 1). DNA analysis made the SAEK speak as the new genetic

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[26] Higher estimates have since been cited. In the most recent Canadian victimization survey, 78.8% of sexual assaults involve a perpetrator that is a friend, neighbor, acquaintance, or relative (Statistics Canada, 2009).

technoscientific witness of sexual assault. Many assumed that this new witness would give corroborative evidence of sexual assault that was unbiased, credible, and inherently trustworthy. The reassembled SAEK with DNA, many medicolegal actors supposed, could not tell a lie. One forensic scientist told me, "it is what it is…the evidence will either corroborate it or not…you just find what you find." (FS3). Many police officers expressed the significance of the new genetic witness and asserted that sexual assault investigations were made abundantly easier when "there is solid DNA saying that it was done" (P1).

New meanings of survivors/victims bodies.

Forensic DNA analysis heightened the value of evidence obtained in the SAEK exam and gave it a new status as evidence that could help "protect" (National DNA Databank, 2010, p. 2) the public. With this shift in the meaning of SAEK evidence, new meanings of survivor's/victim's bodies were enacted in the SAEK exam. Sexually violated bodies became the sites where identity codes of perpetrators of sexual assault could be found. After DNA analysis was introduced, the SAEK's forensic script encouraged survivors/victims to not only conceptualize her own body as a crime scene, which the previous iteration of the SAEK had done, but also as a crime scene that held the evidence to "protect" (p. 2) the public from sexually violent men.

Arguably, this change intensified the pressure on survivors/victims to follow the evidence preservation practices in the SAEK's forensic script. Many nurses and police noted the risk of survivors/victims destroying DNA evidence by washing or wiping their bodies after a sexual assault and described their practices for reinforcing the SAEK's

script. One nurse stated, "a lot of girls hate this; however we tell them don't wipe before and don't wipe after. Because the more they wipe, the more evidence is wiped away" (SANE3). A police investigator expressed a similar thought when he said, "the average victim who is the true victim[27] will normally shower...it's not good for me...unfortunately that will wash off most DNA" (FIU1). Many of the websites for SACTCs now contain instructions for survivors/victims on how to ensure that DNA evidence is preserved (e.g. Joseph Brant Hospital, 2013). While DNA typing strengthened the SAEK's forensic script, it also opened the script up to further revision.

Continued redesign.

Despite all of the medicolegal efforts to stabilize the SAEK's meaning and material form, the SAEK's redesign in 2001 was not its last. It is a technology that is in constant flux. Every two to three years, CFS and the Coordinator for the Ontario Network of Sexual Assault and Domestic Violence Treatment Centres meet to discuss SAEK revisions (FS1).[28] According to one forensic scientist involved in these meetings, the SACTC Coordinator raises nurses' ongoing concerns about the SAEK and how it is impacting survivors/victims and forensic scientists raise issues with the SAEK's design in relation to developing understandings of forensic science and the increased sensitivities of forensic technologies. This process of revising the SAEK's material form

[27] Police investigators' disbelief of women's experiences of sexual violence is pervasive and well documented (Doe, 2003, 2012; Crew, 2012). Ten out of the twelve sexual assault police investigators that I spoke with discussed false accusations of sexual assault as a relatively common occurrence. I discuss this more in chapter 6.

[28] I submitted a Freedom of Information request to obtain the minutes from these meetings. However, I was told that the minutes do not exist.

often results in tensions between evolving scientific understandings and medicolegal practice. Some of these tensions arise from translating shifting science into new practice.

Scientific understandings about foreign DNA and its life inside or on a sexually violated body influence how the SAEK is used. With the introduction of DNA analysis, the time limit after an assault within which the majority of samples in the SAEK could be taken was extended from 24 hours to 48.[29] This timeline was increased several years later to 72 hours to reflect the increasing sensitivities of DNA technologies and shifting scientific understandings of how long foreign DNA can survive in a woman's vaginal cavity (FS1).

By the time I was collecting data for this study in 2012, the scientific claim that foreign DNA can live up to 72 hours in a woman's vaginal cavity had been fully entrenched in medicolegal practice. Many of the SACTC websites cited 72 hours as the maximum time within which they could offer a SAEK exam (e.g. Joseph Brant Hospital, 2013; Credit Valley Hospital & Trillium Health Centre, 2012).[30] Many police investigators, sexual assault nurses, and rape crisis and sexual assault volunteers and staff, similarly asserted that after 72 hours "all evidence is usually lost" (RCC6). One police officer said that after 72 hours, "DNA is washed away, semen, vaginal fluid, it's dried up. DNA would not be transferable at that point in time" (P11). Another stated, "the kit can only be done within 72 hours, and if we don't get the evidence then, we are not going to get it later" (P1). These sentiments were/are commonly reiterated to

[29] CFS, "Sexual Assaults and Forensic Evidence: SAEK Consultation," (May 29, 2001), obtained through FOI request to the Centre of Forensic Science, no. CSCS-A-2012-01825.
[30] This timeline reflects the restriction on biological sampling and not the collection of clothes and documentation of injuries.

survivors/victims, who were/are told that a SAEK exam is only possible if they reported to a hospital within 72 hours of their assault (RCC3).

The way in which the SAEK was/is used suggests that scientists have reached a consensus about the 72-hour time limit on SAEK sampling. However, in the forensic literature, there are varying reports on the life of foreign DNA in the vaginal cavity, which range from three days (Gingras et al., 2009) to seven (Hawkins & Domoney, 2012). To better reflect the scientific literature, in 2012, the timeline for taking vaginal swabs with the SAEK was extended to 7 days (168 hours).[31]

The change in protocol, and the scientific understanding that it reflected, unevenly filtered into medicolegal practice. Despite the change being instituted in January 2012, many medicolegal actors expressed confusion over the new timelines. While many continued to reiterate the 72-hour rule, others said "I forget what the latest memo said, whether it was 72 hours or 96" (OPPA2), and "I really don't even know what the changes exactly are, cuz we have essentially a sheet, a poster that outlines all the changes, but basically…now we have more time to collect this evidence, cuz I guess it is all just getting better" (SANE6). One CFS forensic scientist described the difficulties of translating new scientific claims into practice. He said, "I've heard …nurses being confused about 'when can we use the kit? I thought you are not supposed to use it after 72 hours.' We've spent a lot of time over the years to try to clarify these misconceptions, that being one of them" (FS1). As scientific understandings of DNA continue to change,

[31] CFS, "New Acceptance Criteria for SAEK," (January 24, 2012), obtained through FOI request to the Centre of Forensic Science, no. CSCS-A-2012-01826.

these tensions between scientific understanding and medicolegal practice in the SAEK exam will undoubtedly continue.

Appearances of Stability

Since the technoscientific and legal controversies around the SAEK and DNA typing in 1990s, the reassembled SAEK with forensic DNA analysis has gained the reputation of being an objective, reliable technology that gives irrefutable evidence of sexual assault. The reassembled SAEK has become seemingly *stabilized* in medicolegal practice, a result that has been largely fuelled by the appearance of closed controversies and apparent consensus around DNA.

Outside of medicolegal practice, DNA has, according to some scholars, become a "cultural icon, a symbol, almost like a magical force" (Nelkin & Lindee, 2004, p. 2), and forensic DNA evidence, "a signifier of truth" (Jasanoff, 1998, p. 718) and a "veritable truth machine" (Lynch et al., 2008, p. 1). New forensic science television shows, such as C.S.I. and Law and Order Special Victims Unit have reinforced the apparent credibility

C4 THE TORONTO STAR Tuesday, February 1, 2000

DNA — scientific fiction now scientific fact

Sharlene Azam

"Have you had anything to drink this evening, young lady?"

"No officer. I'm just on my way to visit my grandmother."

"Would you mind stepping out of the car please?"

"Is this for a breathalyzer test or a DNA swab?"

Sound farfetched? I thought so too, but Ricardo Federico a DNA defence lawyer in Toronto says we can expect spot DNA ride programs in the not-so-distant future, given what police in Vancouver and Sudbury are doing.

Suspects in the murder of Renee Sweeney are being asked by Sudbury police to consent to a DNA test. Sweeney was murdered while at her job at an adult video store in January, 1998. More than 500 DNA samples have been collected to date.

"When a suspect comes in we ask them to consent to a DNA test. We've had to obtain a number of warrants where people have refused to consent," says Sudbury Region Police Staff Sergeant Bob Keetch.

Though there is little new about using DNA to link a person to a crime, Federico is worried. While samples obtained under warrant must be destroyed after a suspect is cleared, samples given freely may not be. Keetch says the decision to retain or destroy the DNA given by consent has not yet been handed down by the Crown. If those samples are retained where will they end up?

Starting in July we will have Canada's first DNA data bank in Ottawa in which the DNA of convicted individuals will be kept. A computer will match the DNA sample from the data bank to that at a crime scene and voilà the offender will be identified.

Seems like a foolproof, speedy way of convicting repeat offenders, right?

Well, not exactly.

Most Canadian DNA tests are done in U.S. labs and those facilities are not all created equally. Forensic DNA scientist Dr. Edward Blake, of the O.J. Simpson Dream Team defence, says the accuracy of the results depends on the skill of the scientist. This is shocking given that we treat DNA evidence as absolutely irrefutable. When the perception of a science rises to a level of being foolproof, we are at risk because science is a tool wielded by humans who are wholly fallible.

In an age when police are being accused of planting evidence, where science is promoted as an objective determinant, when there are still all-white juries, are we ignoring the role and possible bias of the stakeholders or participants in the process?

If Guy Paul Morin had given up his DNA the day the police questioned him, and there was no definitive result, would that source of exoneration have been available to him 10 years later?

You can't open a paper today without reading about another groundbreaking leap in DNA technology, but the growth of scientific advancements is exponential while the rights of citizens have stood still.

More and more we are moving toward the belief that society has to be protected, but we have to violate the rights of individuals to do that. In the '60s and '70s, the mantra was: protect me from government and its use of power. Today, it's protect me from my neighbours.

DNA technology has the ability to infringe on the rights of citizens in a way we have not previously seen.

Federico believes we are perched on the tip of a disturbing iceberg. "I don't know how far the state intends to go. They might decide to take DNA samples at birth, or if something happens at a high school, they may decide to ask students to consent to a DNA search."

It's interesting to note that students must provide their fingerprint before writing the law school admissions test. Drug testing is already a requirement at a few corporations Canada, so what you do outside the office is relevant inside the office.

In our zeal to be law-abiding and citizens above suspicion, will we soon have to provide DNA samples before we can join professional associations or hold certain jobs?

Our obsession with the need to protect ourselves from crime suggests we are willing to give up our freedoms to ensure our security. Does that mean we won't eventually be able to defend our rights, or even care about them?

While many agree that DNA is the most significant advancement in forensic investigation in the last 100 years, will we live in a society where we fear the science police?

The younger generation's big fear will not only be Big Brother's use of video cameras or Internet surveillance to keep citizens in line. Instead they'll look forward to bureaucrats with everyone's DNA samples, letting them know who did what, where, when and to whom.

And, of course, it will all be true. It's infallible.

Toronto Star, February 1, 2000
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and objectivity of DNA typing in the public imagination (Nelkin & Lindee, 2004). In these representations, the controversies over DNA typing appear to have been closed and faded into the past.

Medicolegal actors commonly describe forensic DNA evidence as infallible and powerful, as a "priceless" (CA4) "silver bullet" (CA5), a "smoking gun" (National DNA Databank, 2010, p. 8) that is "absolutely indispensible" (CA5), and "the best crime fighting tool we've had" (OPPA1). One police investigator I interviewed described DNA evidence by saying, "it makes your evidence a certainty…you can't fight the DNA" (P1). Another investigator said, "look over your shoulder, we're coming. That's what DNA tells you. It's God's fingerprint" (Slade, 2011, B1). Many investigators I interviewed suggested that DNA evidence has become a new standard in sexual assault investigations. One explained, "without that evidence, our hands are tied. It goes from 100% we can ID the person to your word versus his" (P1). Another proclaimed that, "society has become DNA driven, where it's almost made it a bit more difficult for our cases in court if there is no DNA" (P3).[32] Most medicolegal actors now expect that the SAEK will collect DNA evidence.

Questions about the science behind DNA typing have all but disappeared in Canadian courtrooms. One defence lawyer described the prospect of challenging the science of DNA typing as "a tough row to hoe" (DL2) and another admitted he has "never tried to fight it" (DL3). One forensic scientist recalled the criminal trials of the 1990s and remembered how often he responded to the criticism that "DNA [was] junk

[32] I discuss the influence of SAEK evidence on prosecution rates in chapter 6.

science" (FS1). In recent years, he said, he rarely is challenged on the scientific methods of DNA typing. Referring to the possibility of a defence challenging the science, he suggested that,

> They can try. They are not going to get very far, there is just so much precedent that I can just [snap snap snap] you know, 'are you telling me, and this court that the whole forensic community is misguided? The FBI, the European countries, Australia, that we are all using DNA technology, and it is wrong?' It is a hard argument (FS1).

In the course of a mere two decades, DNA evidence has gone from a contested terrain to a sealed set of practices that many actors claim to be completely immune to criticism.

As DNA evidence has secured an uncontested place in medicolegal practice, proponents of DNA typing have strengthened their claims about the technology's power to protect. In 2005, the National DNA Databank wrote, "the power of DNA to help solve crime is undeniable, and continued support of the National DNA Databank will help to ensure that this power is harnessed and used effectively to support the safety of Canadians" (National DNA Databank, 2006, p. 7).[33] Some Canadian forensic scientists extended claims about DNA protecting public safety by projecting that if the National DNA Databank and DNA typing were used to their full capacity, more than 1,800 sexual assaults could be prevented per year in Canada (Hepworth & McLeod, 2005). While it is unclear how these numbers were calculated, they serve to reinforce the doctrine that

[33] The National DNA Databank professes to have assisted with more than 11,000 investigations, 1,500 of which are sexual assault (Standing Committee on Public Safety & National Security, 2009).

DNA and the SAEK can protect the public, and mainly women and girls, from sexual assault.

Instability within.

Although the controversies around DNA typing have seemingly been closed, and with that the controversies around the SAEK, the increased medicolegal emphasis on DNA evidence has led to new instabilities and controversies in the medicolegal system. Many of these new instabilities revolve around diminished resources and contrasting pressures to expand DNA typing techniques that make the SAEK speak. These controversies reveal how instability can exist within seemingly stabilized technologies and networks.

Delays in the forensic lab.

Since the introduction of forensic DNA analysis, Canadian forensic labs experienced a significant increase in the number of requests for forensic analysis (Auditor General of Ontario, 2007; Auditor General of Canada, 2007). Between 2000 and 2006, the Centre of Forensic Science had a 224% increase in requests for biological forensic testing, which includes DNA typing (Auditor General of Ontario, 2007). The large workload increases have led to substantial backlogs in forensic testing. In 2007, CFS's average turnaround time, which is measured by the time required to conduct the analysis and issue a final report, was 73 days (Auditor General of Ontario, 2009).[34] Around the same time, the standard at the RCMP forensic labs was 30 days, however, this was

[34] It is important to note that this number does not reflect the total range of turnaround times. In 2011, only 26% of the sexual assault cases analyzed at the CFS were completed within the 60-day target date (Centre of Forensic Science, 2011). The length of delay for the other 74% of cases was not reported.

reportedly rarely met, and was more commonly extended to 108-120 days (Hepworth & McLeod, 2005).[35] Current delays in forensic testing, similar to those in the 1990s, have been framed by government officials as public safety risks: "delays or errors in forensic analysis...affect public safety by allowing criminals to remain free to reoffend" (Standing Committee on Public Accounts, 2008a, p. 3).

In addition to the pressures from increased requests for DNA typing, two legislative changes have heightened the workload of Canadian forensic laboratories. Bill C-13 and Bill C-18 were introduced in 2008 and added 172 designated Criminal Code offenses for which a DNA warrant could be sought. Many politicians framed Bills C-13 and C-18 as advancements for public safety. Senator Marilyn Counsell claimed, "there is no doubt that Bill C-18 moves law, justice, and the safety of all Canadians forward" (Counsell, 2007, p. 6). However, in practice, this change sparked many new tensions.

For forensic labs that were already overburdened with increasing numbers of requests for DNA typing, these bills threatened to increase the existing backlogs. In 2009, the Standing Committee on Public Safety and National Security cited the increasing weight that Bills C-13 and C-18 were placing on forensic labs as a significant problem and declared that CFS and its counterpart in Quebec[36] were in "emergency mode" (p. 18). As a way of resisting the new workload, CFS began refusing work that arose from the legislative changes and sent it to the federal RCMP lab, which was experiencing similar pressures (Standing Committee on Public Accounts, 2008a). In 2009, the CFS publically

[35] These numbers pale in comparison to those in the United Kingdom, where there is a two to ten day turnaround time for DNA typing at the national lab that operates 24 hours a day, seven days a week and employs 2,500 staff (Auditor General of Ontario, 2007).

[36] Quebec and Ontario are the only provinces in Canada with their own provincial forensic lab. All other provinces use the RCMP Forensic Laboratory Services.

stated that an additional $11 million dollars over three years would be required to meet their increasingly large workload demands (National DNA Databank Advisory Committee, 2010). I found no evidence that this boost in funding was ever granted.[37] In the absence of increased government funding, forensic labs have responded to increasing workloads in two ways: 1) automation, 2) reliance on privatization.

As a way of increasing the speed and decreasing the cost of forensic DNA analysis, many forensic laboratories have introduced automation/robotics (Hudlow & Buonsristiani, 2012). In 2007, the CFS reported that with automation, their staffing costs in the biology unit decreased by 42% (Auditor General of Ontario, 2007)[38] and by 2009, their turnaround time had been reduced to 66 days (Auditor General of Ontario, 2009). While these numbers were celebrated by the CFS, they obscured the complexities behind automation. Automation does not work for all steps of the DNA analysis process (Standing Committee on Public Accounts, 2008b). Hepworth and McLeod (2005) suggest that automation can have the undesired effect of creating "bottlenecks" (p. 4) at the non-automated stages of the process. Automation, in some Canadian labs, has also produced undesirable results.

The RCMP forensic lab introduced automation to DNA typing in 2005. Shortly after doing so, laboratory officials announced that automation had "increased casework capacity two or three fold while improving the timeliness of reporting results" (Auditor General of Canada, 2007, p. 14). However, internally, forensic scientists were repeatedly

[37] Given the provincial government's pressures on CFS to explore "cost saving opportunities" (Standing Committee on Public Accounts, 2008a) and the more recent cuts and layoffs in the CFS's electronics unit (Bonokoski, 2012), it is unlikely the CFS budget will do anything but decrease.

[38] The number of jobs that were sacrificed to achieve this number was not reported.

raising concerns that the automated systems were producing haphazard results. Management ignored the scientists' concerns for a full year, claiming that the automated system was in fact reliable (Auditor General of Canada, 2007). Only after the Auditor General made the circumstances public, did the RCMP offer to retest all evidence that had been analyzed with the automated process ("RCMP offers," 2007).[39] In this case, automation increased the RCMP's workload and in doing so, did not contribute to eliminating backlogs and delays.

A second development that has arisen from the increased pressures on publicly funded forensic labs is the rise of private DNA labs in Canada (FS2). While private DNA labs have been running in the United States since the 1980s (Halfon, 1998), in Canada private labs have been a more recent development (FS2). Private DNA labs commodify short turnaround times and more sensitive technologies. One private lab in Canada claims to provide a five-day turnaround time for forensic DNA typing (FS2). The marketing director at this lab stressed the benefits of a fast turnaround time by saying, "we say it is high time that Canadian tax payers are given the option to have a DNA profile done very quickly" (FS2). The same private DNA lab also advertises expensive DNA typing technologies that they claim to be more sensitive than those the public labs use.

While private DNA labs may increase the speed of analysis for some cases, they are unlikely to address the widespread problem of forensic backlogs and delays in Canada. If police detachments are forced to pay for individual SAEKs to be analyzed, it could be imagined that this would increase police reluctance to pursue investigations in

[39] I found no report on whether scientists found different results with this retesting than they had obtained with the automated systems.

sexual assault.[40] Through this change in practice, a new axis of inequality could be formed within the legal system.

Expanding DNA typing in Canada.

Despite the mounting pressures on forensic labs and the evidence of backlogs and delays, some Canadian groups are lobbying for increased DNA testing. The focus has been most predominantly on expanding the DNA Databank. The argument has been made in two ways.

Approximately 36,000 convicted offender profiles are uploaded to the DNA Databank each year under the current legislation requiring a court order (Standing Committee on Public Safety and National Security, 2009). In the 2009 Statutory Review of the DNA Identification Act, the committee in charge problematized the administrative time required for the crown to secure court orders for DNA sampling and highlighted the regional differences in the number of court orders that are made (Standing Committee on Public Safety and National Security, 2009). In response, the committee recommended that DNA samples be taken immediately, without a court order, upon conviction. The committee estimated that the change in legislation would increase the number of profiles uploaded to the DNA Databank to 113,000 per year, which, according to them, would justify a significant increase in the funding for the National DNA Databank. The Canadian Association of Chiefs of Police have gone even further to argue that police should have the right to obtain DNA samples upon arrest of an accused for any of the primary designated offences, such as sexual assault, aggravated sexual assault, and

[40] The number of reported sexual assaults that Ontario police consider to be founded and therefore worthy of investigation is already very low (Crew, 2012). I address this issue more in chapter 6.

murder (Canadian Association of Chiefs of Police, 2011). Several lawyers I interviewed suggested that eliminating court orders for DNA sampling would be highly unlikely under the Canadian Charter of Rights and Freedoms. However, as the history of DNA typing and banking in Canada has shown, it is imaginable that claims of collective safety could be used again to surpass Charter rights.

A second push to expand the DNA Databank has come from pressures to develop two additional indices in the bank: a Missing Persons Index that would collect DNA samples from family members of missing persons that could be compared to unidentified human remains, and a Victims of Crime Index that would bank DNA profiles of victims of designated offenses (Bernier, 2010). Both indices would open the door to a new practice in Canada of banking DNA profiles of individuals who have not been convicted of a crime and have been obtained with consent.

The Canadian Association of Chiefs of Police and victims advocacy groups have been actively lobbying for a Missing Persons Index (Canadian Association of Chiefs of Police, 2012; Miller, 2012). However, the Canadian government has been reportedly resistant to invest the funds necessary for the new index (Miller, 2012). The Victims of Crime Index, although included as a possibility, has been less commonly cited and its imagined use, significantly less defined.[41] If this index was implemented, the SAEK might become directly implicated in DNA banking, as it would supply survivor's/victim's DNA samples to the databank. Both the Victims of Crime and the Missing Persons index would require a survivor/victim or her family members to give

[41] It is very unclear what purpose this would serve in medicolegal practice. I found no clear explanation of how this index would be used and what value it would have.

informed consent to have their DNA banked. However, as I will argue in the following chapter, there are unanswered questions about what informed consent is in the face of trauma, expert technoscientific practice, and a growing reliance on the genetic witness to protect the public from violence.

Brewing controversies: Banking scientific findings.

Banking scientific findings is a complicated task, particularly in the context of a rapidly changing scientific practice. New technologies for forensic DNA typing are in constant development (National DNA Databank Advisory Committee, 2010). However, the technologies that the National DNA Databank uses to develop banked DNA profiles have stayed relatively constant since the databank's inception in 2000 (FS2). A new tension between shifting technologies and banked scientific findings may be in the near future.

The DNA profiles in the National DNA Databank are nuclear DNA profiles derived from PCR/STR technology and can only be compared with DNA profiles that are created with PCR/STR technology. Profiles that are derived from new technologies, such as mitochondrial DNA analysis, are not comparable with those in the databank (FS2).[42] As new DNA typing technologies become more prevalent and displace older technologies, the capacity of the databank to fulfill its promise to identify matches between banked DNA profiles and newly derived DNA profiles will be in question. One crown attorney described this prospect by saying, "the technology is changing…it's past the DNA data bank. And that's a big problem. I don't know if the public appreciates how

[42] See Quinlan (2008) and Quinlan, Fogel, & Quinlan (2010) for further discussion.

big of a problem that is" (CA3). The development of new DNA typing technologies may be the basis of a new wave of controversies around DNA typing and banking in Canada.

Concluding Thoughts

The rapid growth and acceptance of DNA typing in Canada inspired the reassembly of the SAEK's meaning and material form. As I have shown, DNA has drastically shifted, and is continuing to shift, the techniques that forensic scientists use to make the SAEK speak. Through legal and technoscientific controversies, a new meaning of the SAEK as the genetic technoscientific witness of sexual assault that protects the public from sexual violence emerged and gained stability in medicolegal practice.

Despite the SAEK's stability in contemporary medicolegal practice, controversies around forensic DNA typing have not closed or faded into the past. Rather, they are active and imminent. As I will explore in the next chapter, in the face of the contemporary SAEK's stability, there are many other brewing and ongoing instabilities within the SAEK.

Chapter 6
(De)Stabilizing the Contemporary SAEK: Contested Terrains of Practice, Expertise, and Private Suffering

In 2010, at least three sexually assaulted women were turned away from a Sexual Assault Treatment Centre in Ottawa because there were no qualified nurses available to administer the SAEK (Seymour, 2011, C1). Emergency room staff told the women to come back later or travel to a SACTC an hour outside of Ottawa. One woman, who had no funds to travel, and no wish to delay the SAEK exam, chose not to return to the Ottawa Hospital (RCC9). Months later, when her assailant was brought to trial, the judge dismissed the charges, concluding that it was "disturbing" that no SAEK exam had been done and that without it, her evidence was too unreliable to find the accused guilty (Seymour, 2011, C1).

***

At a sexual assault conference in 2009, Jane Doe, a well-known anti-rape activist, stated to a room of scholars, activists, and survivors/victims that the SAEK has become the new standard for sexual assault cases, despite the fact that it perpetuates dated rape myths, is seldom used in court, and rarely works in women's interest. One woman near the back of the room identified herself as one of the activists who had participated in the political struggles to develop the SAEK in the late 1970s. After recounting some of this history, she said to Jane Doe, "they turned it against us."[1]

The events at the Ottawa hospital and at the sexual assault conference in 2009 reveal some existing conflicts around the contemporary Sexual Assault Evidence Kit (SAEK) and the medicolegal practices it works within. Both events reveal the ongoing and brewing controversies around how the SAEK *acts* in the medicolegal network. In this chapter, I use both events as an entry point into the SAEK and consider the question they collectively pose: how does the SAEK act in the contemporary medicolegal network, for what purposes, and to whose benefit?

[1] These events occurred at the conference titled "Sex Assault Law, Practice, and Activism in a Post-Jane Doe Era," held in Ottawa, Ontario in March, 2009.

Every day, approximately five to ten SAEKs are submitted to the CFS for analysis (FS1).[2] In raw materials alone, each SAEK costs $67, and in 2012, the Centre of Forensic Science (CFS) paid $120,000 for a yearly supply of SAEKs for Ontario.[3] These numbers suggest that the SAEK has become deeply integrated into contemporary medicolegal practice. Given the SAEK's apparent stability, I argue that it is crucial for feminist scholars to examine how the contemporary SAEK works and for whom.

As I have shown in preceding chapters, the SAEK's history in Ontario has featured significant changes in the medicolegal network, or the "webs of relations" (Law, 2007, p. 1) in which the SAEK works. New actors have been envisioned and incorporated into the SAEK's practice (i.e. SANEs), new tools for organizing actors and practices have been devised (i.e. legal reforms and protocols), and new physical spaces have been built (i.e. SACTCs). Through a diffracted imagining of the SAEK, I have shown how the SAEK has shifted in meaning and material form through scientific, medical, technoscientific controversies, legal reform, and technological change. I have argued that through this shifting terrain, the SAEK has gained stability in medicolegal practice as the objective technoscientific witness of sexual assault.

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[2] To my knowledge, there is no publically available provincial data on the number of survivors/victims who access sexual assault treatment centres and request SAEK exams. However, other provincial data on sexual assault offers some insight. In 2011, 7,821 sexual assaults were reported to police in Ontario, which represents a small decrease from 2002, when 8,362 sexual assaults were reported to police (McInturff, 2013). Police reports represent a small fraction of sexual assaults in Ontario. Over the last decade, self reported sexual assaults in Statistics Canada victimization surveys increased by 100,000, from 179,000 in 1999 to 265,000 in 2009 (Perreault, Brennan, & Brennan, 2011). Likely, the number of survivors/victims who report to sexual assault treatment centres is between estimates from police reports and Statistics Canada.

[3] CFS, "Untitled," (2013), obtained through FOI request to the Centre of Forensic Science, no. CSCS-A-2013-01382 and 1411.

Haraway (2000) reminds us that diffraction involves seeing the history of how an object came to be as well as what it simultaneously is. This chapter builds on the previous chapters, where I traced how the SAEK has come to be, to perform the other part of diffraction, where I will examine what the SAEK simultaneously is. I do so by investigating how the SAEK acts and is enacted as the technoscientific witness of sexual assault in contemporary medicolegal practice.

I begin with the questions: who benefits from the SAEK's stability as the technoscientific witness?, what purposes does its stability serve?, and what are the costs of its stability to whom? I argue that by tracing medicolegal practices that involve the SAEK, it is possible to see who benefits from the SAEK's stability and who does not. As I explained in chapter 2, Star (1991) proposes a critical shift in Actor-Network Theory (ANT) when she argues, "it is both more analytically interesting, and politically just to begin with the question, *cui bono?* than to begin with a celebration of the fact of human/non human mingling" [emphasis added] (p. 43). Here I explicitly take up Star's reimagined ANT to ask of the contemporary SAEK: cui bono?[4]

Embedded in the question *who benefits from* the SAEK is a more theoretical one: for whom is the SAEK stable? Star (1991) contends that, "no networks are stabilized or standardized for everyone" (p. 44). She argues that public stability of technologies and networks is often accompanied by "the private suffering of those who are not standard – who must use the standard network, but who are also non-members of the community of

[4] By beginning with the question *who benefits from* the SAEK, I follow in Jane Doe's (2012) path, who in a recent article, began her investigation of the SAEK with the same question. Doe's work explores this question through survivors'/victims' and advocates' perspectives of the SAEK. This chapter takes a different approach. Here, I explore who benefits by investigating medicolegal practice: who does what, when, where, how, and why?

practice" [emphasis added] (p. 43). For these non-members, Star argues, stabilized networks are not sources of order and stability, as they are for members. Instead, stabilized networks are more often "a source of chaos and trouble" (p. 42). In this chapter, I reveal some of the chaos, trouble, and private suffering embedded in the SAEK's stability by exploring the practices that maintain them. I suggest that this private suffering is central to how the SAEK acts and has stability as the technoscientific witness of sexual assault in the medicolegal network.

This chapter reveals how the SAEK has stability for medicolegal actors who access "truths" of women's reports of sexual assault and for some survivors/victims who fit the narrow definition of the ideal implicated user of the SAEK. Here, I show how the SAEK does not have stability for survivors/victims who do not fit into the definition of the ideal implicated user of the SAEK. Through this, the chapter illustrates how the definition of ideal implicated user is enacted in practice, and how this enactment gives the SAEK and its network stability for many medicolegal actors and very few survivors/victims. Alongside all of this, I sketch some of the brewing controversies and uncertainties about the contemporary SAEK to reveal some instabilities that may shake the SAEK's stability in the future.

As I have argued throughout this dissertation, stability is not a finalized outcome of controversy. Rather, it is a moment, easily disrupted, when consensus and order is seemingly reached. Here, I offer more nuance to the term by illustrating how consensus and order is not universal amongst all actors in the SAEK's network, but is instead, unequally distributed between and among medicolegal actors and survivors/victims.

I begin this chapter by sketching some of the clusters of practices that make up the terrain of practice and expertise within which the SAEK currently acts. I illustrate several clusters of practices and argue that they directly or indirectly support and shape the flow of medicolegal action through which the SAEK moves. I focus on police practices of determining "truths"[5] about women's reports of sexual assault and the shifting terrains for rape crisis centres (RCCs) and Sexual Assault Care and Treatment Centres (SACTCs), in which rape crisis centre workers have been pushed to the margins of SAEK's practices and medicolegal actors have claimed expertise over the SAEK exam, and increasingly, sexual assault, and sexual assault care and advocacy.

I then trace how the SAEK acts and is enacted as an objective technoscientific witness of sexual assault in contemporary medicolegal practice. I examine four points of action in the medicolegal network: 1) accessing the SAEK, 2) staging the SAEK, 3) obtaining (un)informed consent to the SAEK, and 4) reading the SAEK, to illustrate *who* the SAEK stable for and who it is not, what purposes its stability serves, and at what costs and to whose benefit.

Contested Terrains of Practice and Expertise

Contemporary media reports often claim that medicolegal practices around sexual assault have vastly improved in sensitivity and efficiency since the 1970s and early 1980s (Lonsway & Archambault, 2012). Many of the medicolegal actors I interviewed reiterated media assertions of progress by stating that since the 1980s, reforms in medical

[5] I use quotations here to emphasize that the "truths" police and other legal actors claim about sexual assault are a product of their values, beliefs, and practices, and often not of a woman's experience of sexual assault.

and legal practice in Ontario have resulted in a "landscape that has dramatically changed" (CA5) and a process that "typically goes quite flawlessly" (PA3). These participants claimed that survivors'/victims' experiences in the medicolegal system have drastically improved as a result of sexual assault legal reforms; contemporary medicolegal experts for sexual assault, such as SANEs and police sexual assault investigation squads; new protocols, such as mandated police training in sexual assault and hospital protocols for evidence collection; and new services and spaces for survivors/victims, such as victim services and the SACTCs. While the medicolegal network has undoubtedly shifted, it is perhaps too premature to claim progress. Through the terrains of practice and expertise that surround the SAEK, I suggest a more nuanced estimation of the contemporary medicolegal network, which highlights that stability of the SAEK's network benefits few survivors/victims.

Police practices and manufacturing distrust.

Many feminist scholars have argued that sexual assault policing is guided by a general disbelief of women who report sexual assault (Estrich, 1986; Doe, Dale, & Bain, 2009; Crew, 2012; Alderden & Ullman, 2012). Russell (2011) argues that despite the initiatives to improve Canadian sexual assault policing, "many troubling aspects of police response remain unchanged since the 1970s" (p. 28). One aspect of police practice that has remained relatively constant since the 1970s is police (and other legal actors) disbelieving women reporting sexual assault. The SAEK is enacted as the technoscientific witness through a set of police practices that maintain a systemic disbelief of women and their reports of sexual assault. In a later section, I investigate how

the SAEK is integrated into police practice as an objective tool for determining "truth." Here, I briefly sketch some of the police practices that support and shape the SAEK's use as an objective and credible tool.

Police are *trained* to disbelieve women reporting sexual assault. Police training manuals, as Crew (2012) notes, commonly equate sexual assault with false reports by asserting that sexual assault investigation is plagued with frequent false reporting. The "Baeza False Report Index" (p. 177) in Baeza and Turvey's (2002) training manual lists sixteen "red flags" (p. 177) of false reports of sexual assault, which include a range of indicators such as, a survivor/victim requesting to speak to a female officer, missing her curfew on the night of the assault, moving to a new home during the investigation, having a psychiatric history, having a past experience of reporting a sexual assault, and/or displaying "TV behavior" (p. 177).[6] These "red flags" (p. 177) rest on and perpetuate a narrow definition of the "real rape victim" (Estrich, 1986, p. 1088)[7] who is untouched by men, unlabeled by psychiatrists, and seemingly unaffected by her own rape. Training texts, such as Baeza and Turvey's, act on and within police practice by shaping and coordinating how sexual assault investigation is done.

One of the most revealing works on Ontario policing practices is Blair Crew's (2012) study of unfounded rates for sexual assault, i.e. the number of sexual assault reports where police conclude that no violation of the law took place or was attempted.

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[6] "TV behaviour," according to Baeza, encompasses anything that could be defined as "mimicking the way that stereotypical victims act on television…(hysterical, demanding female officer, catatonic, etc.)" (p. 177).

[7] Susan Estrich (1986) describes "real rape victims" (p. 1088) as the victim whose identity and rape fit the sexist and racist stereotypes that define which rapes police choose to believe.

Crew (2012) found that in some regions of Ontario, the unfounded rate for sexual assault can be as high as 32.45%, compared to the rate for other crimes, which at it highest, ranges from 2.39-3.43%. I asked police officers to estimate how often they conclude that sexual assault reports are unfounded and I received varying reports from "the odd one" (P7) to over 50% (FIU1).

Police practices for determining the "truth" of sexual assault reports are relatively invisible to those that do not directly observe them (Alderden & Ullman, 2012). I filed a Freedom of Information request to access the teaching materials for the police training on "deceitfulness and truthfulness"[8] and I was denied access on several grounds, one being that: "the ministry may refuse to disclose a record if the disclosure could reasonably be expected to facilitate the commission of an unlawful act or hamper the control of crime."[9] Police practices for determining "truth" are heavily guarded on the presumption that visible practices would facilitate false reports of sexual assault. I asked police how they determine if a sexual assault report is false, and while some were hesitant to divulge investigating skills, others were forthcoming. Some police described how they detect false reports through a variety of signs, many of which mirrored Baeza and Turvey's index and others, popular psychology. Some of these techniques included: a survivor's/victim's emotional state, her level eye contact, and the number of times she touches her face, and changes in her tone, speech, word choices and level of detail when she describes the assault. Many police claimed that if a survivor/victim is falsely

[8] One of my participants identified this training session in the course of the interview.

[9] Section 14(1)(l) of the Freedom of Information and Protection of Privacy Act. Letter from Ministry of Community Safety and Correctional Services, June 11, 2002, FOI request no. CSCS-A-2012-01832.

reporting, she cannot describe her assault backwards, rarely knows if her assailant was circumcised, often reports with her boyfriend the next morning, or does not report at all, is desperate for attention, and likely has a motive such as, she was late for curfew or she needed an excuse for an upcoming exam.[10]

Police also base their judgments of a survivor's/victim's believability on her social location (Irving, 2008; Doe, 2012). Many of the rape crisis centre workers I interviewed confirmed this when they said that police are far less likely to believe women of colour, Aboriginal women, disabled women, women with mental health diagnoses, trans women, sex working women and far more likely to label their reports as unfounded. Police techniques for determining "truth" configure a narrow definition of *who* can be trusted and in so doing, help to manufacture police distrust of women reporting sexual assault.

Police practices that manufacture disbelief set part of the medicolegal terrain in which the contemporary SAEK acts. Other aspects of the terrain are characterized by shifting claims of expertise in sexual assault care and advocacy and some of the resulting tensions within and between RCCs and SACTCs.

A shifting terrain for RCCs.

Contemporary anti-rape activism is operating in "a radically altered terrain" (Beres, Crow, & Gotell, 2009, p. 144) from its origins in the collectively run rape crisis centres of the 1970s. According to many feminist scholars and activists, the pressures to professionalize sexual assault advocacy and transform RCC collectives into

[10] These criteria have been paraphrased and assembled from multiple interviews with police investigators.

hierarchically run services in the 1980s and 1990s, which I described in chapters 3 and 4, have coalesced with more contemporary pressures from severely diminished funding for activist organizations and pressures from funders and policy makers to redefine RCCs as de-gendered/de-politicized service providers for sexual assault (Beres, Crow, & Gotell, 2009; Russell, 2011; Doe, 2012).

While in the 1970s and 1980s, rape crisis centre workers were active in the SAEK's design, and consultations and medicolegal training on the SAEK, now, they are not involved in redesigning the SAEK or SAEK consultations and are more often receiving police and nurse training on the SAEK than giving it (RCC1). I argue that in the contemporary medicolegal network, rape crisis centre workers have been situated as non-users of the SAEK who have very little influence on how the SAEK acts and is enacted in medicolegal practice. They are now on the margins of medicolegal practices involving the SAEK.

In arguing this, I am *not* suggesting that RCCs are no longer part of practices involving the SAEK. Quite the contrary: many contemporary RCCs continue to offer survivors/victims advocacy in SAEK exams (when nurses allow them in the room)[11] and during police investigations and court proceedings. However, what I am commenting on is the different positioning that RCCs have relative to the SAEK. They are no longer involved in the SAEK in the same ways that they were during the SAEK's beginnings.

[11] Some nurses that I interviewed stated that they have an explicit policy not to allow rape crisis centre workers, or any other support people, to be in the SAEK exam room. Others described how social workers in SACTCs have now taken on the role of advocacy in the SAEK exam. These policies and practices are one of ways that rape crisis centre workers have been displaced in practices involving the SAEK.

Changes in practice and pressures on contemporary RCCs have contributed to significant shifts in the anti-rape movement. In response to the pressures to professionalize RCCs, many contemporary RCCs have moved away from feminist peer counseling to professionalized counseling by social workers and psychologists (RCC11). New programs, such as George Brown's Assaulted Women's and Children's Counselor/Advocate Program, which was developed by several anti-rape activists in Toronto, now offers formalized training for new advocates in rape crisis centres. Most RCC's operate under a hierarchical or modified collective model and few collective organizations remain (RCC11). One advocate in a collectively run RCC described the decline in collectives by saying, "it is slowly becoming more lonely...we are trying to operate as a circle in a triangle world" (RCC9). Under these pressures, sexual assault advocacy is being redefined in some RCCs as an individualized service that is managed and conducted by professionals.

Many RCCs have opened their services beyond women and children to include men, a change that, according to some, has largely arisen from demands of government funders (RCC13). For some rape crisis centre workers, this shift signals a larger move away from gendered analyses of sexual assault both within and outside of the movement and a new context for RCCs in which "women only spaces are shrinking" (RCC13). Some of the advocates who work at the few remaining RCCs that are reserved for women described some of the informal pressures to open their doors to men; several suggested that other service providers routinely accuse them of "discriminating" against male

survivors/victims (RCC3; RCC7). These pressures mark a new climate for RCC advocacy.

One rape crisis centre worker suggested that in the face of the pressures to transform RCCs, the anti-rape movement has become "much more mainstream…we've lost some of our activism along the way" (RCC13). Concurring with this view, Sunny Marriner (2012), an anti-rape activist in Ontario, explains this further,

> In a culture of increasing credentialism and professionalization, we see sexual assault centres moving even-further from the radical challenges of feminism, the expert knowledge it developed, and its at-once hopeful and skeptical aspiration to alter the social terrain for women (p. 412).

Beres, Crow, and Gotell's (2009) recent national survey of contemporary Canadian RCCs revealed that funding constraints on RCCs have significantly reduced their time for political activism, but have not significantly reduced feminist politics. Marriner argues the opposite: "in what appears to be a bid to win the contest of 'experts' with psy- and institutionally based services, many of todays SACs have attached credibility to being perceived as 'every bit as professional' as government-created apolitical victim-service models" (p. 445). According to Marriner, this shift suggests that RCCs have been complicit in a larger effort to displace feminist expertise in psy- and institutionally based services. RCCs have, she argues, decentered their own feminist expertise with professionalized, apolitical, models of practice.

Many of the rape crisis centre workers that I interviewed explicitly identified themselves and their centres as feminist. However, some did not and instead emphasized

the professionalized counseling and other services that their centres' offers. Taken together, this evidence suggests that many aspects of RCCs are shifting in a shifting terrain.

Shifts within the RCC and anti-rape movement have coincided with medical actors using their established expertise on the SAEK to increasingly claim expertise over sexual assault and sexual assault advocacy and care. As I will show in the following section, SANEs are increasingly taking up advocacy and public education practices that RCCs once claimed and in so doing, are transforming terrains of expertise on sexual assault.

SANEs practicing expertise.

The 35 SACTCs that are dispersed across the province of Ontario vary substantially in their histories, models of practice,[12] compositions of staff, and funding structures (SANE3). Despite their differences, media, scholars, and many medicolegal actors credit contemporary SACTCs with providing more supportive environments for survivors/victims, shortening SAEK exam times, improving collaboration with law enforcement, and producing higher prosecution rates (Du Mont, White, & McGregor, 2009; Erickson, Dudley, McIntosh, Ritch, Shumay, & Simpson, 2002; Stermac & Stirpe, 2002).

In chapter 4, I illustrated how the SAEK contributed to solidifying SANEs' expertise in sexual assault treatment. For much of the 1980s and 1990s, SANEs' expertise was restricted to the SAEK exam and emergency medical care. Now, many

[12] Some centres rely on physicians to order blood work and prescribe medications, while others operate on the basis of medical directives that give SANEs/RNs the authority to provide those options (SANE3).

contemporary SACTCs have expanded their services to include professionalized counseling. This counseling is incorporated into existing professionalized models of care and as such, it fits neatly within the frame of professionalized sexual assault services that funders and policy makers have pushed in recent years.

With the SACTCs range of individualized medical and counseling services, the centres have been dubbed the "one stop shop" (Burnett, 2007)[13] for sexual assault survivors/victims. This language situates RCCs and the advocacy that they provide as redundant and positions SACTC staff as central actors in the SAEK's network. This is evident in the structural shifts in contemporary RCCs and SACTCs, in which some Ontario RCCs are being subsumed/replaced by SACTCs. In Sudbury, the Sexual Assault Crisis Centre (SACC) recently closed and was replaced with the *Health Science North, Violence Intervention and Prevention Program*, a program that provides SAEK exams and counseling ("Sudbury to get," 2011). When the new program was announced, some media reports downplayed the different purpose it had than its predecessor and cast the program as the "*new* Sexual Assault Crisis Centre" ("Sudbury to get," 2011). Doe (2012) suggests that this is not an isolated example and that there is a larger trend afoot, in which many RCCs are being transformed into SACTCs. In this way, some RCCs are being *literally* erased by SACTCs. In this way, SACTCs, and the government and policy agendas driving them, are contributing to pushing rape crisis centre workers to the margins of practices involving the SAEK.

[13] Many participants in this study, including some rape crisis centre workers, used this term during their interviews.

Amidst these shifts, SANEs and SACTCs have claimed expertise in sexual assault, sexual assault advocacy, and care. In so doing, they have adopted and transformed feminist inspired anti-rape expertise, services, practices, which were once the sole purview of RCCs and the anti-rape movement.

Medicolegalizing sexual assault care.

Under the medicolegal model for sexual assault care in the SACTC, sexual assault nurses are placed in the contradictory position of being an objective advocate: s(he) is caught between being a supportive care giver and an objective forensic evidence collector (Du Mont & Parnis, 2003). Doe (2012) calls this contradiction, "a competition of cultures" (p. 20). Several nurses that I interviewed suggested that they contend with the competing pressures by siding with the SAEK's forensic script, which they argue is in the survivor's/victim's best interests. One said, "it sounds very callous, but it's for their own protection...you have to tell them right off the bat...you don't want to hear all the extra details" (SANE3). Another said, "I don't need to know if it's not on the form" (SANE1). Sexual assault care in the SACTC is thus shaped, and is at times determined by, the SAEK's forensic script and the medicolegal model it is part of. With the SAEK, SACTCs have been part of transforming sexual assault care from a non-professionalized, community based service that RCCs offered to a medicalized/professionalized service largely dictated by the needs of the legal system.

Although the provincial network of SACTCs describes the centres as inherently feminist (Ontario Network Sexual Assault/Domestic Violence Treatment Centres, n.d.), the data in this study suggests that many SACTCs have adopted what Beres, Crow, and

Gotell (2009) have called, a "gender-neutral victim services model" (p. 144), in which sexual assault is seen as an individualized and depoliticized issue. Some SACTCs are considering expanding their scope of practice to other areas of victimization, such as elder abuse (SANE2), and other domains of medical care, such as bodily fluid exposure (Stoner, 2003). These changes in practice might further solidify SACTCs conceptions of sexual assault as a de-gendered victims issue and sexual assault care as an individualized medical service.

Public education and tensions in expertise.

Being expert users of the SAEK, SANEs have secured a place in the contemporary medicolegal network as experts of sexual assault. Building on this secured placement, many SACTCs have expanded their scope to include community outreach and public education. In doing so, SACTCs have adopted the practices and claimed expertise that most community based RCCs had claimed as their own in the 1970s and 1980s. Much of SACTC's public education work focuses on advertising SACTC services and educating women on the SAEK exam (Colby, 2008).

According to SACTC network newsletters, however, some SACTCs have adopted a broader purview of public education, which includes developing sex awareness curriculum for secondary schools (Kaplan, 2004), training sessions for lawyers, police, and paramedics (Furst, 2005), and education programs for secondary schools on the gendering of toys (Toppozini, Maxwell & Mesch, 2003), drugs (Fitzgerald, 2006), personal safety, and bullying (Maxwell, 2006). In some nurses' descriptions of SACTC public education programs, sexual assault is described as a "personal safety issue"

(Maxwell, 2006), which often involves "three stages of healing: victim to survivor to 'thriver'" (Caufield, 2003). Sexual assault, in these descriptions, is an individualized experience that fits into medicalized definitions of trauma. Educational programs from this framework are a stark contrast to many anti-rape activists' education programs in the past, which asserted that sexual assault was not an individual problem and advocated for a collective and political response to addressing trauma.

In some communities, SACTCs' public education work has sparked tensions with rape crisis centre workers. One advocate from Northern Ontario described SACTC's public education work on the SAEK in relation to the racism she sees permeating SACTCs and the medical system of which they are a part. She said,

> "I couldn't emphasize enough the racialized experience in [name of city]...it's kind of like we don't have missionaries anymore, we have *medical missionaries*. They are those kinds of people who think that Indigenous people are the fringes of a dying society, who should either just jump on board with mainstream culture or fuck off [emphasis added] (RCC7).

In her description, SANEs and other experts from the SACTCs often act as white "medical missionaries" (RCC7) who attempt to "educate" Aboriginal women and women of colour on "healthy relationships," sexual assault, and the proper uses of the SAEK. She reflected on some of the SACTC public education programs and said, "there are huge gaps in the level of understanding that most practitioners have around the social determinants of health, and the context in which Indigenous people are living" (RCC7).

These gaps in understanding, she argued, are evident in the content and language that many SANEs use in their public education programs.

Some of the language that the rape crisis centre worker referred to above arose in several SANEs' descriptions of their services and education programs for Aboriginal women. Many of the SANEs descriptions situated Aboriginal women as vulnerable and passive members of a homogenous non-white culture that accepts sexual assault as an unquestioned social norm. One said that in Northern communities, sexual assault "is an accepted norm…it is a perceived cultural bit that this is a normal right of passage" (SANE5). Others described how Aboriginal women are often "police shy" (SANE4) and need to be encouraged to report and follow the SAEK's forensic script for proper evidence preservation. One nurse, explaining why Aboriginal women rarely report their experiences of sexual assault, said "they are a very close culture and don't like to share and wash their laundry in public" (SANE1).

As SANEs are increasing their purview in the SAEK's network, some rape crisis centre workers are growing increasingly concerned that SANE's work is appropriating and transforming anti-rape advocacy and education (RCC7; RCC1). For one advocate in particular, SANE's educational work is failing to reflect women of colour and Aboriginal women's experiences and is abusing the expertise that SANEs appropriated from rape crisis centres. These sentiments suggest that there are growing tensions and perhaps a new contested ground between RCCs and SACTCs over expert knowledge on sexual assault. This may contribute to new instabilities in the SAEK's network in the years to come.

Unsteady terrain: Funding cuts and shifts in experts.

Despite the expert status that SANEs and other professionals in SACTCs have secured over sexual assault care and advocacy and the central placement that they have secured within the SAEK's network, their positioning within the medical system is relatively tenuous. In 2008-2009, the funding structure for Ontario SACTCs shifted from secure funding from the Ministry of Health and Long Term Care to global funding allocated by individual hospitals. One SANE described global funding as "very much stat driven" (SANE2) and as allocated purely on the basis of the volume of patients that a hospital program serves. The global funding model prioritizes emergency wards that can serve up to 300 patients a day and other similar departments, and not SACTCs, which in some cases, serve around 35-45[14] cases a month. According to several nurses, the shift to global funding has resulted in significant cuts to nursing, counseling, and management staff in many SACTCs (SANE2; SANE4). For example, during 2008-2009, the number of full-time equivalent positions at the SACTC at Trillium Health Partners hospital dropped from 8.13 to 6.47, as did their medical services budget, from $310,912 to $193,887 (a drop in $118,025).[15] For some SACTCs, the cuts have eliminated available funds for nursing education and training. One SANE reported that her centre does not have the funds to pay nurses for their training time on revised SAEKs (SANE5). She said, "the nurses aren't paid for their time to do it...but yet they have to maintain a high

[14] This number reflects the average number of patients the Ottawa SACTC sees per month (Louisa, 2010, A1).

[15] THP, "SADV Budget," (2012), obtained through FOI request to the Trillium Health Partners, no. 13-008. Some of what was lost through these cuts was regained by 2012-2013, when the number of full-time equivalents was raised to 7.3.

level of knowledge and competency especially in the forensic sides of things...that is a real challenge" (SANE5). While significant resources are being funneled into revising SAEKs, the actors using them are not given the resources necessary to learn the intricacies of the revised tool.[16]

In addition to funding challenges for SACTCs, according to the SACTC newsletters, many centres routinely struggle with retention and recruitment of Registered Nurses (RN) (Siedlikowski, 2004; Louisa, 2010, A1). Sexual assault nursing salaries can be unpredictable and variable, as much of the hours are on call with marginal compensation (SANE5). To supplement the salary, many nurses seek more secure employment in other positions, which can interfere with call hours (SANE3). Beyond salary, nurses commonly identify burnout, compassion fatigue, and vicarious trauma as significant challenges and barriers to SANE work (Sievers & Stinson, 2002; Dempsey, 2009). One nurse I interviewed explained the emotional difficulties of the work by describing how sexual assault care, particularly for women, often leads to increased feelings of vulnerability to sexual assault. She said, "we see in here all these things that we are at risk for" (SANE6). Challenges of sexual assault nursing have coupled with the cuts in SACTC funding to result in understaffing of some SACTCs, such as the Ottawa SACTC described at the beginning of this chapter.

In the face of pressures to cut costs and increase numbers of sexual assault nurses, some centres have expanded their recruitment to include Registered Practical Nurses

[16] In 2011, the Ontario government released a Sexual Violence Action Plan, which promised $15 million over the next four years for service provider training, public education, and prevention (Ontario's Women's Directorate, 2011). Although the plan promises increased levels of training for SACTC medical staff and counselors, it does not include any allocated funds for this purpose. In fact, none of the $15 million was explicitly allocated to SACTCs.

(RPN).[17] In 2006, the RPN scope of practice was expanded by the Ontario College of Nurses, allowing RPNs to conduct most steps in the SAEK exam (Fitzgerald & Rioch, 2009).[18] Following this change, the number of RPNs in sexual assault nursing has significantly increased: in one northern SACTC, four out of ten nurses are RPNs (Fitzgerald & Rioch, 2009). Including RPNs in sexual assault nursing marks a significant shift from the early years of the SAEK, when physicians were considered to be the only qualified experts that could conduct the SAEK exam. As I described in chapter 4, when physicians started to assert that the SAEK exam was an undesirable responsibility, RNs replaced them and became expert SAEK users. Now, as RNs are becoming increasingly difficult to retain, particularly in northern Ontario, RPNs are being used to fill the void. Similar to how RNs solidified and secured their expertise over the SAEK in the 1990s, medical actors are now describing RPNs as "professionals" that have the "knowledge, skill, and judgment required for the role" (Fitzgerald & Rioch, 2009, p. 4) of the SAEK examiner. This illustrates how the SAEK expert user has shifted historically in response to increasing pressures to cut health care costs, expanding scopes of practice for medical practitioners, and the medical actors' resistance to the SAEK.

In response to the many uncertainties in SACTCs, several nurses I interviewed expressed doubt about how the centres will look in the future (SANE4; SANE5). With the cuts to funding, the difficulties in recruiting and retaining RNs, and a predicted rise in retirements in the near future, these nurses suggested that significant changes in the

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[17] In Ontario, most RPNs have a two-year college diploma, whereas most RNs have a four-year undergraduate degree.

[18] RPNs' scope varies between centres. However, one centre has RPNs conducting all parts of the SAEK exam, including the pelvic exam. Prior to 1995, RNs did not have the authority to do (SANE4).

SACTCs may be on the horizon. Through this terrain, it is clear that SANEs' positioning in the SAEK's network is not fixed and the network itself is not inherently stable. Rather, in its stability is potential for instability, as the network itself is characterized by shifting practices and relations between actors. I now turn to discuss the SAEK's stability in more detail and describe how it acts and is enacted as the technoscientific witness within the network.

The SAEK: Cui Bono?

After 34 years of medicolegal efforts to stabilize the SAEK in the medicolegal network, the contemporary SAEK has gained stability as the objective technoscientific witness of sexual assault for sexual assault investigation and prosecution. In a recent report, the United States Department of Justice (2013) praised contemporary sexual assault kits by asserting that,

> A timely, high-quality medical forensic examination can potentially validate and address sexual assault patients' concerns, minimize the trauma they may experience, and promote their healing. At the same time, it can increase the likelihood that evidence collected will aid in criminal case investigation, resulting in perpetrators being held accountable and further sexual violence prevented (p. 4).

In a recent Canadian Radio Cooperation broadcast, one policy analyst praised sexual assault kits' ability to "affirm the presence of the suspect...affirm the victim's version of events...and potentially match suspect[s] to other rape cases" (CBC, 2013). In these statements, contemporary sexual assault kits are credited with enhanced investigations,

increased prosecutions, and improved and less traumatizing experiences for sexual assault survivors/victims.

Many medicolegal actors I spoke with reiterated these sentiments by claiming that the SAEK has "advanced a lot of investigations" (FSM), "led to better convictions" (SANE5), and "has brought the justice system a little further ahead" (SANE2). Others claimed that the SAEK is "beneficial for victims" (P11) because it often "give[s] legitimacy" to her story (SANE3) and in so doing, "assist[s] complainants in allegations of sexual assault" (FS1). A few rape crisis centre workers concurred with the medicolegal actors and said that the SAEK is a tool that "has been helpful" (RCC12) and has assisted "women [in] build[ing] their cases" (RCC8). Many nurses, police, and forensic scientists stated that without the SAEK, sexual assault investigations and trials are reduced to the difficult conundrum of "he said, she said" (SANE1).[19] The most emphatic medicolegal descriptions of the SAEK proposed that it was necessary for justice: one police officer said, "it is so important that she takes the kit, if she doesn't take the kit like, I mean if you don't have that in court, we are not going to do her justice" (P6).[20]

These views suggest that there is consensus around the SAEK's value in the contemporary medicolegal network and that it has an unquestioned stability within the medicolegal network. However, some medicolegal descriptions of the SAEK suggested that there may be some instability within. Alongside the common depiction of the SAEK

[19] This was a common phrase that many medicolegal actors and rape crisis centre workers, most often in the context of describing the apparent impossibility of determining truth in sexual assault cases.

[20] This quote can be read in one of two ways: 1) as a statement of fact, as in "we won't be *able* to do her justice without the SAEK," or 2) as a threat, as in "we *won't* do her justice without the SAEK." As I examine in this section, police practices around the SAEK reveal the potential of both meanings.

as a valuable tool, several medicolegal participants stated that in practice, the SAEK is a small part of sexual assault investigation and trials and that, in isolation from other evidence, the SAEK rarely proves that a sexual assault occurred and rarely facilitates conviction. Most of the rape crisis centre workers expressed a similar view and described how, in practice, the SAEK rarely works to the survivor's/victim's benefit: "in theory it's awesome, but in practice, and legally it doesn't work for the survivor" (RCC1) and the SAEK's "intention is great, but it doesn't really serve its intention" (RCC2). These contentions suggest that there is not complete consensus over the SAEK's value and that the SAEK's stability does not create order for everyone involved in medicolegal practice.

Rape crisis centre workers' reservations about the value of the SAEK in practice are similarly reflected in the scholarly literature on sexual assault and investigation and prosecution, where there is conflicting evidence on the impact that SAEKs have on sexual assault investigations and outcomes of sexual assault trials (Du Mont & White, 2007). Some studies have found that evidence from SAEKs increase the likelihood of arrest and conviction (Campbell, Patterson, Bybee, Dworkin, 2009), whereas others have found that SAEK evidence increases the likelihood of a police charge and arrest, but not conviction (Johnson, Peterson, Sommers, Baskin, 2012), and others still have found that SAEK evidence has minimal, if any, impact on outcomes of sexual assault investigations and trials (Feldberg, 1997; McGregor, Du Mont, & Myhr, 2002).[21]

[21] Feldberg (1997) and McGregor, Du Mont, and Myhr's (2002) studies are the only two in this list that were conducted in Ontario. The others were conducted in the United States. These regional differences may be significant when interpreting their results.

The conflicting evidence and assertions about the SAEK and its value in the contemporary medicolegal network reveals existing tensions within the stability of the contemporary SAEK. In the following section, I diffract the SAEK to see how it acts and is enacted in practice in order to see how its stability benefits some and not others and to explore some of the chaos, trouble, and private suffering embedded in the SAEK's stability.

Networks, according to Latour (2005), are best understood as "work-nets" (p. 132), which take shape through, and as a result of actors' work. As I have shown in this dissertation, the medicolegal network has been, and continues to be, shaped and constituted by scientific, legal, and medical controversy and practice. The SAEK travels through this network, linking practices in the examination room, the police station, the forensic laboratory, and the courtroom, and acting with other medicolegal actors to assemble legal "truths" about sexual assault. In the following section, I zoom in on four points of action[22] that involve the SAEK within the contemporary medicolegal network: 1) accessing the SAEK, 2) staging the SAEK, 3) obtaining (un)informed consent to the SAEK, and 4) reading the SAEK. In these points of action, I show how the SAEK acts and is enacted in particular segments of the contemporary medicolegal network to see for what and for whose benefits the SAEK's stability as the technoscientific witness serves.

[22] By using the phrase "point of action," I do not mean to imply a singularity or simplicity of practice. Rather, I understand these points of action to include an assembly of actors and actions around a particular step in the SAEK's travel through the medicolegal network.

Accessing, staging, and consent: The SAEK as an empowering choice?

Many of the medicolegal actors I interviewed framed the SAEK in terms of choice and empowerment. Several police officers and administrators described the SAEK as a tool that all survivors/victims can choose to use for their benefit. Similarly, all of the nurses I interviewed described the SAEK and all things associated with the exam as a survivors'/victims' choice. Several nurses stressed that in the SACTC, "everything is [survivors'/victims'] choice" (SANE1). In the "one-stop shop" (Burnett, 2007) of the SACTC, nurses present survivors/victims with what they describe as "a big menu…we just say, here's what we have to offer, take whatever will be of use to you, and leave the rest" (SANE7). Many nurses suggested that giving the survivor/victim the choice of the SAEK can counteract the lack of autonomy and agency that characterize sexually violent attacks: "we want to let them take some of that control back" (SANE1).

Medicolegal actors frame the SAEK as a tool that survivors/victims can use to regain some control, autonomy, and choice. However, by framing SAEK as an empowering choice, medicolegal actors obscure practices that limit and impede choice around the SAEK. In what follows, I use three points of medicolegal action that involve accessing, staging, and consenting to the SAEK in order to complicate and diffract the framing of the SAEK as an empowering choice. In doing so, I reveal how the SAEK is rarely stable for survivors/victims who do not fit the narrow definition of the ideal implicated user of the SAEK.

Before doing so, it is important to note that some survivors/victims do experience the SAEK exam as empowering. Du Mont, White, McGregor (2009) found that several of

the women they interviewed felt that the SAEK exam gave them an empowering course of action to take in response to their experience. However, equally importantly, many do not experience the SAEK in this way. Du Mont, White, McGregor also interviewed women who described the SAEK as a revictimizing violation that was akin to the sexual assault itself. The variability in women's experiences of the SAEK is an important backdrop to the following discussion of practice. By tracing the medicolegal practices that complicate choice around the SAEK, I do not mean to deny survivors'/victims' capacity to make choices in regard to the SAEK nor erase the range of experiences survivors/victims have with the SAEK. My interest is instead in what medicolegal actors do to impede empowering choices around the SAEK.

1) Accessing the SAEK.

Medicolegal framing of the SAEK as an empowering choice obscures the difficulties many survivors/victims have accessing the SAEK. With the advent of SANEs and SACTCs and their specialized expertise in the SAEK, emergency room doctors and nurses have become quick to refuse to conduct SAEK exams, and as a result, access to the exam has become more difficult. Medicolegal practices shape, and in some cases preclude, access to the SAEK exam, particularly for those survivors/victims who do not fit the definition of the ideal implicated user of the SAEK.[23] For survivors/victims whose geographical location, race, language, disability, residency status, and financial means

[23] In sketching the access restrictions on the SAEK, I am not arguing that the SAEK is necessarily a tool that *should* be accessed. Rather, I draw out these practices to investigate how the SAEK is enacted and whom it is enacted for.

prevents them from using the SAEK, the SAEK is not a stabilized tool that creates order. Instead, it is a tool that can create more trouble and perhaps private suffering.

A survivor's/victim's geographical location and access to safe transportation can severely restrict her capacity to access the SAEK exam. The 35 SACTCs in Ontario that provide SAEK exams are all in urban hospitals and are responsible for providing services for large geographical areas that often include both urban and rural communities for populations ranging from 11,000 to 1,000,000 people (Macdonald & Norris, 2007). One nurse humorously recollected her centre's geographical purview a few years ago by describing it as "an area bigger than France, with room to spare" (SANE5).

As a result of the SACTCs' established claim to expertise in sexual assault treatment, many other hospitals that do not have SACTCs refuse to treat survivors/victims and instruct them to travel to the nearest SACTC, which in some cases can result in up to three hours of driving.[24] In northern Ontario, survivors/victims have to fly to the SACTCs in Sioux Lookout, Kenora, or Thunder Bay. In these cases, survivors/victims must either finance air travel themselves, apply for air travel funding from their employer, or, if they live on a reserve and are eligible, from their band council (PA2). Receiving air travel funding often requires a detailed rationale and documentation, which can mean that survivors/victims are forced to disclose that they have been assaulted (SANE4). Travel arrangements must be made within the SAEK's prescribed one-week window, if a survivor/victim wants a SAEK exam. The geographical dispersion

[24] There are some exceptions, particularly in some remote northern Ontario communities, where access to urban SACTCs is severely restricted. In some of these communities, SACTC nurses are providing outreach training for nurses who conduct the SAEK exam (SANE7).

of the SACTCs helps to enact the SAEK as a tool that can only be used by survivors/victims who have the means, access, and financial capital to secure safe transportation, as well as the time, and/or the desire to travel long distances immediately following a sexually violent attack.

In addition to the challenges that geographical distance poses, accessing the SAEK exam also requires that a survivor/victim has access to information about what the SAEK is and where it is done, which is often only available online or at public educationals. She must also have the English or French (if the centre provides bilingual service) language skills to navigate the hospital emergency rooms and the SACTCs or be comfortable with the translators they provide, who are in some cases are available only by phone (RCC2). She must have an OHIP or Canadian health card, or another health insurance equivalent, which, depending on her immigration status, she may not (RCC11). She must also have confidence in professionalized medical services to respond to her respectfully and equitably, which, if she is a woman of colour or an Aboriginal woman who has experienced racism in institutional contexts, she might not. One Indigenous rape crisis centre worker described how access to the SAEK can be troubled by racism in the medical system,

> It would be white faces in the hospital. And most of women coming through the door are Indigenous…A lot of the hospitals in the North are notorious for poor treatment of Indigenous people…So it's not like you are going to walk through the door and see yet another white person in this hospital system and feel

immediately safe. That doesn't happen. So many people just get so tired of struggling with the mainstream organizations, they just don't bother (RCC7).

In addition to her faith in how she will be treated, the woman who accesses the SAEK must also have some confidence that she will be believed, which many women do not, particularly those who have been branded with psychiatric labels from other medical experts in the past. Another rape crisis centre worker explained these difficulties around access by asking the rhetorical question, "if you have disabilities, or you have mental illness, or you are a young woman whose…[been] medicated or diagnosed...are you going to the same profession to try to be believed?" (RCC3). According to many rape crisis centre staff, survivors/victims who do not fit the ideal profile of women using the SAEK, choose not to access the SAEK exam (RCC2; RCC1; RCC6).

Access restrictions on the SAEK also play out in the context of the exam. The SAEK's protocol for taking, and often not returning, survivor's/victim's clothing for the purposes of analysis can present barriers for women experiencing poverty. Several rape crisis centre workers and some nurses described instances where women were pressured to give up their clothing despite the fact that they did not feel they could afford to do so. One rape crisis centre volunteer said, "I remember distinctly one woman saying 'do you know how much jeans cost? I can't afford that!'" (RCC8). A nurse recalled a debate she had had with a police officer about the efficacy of seizing a child survivor's/victim's only winter coat, during which the police officer argued that the coat was necessary to "set the scene" despite the fact that it was winter and the child's mother had expressed concern about how she would afford another coat (SANE7). The SAEK's protocol for seizing

clothing enacts the SAEK as a tool that is only accessible to those who can afford, and are willing, give up some of their personal possessions.

The restricted access to the SAEK enacts the contemporary ideal implicated user of the SAEK: a survivor/victim who has the financial means, the residency status, the language, and the faith in the medical system to support her accessing the SAEK exam. Since the medicolegal practices are geared towards supporting her, the ideal implicated user of the SAEK may feel the stability of the SAEK and its network. She may even benefit from it if she wants her perpetrator to be convicted and the SAEK helps to facilitate this. However, for the woman sitting outside of the bounds of the ideal implicated user, the SAEK has little stability and is likely to be of little benefit.

For those survivors/victims who do access the SAEK, the choice of having an SAEK exam is often shaped by pressures to follow and consent to the SAEK's forensic script. Chandler (2010) suggests that technologies can erode choice and autonomy when they are considered to be indispensible to action and are configured as "offers you cannot refuse" (p. 15). In what follows, I trace the medicolegal practices that turn the SAEK into an offer that survivors/victims cannot easily refuse, by looking at how the SAEK is *staged*[25] and how (un)informed consent for the SAEK is obtained.

2) Staging the SAEK.

Medical and legal actors (nurses, doctors, police, and victim services) stage the SAEK in ways that are often geared towards defining a survivor's/victim's choice to have the SAEK exam. This is done most clearly by police investigators, who become involved

[25] I use the word staging to refer to the series of practices that medicolegal actors take to present, describe, and at times, moralize the SAEK exam to survivors/victims.

in staging the SAEK if a survivor/victim reports her assault to the police within the SAEK's 72-hour time frame. While many police officers I spoke with insisted that they routinely give survivors/victims a choice about whether to have an SAEK exam, some of their practices suggest otherwise.

Police often stage the SAEK with explicit or implicit depictions of the SAEK as a necessary tool for achieving "justice" (P10). By doing so, police assert the SAEK's stability as a necessary tool in medicolegal practice. Often police's staging of the SAEK is coupled with a deliberate disregard of a survivor's/victim's interest in having a SAEK exam. One nurse described an interaction she observed, where a police officer explicitly described the SAEK as entirely necessary:

> There was a young woman who was in here who was sexually assaulted and the police kept saying 'you've got to do a rape kit, you've just got to do a rape kit!' And she said, 'why do I have to? I don't want to. I know him, I know who did this to me, why do I have to do a kit?' And the police kept saying, 'well we need the evidence!' (SANE2).

Not all staging practices are as aggressive and explicit. One police officer claimed, "I've never had a person outright refuse a kit. I've had them say no, and I'll just sit them in the car, and I'll drive them there myself, and I'll say 'well we are here now, let's go in and do it'" (P1).[26] He continued by saying, "they are usually pretty *up for anything* as far as we *need* to get this done" [emphasis added] (P1). Other police officers claimed that they always tell survivors/victims that the SAEK is "voluntary" (P2) and that they never

[26] The "drive" this police officer referred to was to an SACTC in a neighbouring city, a half an hour away.

"insist on doing something medically to her that she doesn't want" (PA1). However, many officers also claimed that they commonly describe the SAEK as a tool that will ensure "a more thorough investigation" (P10) and will give police "a better shot at finding who did this, so that he won't do this to you or anybody else again" (PA1). Another said that he describes the SAEK as a step the survivor/victim can take to "help us out," and in return, police can "giv[e] them some sort of justice" (P10). Survivors/victims who have been coerced into going to a SACTC and have been told that the SAEK is a necessary step for ensuring the safety of themselves and others are given little room to choose not to have an SAEK exam.

SANEs often have different staging practices around the SAEK. Many SANEs I interviewed stressed that they routinely tell survivors/victims that the SAEK is not compulsory and instead, present the SAEK as one of the many options at the SACTCs. This finding could be understood through Du Mont and Parnis's (2003) research that suggests that SANEs are less likely to perceive the SAEK as important and are less likely to encourage survivors/victims to have an SAEK exam. However, several rape crisis centre workers provided a different view. Some contended that some SANEs indirectly shape and control survivors'/victims' choices by excluding discriminating information in their description of the SAEK, such as the limited chances that it will contribute to a conviction (RCC7; RCC9; RCC11).[27] Others suggested that the choice that most SANEs presented is a false one. One explained,

[27] See Du Mont and White (2007), Johnson, Peterson, Sommers, Baskin (2012), and McGregor, Du Mont, & Myhr. (2002).

> I think there is a tendency within the sexual assault treatment program to say 'women who have been sexually assaulted in the following ways should have the following exams, and should have the following medical treatment' and there is a tendency to sort of give the choice, but it is sort of a prescribed choice (RCC7).

These observations suggest that SANEs can at times stage the SAEK in ways that reinforce the SAEK's forensic script and stability in medicolegal practice and in so doing, place boundaries on a survivor's/victim's choice in the SAEK exam.

Medical and legal actors stage the SAEK differently for different women. According to many rape crisis centre workers, women of colour, Aboriginal women, disabled women, women in the sex trade, and women experiencing poverty are far less likely to be encouraged to have an SAEK exam and more likely to be dismissed as unbelievable (RCC1; RCC7; RCC6; RCC8). Many of these activists contended that white, middle class women were far more likely to be seen as "undeserving victims" (RCC7) and more likely to be pressured to have the SAEK exam. The SAEK and its stability is thus staged differently for different survivors/victims, and therefore is experienced unevenly. In this context, choice carries little meaning when women are pushed to either adhere to the SAEK's forensic script or accept that the script was not designed for them.

The medicolegal staging practices around the SAEK reinforce notions of the ideal implicated user of the SAEK who follows the SAEK's forensic script and participates in forensic evidence collection to protect herself and others from violence. One survivor/advocate recalled how much pressure she felt to be the ideal implicated user

during her own experience in the SAEK exam; "all I was thinking was 'be the best possible patient, be the best possible victim, answer all the questions" (SA1). Some rape crisis centre workers shared a similar sentiment when they described what they often hear from survivors/victims: "they say 'well I need to go get the evidence, like I'm not a *good citizen* if I don't do that and get this guy off the street'" (RCC3) and "am I being a *bad victim* if I don't want to do this?" [emphasis added] (RCC3). Medicolegal staging of the SAEK exam as necessary or an expected action reinforces the SAEK's forensic script and the expectations of being the ideal implicated user that are embedded within it. Medical staging of the SAEK thus situates the tool as one that is difficult to refuse for some and is unavailable for others.

3) Obtaining (un)informed consent.

If a survivor/victim chooses to have an SAEK exam, she must first give her consent, which she expresses in the written consent form(s) that accompany the SAEK.[28] Here, I examine the medical actors' practices of obtaining what I am calling (un)informed consent[29] to the SAEK exam.

According to the SAEK protocols, "patients must be able to understand the information that is *relevant* to making a decision about the use of the kit and be able to

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[28] In the 2001 revision of the SAEK, two separate SAEK consent forms were drawn up: one that indicates consent to the exam, and another that indicates consent to police seizing the SAEK for analysis (Griffiths, 1999). Survivors/victims can "choose" to skips parts of the SAEK exam (although not the DNA buccal swap, which is required for all SAEKs) or stop it at any point once it has begun (SANE1). However, according to many rape crisis centre workers, these "choices" can be later used as evidence that she is not being truthful.

[29] By using the phrase (un)informed consent, I do not mean to suggest that survivors/victims are not able to provide informed consent to the SAEK. Some survivors/victims have past experiences with the SAEK, informed advocates, access to resources, and other supports that facilitate their informed consent to the SAEK exam. What I trace in this section are the *medicolegal practices* that limit, and in some cases preclude, women's informed consent to the SAEK.

appreciate the reasonably foreseeable consequences of a decision or lack of decision" [emphasis added].[30] This definition mirrors the Ontario Health Care Consent Act's (S.O. 1996) definition of informed consent, which states that consent is only informed if patients are given an explanation of a medical treatment's benefits, risks, side affects, alternatives, and the consequences of not having the treatment. In the context of the SAEK exam, medicolegal actors have significant freedom in defining what information about the SAEK is relevant for survivors/victims.

In her study on women's experiences of the SAEK exam, Doe (2012) found that most women are given very limited information about the SAEK. Of the twelve survivors/victims that Doe interviewed, none were informed about how the evidence would be used after it was collected and the possibility and likelihood that it could be used against her during the investigation and/or the trial. From this, it is clear that medical actors narrowly define relevant information on the SAEK to the actions within the exam room.

> *"It felt more immediate, like this is what we are going to do, and this is what happens... it wasn't necessarily saying 'this is how the evidence is going to be used, or not going to be used.' They didn't go into that kind of detail. It was just very concrete, like this is what's happening right now... I don't feel like they gave a big back story to the implications of what can happen with the evidence or how it can be used or not used" (SA2).*

Several medical and legal actors justified the limited information that survivors/victims receive on the SAEK by suggesting that trauma can inhibit or preclude survivor's/victim's capacity to understand complexities. One nurse said that she always explains the SAEK by describing the steps it involves "in the simplest terms as possible" (SANE7) so as not to overwhelm survivors/victims with too much information. While the

[30] CFS, "Hospital Instructions," (2012), obtained through FOI request to the Centre of Forensic Science, no. CSCS-A-2012-03930.

intention driving this practice may be to provide a more sensitive service, it arguably reinforces paternalistic and homogenizing understandings of survivors/victims as traumatized women who do not want, or cannot handle, a more detailed explanation of the SAEK and its implications. One police administrator who trains hundreds of sexual assault investigators in Ontario bluntly articulated this understanding of survivors/victims when she said;

> People who are sexually assaulted, they are in a terrible terrible turmoil and...when something really awful happens to you can't go to the logical side of the brain, you are thinking emotionally, you can't reason, you can't make sense of things, and you can't remember things. And we know that (PA1).

The assumption that women in trauma are incapable of logical thought has pervaded the handling of the SAEK since its origins[31] and has been used to rationalize the absence of detailed information about the SAEK beyond the exam room. Without information about how the SAEK can act outside of the exam room, it seems questionable whether survivors/victims can give informed consent to the SAEK exam.

Determining capacity to consent.

The practices for obtaining (un)informed consent change when a survivor/victim is deemed to be incapable of giving consent, such as in cases where she is heavily intoxicated or unconscious. In the Ontario Network of SACTCs, debates ensued in the mid 2010s around the efficacy of collecting forensic evidence from unconscious

[31] The booklet that accompanied the first SAEK in 1979 warned medicolegal practitioners that, "individuals in crisis are severely disorganized and have difficulty making decisions" (Provincial Secretariat for Justice, 1979a, p. 52). This understanding of women who experience sexual assault is clearly still firmly entrenched.

survivors/victims. These debates are particularly significant as they reveal the value that medicolegal actors place on informed consent in the context of the SAEK exam.

According to the Ontario Health Consent Act (S.O. 1996), other individuals, who are deemed to be authorized substitute decision-makers, can consent to medical treatment on someone's behalf when medical staff deem an individual to be incapable of giving consent (s. 40.1). Although this section of the Act gives medical practitioners permission to treat unconscious patients, the Act does not formally extend to non-medical forensic procedures such as the SAEK exam (Macdonald & Norris, 2007). The debates in the Ontario Network of SACTCs in 2010 on collecting forensic evidence from unconscious survivors/victims were centered on the larger question about the extent to which the Act, and its allowance of substitute decision-makers, informally applies to the SAEK exam.

In a SACTC Network newsletter in 2005, Alice Stoner, a SANE in Ontario, suggested that nurses' decisions to collect evidence from unconscious survivors/victims are "ethical dilemma[s]" (p. 3). She argued that there are "equally compelling ethical reasons" (p. 3) to give a survivor/victim the ability to consent to an SAEK exam and to give a survivor/victim the "opportunity" (p. 3) to have forensic evidence collected, despite her unconscious state. In Stoner's analysis, a survivor's/victim's right to consent to forensic acts on her body was equally weighted with her right to an SAEK exam. Joanne Barbera challenged Stoner in a subsequent newsletter in 2006 when she argued that it is not legally or ethically sound to conduct SAEK exams on unconscious survivors/victims and that the Ontario Health Consent Act and its allowances for substitute decision-makers do not apply to the SAEK exam. These debates were largely

settled by 2007 when the provincial network of SACTCs devised a set of guidelines for evidence collection from survivors/victims who cannot consent (Macdonald & Norris, 2007). Although the guidelines state that "collecting evidence without consent is contrary to our own program values and philosophy" (p. 2), they lay out a series of steps for securing consent from substitute decision-makers to conduct an SAEK exam on unconscious survivors/victims.

Consent given? And private suffering.

Much of the existing scholarly research on consent in the SAEK exam suggests that survivors/victims commonly report that they did not feel that they gave consent to the SAEK exam. Du Mont, White, and McGregor (2009) found that many women did not know they had the option to consent. This finding was supported by Doe (2012) who found that the survivors/victims she interviewed had one of three experiences around consenting to the SAEK exam: "a) they had no memory of consent, b) they felt coerced into agreeing, or c) they believed their consent was necessary for the state to pursue criminal charges or otherwise "protect" them" (p. 15). In these experiences, I argue, lies some of the private suffering within the SAEK's stability in medicolegal practice.

> *"It wasn't explained what was going to happen... I have no memory of that... I didn't know what it entailed, I didn't know what it meant" (SA1)*

> *"That is the really frustrating part... you had no choice in your process over your own body. Again, just like the sexual assault. So people are doing things to your body and you don't even know what they are going to do next and you feel like you don't have a choice. You are trying to be as good as possible and oblige by all the rules and this is what you are supposed to do so you feel like you can't say anything or you can't say 'no stop this I don't want this done' because that is going to influence what happens later" (SA1)*

Ironically, many of the medicolegal practices for obtaining (un)informed consent to the SAEK exam would be

deemed invalid bases of consent in Canadian sexual assault law. In the Criminal Code of Canada, consent in the context of sexual assault is defined as a "voluntary agreement" that has *not* been obtained by "abusing a position of trust, power, or authority" (s. 273.1, 1992, c. 38, s. 1).[32] For many survivors/victims, police and medical practitioners are in relative positions of trust, power, and authority, and as such, it is questionable how their practices of securing consent, often through varying degrees of pressure, can elicit voluntary agreement. The Criminal Code clearly states that consent cannot be legally assumed if "the complainant is incapable of consenting to the activity" (s. 273.1, 1992, c. 38, s. 1). In sexual assault law, "incapability" has been most commonly been defined as a state of unconsciousness (R. v. Mullaney, 1998).[33] Upon this definition, medicolegal practices that involve conducting SAEK exams on unconscious survivors/victims is a clear violation of a survivor's/victim's bodily integrity. Given the fact that many survivors/victims have reported that they experienced the SAEK exam as a "second assault" (Doe, 2012; Du Mont, White, & McGregor, 2009; Du Mont & Parnis, 2003), perhaps the Criminal Code definitions of consent are more relevant to the SAEK than they may first appear. The current consent obtaining practices in the context of the SAEK exam may, for some survivors/victims, transform the SAEK into a tool that resembles and replicates the very act (sexual assault) that it promises to prevent.

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[32] Three other requirements stipulate that the consent cannot be expressed by someone other than the complainant and that no consent can be assumed if the complainant expresses a lack of agreement to participate or to continue participating in the sexual activity (s. 273.1, 1992, c. 38, s. 1).

[33] Incapability has also been defined as a more general state of incapacity to "understand the risks and consequences associated with the activity" (R. v. Siddiqui, 2004).

Consensual seizure of evidence?

According to Canadian common law, obtaining bodily samples from an individual in the context of a criminal investigation without her/his consent or a warrant "constitutes an intrusive invasion of [her/]his privacy and a clear breach of [her/]his s.8 Charter right to be secure from unreasonable search or seizure" (R.v. Farouk, 2004). As I described in chapter 5, this common law understanding of bodily evidence collection has arisen from the legal challenges around the constitutionality of collecting bodily evidence from suspects. It has been established in common law that obtaining bodily evidence *without* consent is an "intrusion of privacy" (R. v. Farouk, 2000), a violation of "bodily sanctity" (R.v. Stillman, 1997) and a "threat [to] bodily integrity" (R. v. S. F., 1997). If consent is obtained, common law has established that it must,

> *"You...feel like a piece of crap...I felt violated...[S]itting naked on a table with your legs spread, and someone in between your legs, and you're just like 'what the hell...this isn't right'...it was hell...the last thing I wanted is to be violated, sitting in a room half-naked having blood-work done and being touched" (survivor/victim cited in Du Mont, White, & McGregor, 2009, p. 777).*

> ...be voluntary in the sense that it is *free from coercion.* It must be made knowingly in that the consenter must be aware of what he is doing and aware of the *significance of his act* and the use which the police may be able to make of the consent [emphasis added] (R. v. Goldman, 1979).

In some cases, DNA samples taken from suspects have been deemed to be inadmissible evidence, because the consent upon which they were collected was deemed invalid because it was proven to be a product of police coercion (e.g. R. v. Farouk, 2000).

Legal understandings of (un)consensual bodily evidence collection have led to greater legal protections for suspects, such as the Criminal Code restrictions on obtaining warrants for evidence collection (s. 487.05) and the common law rulings on the necessity and nature of voluntary consent. I do not know of any existing legal argument that extends the well formed legal understanding of (un)consensual bodily evidence collection from suspects to the survivor/victim who undergoes the SAEK exam. In the case of the SAEK, consent is the hinge upon which the exam is considered to be a legal search and seizure of bodily forensic evidence.[34] However, given the fact that medicolegal practices for obtaining consent to the SAEK at times includes *coercion* and lack of information about the SAEK and its *significance*, the SAEK exam is perhaps on more dubious legal grounds than has been previously considered. Perhaps this will be a source of future instability in the SAEK in the years to come.

Reading the SAEK: Making (meaning of) visible traces.

Once a SAEK exam has been conducted and submitted to the police for analysis, its contents are analyzed and read in the context of the police investigation and possibly in a subsequent criminal trial. Reading the SAEK constitutes the final point of medicolegal action that I will trace. In chapter 5, I described many of the scientific practices that make the SAEK's contents *speak.* Here, I describe the practices that medical and legal actors use to make the SAEK's contents visible and to interpret the meaning of the SAEK's visible contents; a process that I am calling *reading* the SAEK.

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[34] In *R. v. Borden* (1994), it was found that "where there is no statutory authorization for the seizure of bodily samples, consent must be obtained *if the seizure is to be lawful* [emphasis added]."

As I will show, there are several controversies brewing amongst medical and legal actors about how to read the SAEK's contents. These controversies, I argue, are creating some degree of instability within the contemporary SAEK and its network. Many of these controversies, are centered on the question of whether sexual assault is visible on sexually violated bodies. As the history of the SAEK has shown, *visibility* is a product of the tools and modes of analysis that medicolegal actors use to see: what is made visible shifts with changes in technologies, legal definitions, and medicolegal practices. In tracing the controversies around visibility, it is crucial to remember that visibility is an outcome of action, and not an inherent state. In the existing controversies around how to read the visible SAEK contents of DNA profiles and evidence of injury, I will show how the value of the tool itself has been put on trial.

Seeing traces of injurious sexual assault.

As I described in chapter 4, SANEs document traces of visible injury on the SAEK body maps and with photography. They also use several tools to see traces of forceful sexual activity that might not be visible otherwise (White & Du Mont, 2009). Some of these include: the colposcope, which is a large binocular microscope that nurses use to magnify and photograph micro trauma in and around a woman's vaginal cavity, and toluidine blue, which is a liquid dye nurses use to determine the extent of cellular damage in and around a woman's vagina.

Many current victimization surveys, medical reports, and scholarly articles concur that visible physical injuries in sexual assault are rare (Brennan & Taylor-Butts, 2008; Du Mont & White, 2007). In 2008, Statistics Canada reported that 77% of sexual assaults

involve no visible signs of physical injury (Brennan & Taylor-Butts, 2008). While several nurses and a few police officers and lawyers interviewed in this study referenced the fact that visible injuries are rare, many described the ways that visible injuries are still used as indications of lack of consent, and therefore of sexual assault.

When I asked police officers how they determine if a sexual incident was consensual, many responded by saying that they look in the SAEK for evidence of trauma (P11), bruises (P2), torn clothing (P9), broken buttons (P2), skin under a survivor's/victim's fingernails (P6) and "redness, soreness, or any marks on the vagina" (P1). One police officer described visible injuries as "good solid medical evidence that will support the crown's case when [the defence] are arguing consent" (P2). Many crown and defence lawyers also described how injuries are useful in illustrating non-consent. These statements reveal that legal actors' continued expectation of visible signs of force and suggest that many of the legal practices around sexual assault in the 1970s and early 1980s that required evidence of force and violence, which I described in chapter 3, have not significantly changed.

Over the past several years, SANEs have increasingly been called as expert witnesses to testify that consent to a sexual act cannot be assumed from a lack of visible injuries (CA1; P4; P5). Through SANEs expert testimonies, current medical understandings of how sexual assault appears (or does not appear) on violated bodies have moved into the courtroom and have been debated in cross examination. Several defence lawyers described their common tactic that involves challenging SANEs' capacity to give expert evidence on injuries by arguing that SANEs do not have

experience or training in examining women who have consented to the sexual activity, and therefore have no valid basis of comparison to the non-consenting bodies that they examine. In *R.v. Thomas* (2006), defence lawyers laid out a clear attack on the testifying SANE's expertise, and in so doing, successfully discredited the existing medical knowledge around injuries in sexual assault by proposing that "there is no science that can deal with whether the injuries are the product of a consensual sex or not."

Defence lawyers have used the claim that there is "no science behind" the meaning of injuries in sexual assault to argue that the presence of injuries does not necessarily indicate a lack of consent. One defence lawyer told me that he commonly argues in court that bruising and tearing in a woman's genital area is "fully consistent with vigorous or clumsy intercourse or foreplay" (DL3) and is therefore meaningless evidence of lack of consent. Another defence lawyer, touting a similar claim, described how she discredits evidence of vaginal redness and soreness by asking women on the stand questions such as, "where are you in your cycle? If you are far from ovulation, do you have dryness issues? Is that customary? Do you normally have to use a lubricant?'" (DL3). According to many rape crisis centre workers, police often mirror these practices and discount any signs of violence in the SAEK as indications of sexual activity or bodily function. One described this by saying: "we've heard horror stories...everything from 'she inserted her tampon roughly' [to] 'the bleeding was probably her period'...everything can get explained" (RCC3).

"In cases of sexual assault, evidence doesn't actually matter" (SA1).

Seeing traces of DNA.

DNA profiles are another way that the contents of the SAEK become visible. In chapter 5, I described some of the scientific practices that are used to transform bodily evidence into DNA profiles. Despite the excitement around DNA evidence as a revolutionary technology for sexual assault investigation, it is not routinely found in SAEK contents. In a study at a Canadian laboratory, DNA profiles were retrieved from only 32% of SAEKs (Gingras et al., 2009).[35] Making DNA visible can be hindered by decay in samples, testing procedures, and delayed collection of bodily evidence (FS1). Additionally, if a perpetrator uses condoms, masks, gloves, or inanimate objects and/or he does not ejaculate during the assault, DNA traces are far less likely to be found (Ledray, 2001).

> *"I wasn't feeling like I was believed, I wasn't feeling like I could provide any more evidence, I'm like 'well what about the tear, I don't understand is that not evidence?' And the investigating officer's response was 'oh you could have like it like that' meaning, I could have liked it rough. So that's that. Basically it's like fruitless evidence" (SA1).*

Despite the difficulties in making DNA evidence visible, its weight in the courtroom still looms large, so much so that the absence of DNA evidence often carries its own weight. Many lawyers (both crown and defence) that I interviewed discussed how useful no DNA evidence can be for the defence. One defence lawyer described this by saying, "non evidence becomes evidence" (DL1). Another explained,

> We live in an era now where everybody has watched all these CSI programs and stuff, jurors in particular expect scientific evidence…if it comes back with no DNA for instance, I find that is helpful, because it is like the science processes

[35] When other exhibits were included, such as the survivor's/victim's clothing, the percentage was raised to 50%.

didn't work, and they haven't come back with anything, that's almost worse than not doing any science at all (DL2).

The prevailing view that DNA analysis is an objective, fail proof science supports the inference that the lack of visible DNA indicates that a sexual assault did not happen. Another defence lawyer summarized, "from my standpoint the best possible result is we did a sexual assault kit and we didn't find anything" (DL6).

When DNA is visible, many police, nurses, and lawyers I interviewed agreed that DNA is rarely useful in legally demonstrating that a sexual assault occurred. While there is consensus amongst most actors that DNA evidence can identify *who* was involved in a sexual act, most of the medicolegal actors that I interviewed emphasized that DNA evidence does not reveal *how* a sexual act was committed, in particular, whether the act was consensual or not. According to the Criminal Code of Canada, lack of consent must be demonstrated in court for a sexual act to be legally considered a sexual assault. In the Canadian courtroom, DNA evidence can make a sexual act visible, by revealing traces of DNA profiles in regions of the body that are considered to be sexual, but cannot make the non-consensual act of sexual assault visible. Several police and lawyers concurred that the most common defence that perpetrators use in sexual assault cases is that the act was consensual, and in those cases, DNA evidence is rarely helpful. Legal actors' acknowledgment of the SAEK's limitations echoes many of the early arguments anti-rape activists forwarded against DNA evidence I charted in chapter 5.

The SAEK's inability to reveal consent (or lack thereof) to a sexual act has lead many actors to question the value of the tool. Some medicolegal actors criticized the

SAEK by suggesting that when a perpetrator's defence is consent, the SAEK and its contents become a "moot point" (P3) that offers little insight into whether a sexual assault occurred. A defence lawyer questioned the SAEK's value to the police and crown prosecutor by saying,

"It is my word against his, and he is saying that I consented and I am saying I didn't, then the evidence kit is worthless, it is nothing. Because I could have consented to everything that the kit is examining... it's bullshit" (SA1).

> So if I'm right that the...primary benefit of the sex assault kit is to ID the perpetrator, because most of them are between people they know, then *where's the value*? Because even if there are injuries, minor injuries, like nothing major, but if there is some minor redness, that doesn't mean they didn't consent [emphasis added] (DL3).

The defence lawyer's question, "where's the value?" was answered by several police and defence lawyers, who described how the SAEK is in fact valuable to them, despite the fact that it does not reveal consent and has a contested capacity to make sexual assault visible.

Testing "truth" with the genetic technoscientific witness.

Many police officers and defence lawyers described the SAEK as a valuable tool for determining the truthfulness of a survivor's/victim's narrative of sexual assault. In doing so, they described how the SAEK acts as the technoscientific witness of sexual assault that tests the truth of a survivor's/victim's report of sexual assault. In this section, I consider the ways that the SAEK is read in ways to determine "truth" and reveal how

the SAEK's stability as the technoscientific witness benefits many medicolegal actors, but rarely benefits survivors/victims.

In the context of police routinely disbelieving survivors/victims and accusing them of falsely reporting sexual assault, police often use the SAEK to determine whether a survivor/victim is telling the truth in her sexual assault report. According to many of the police officers that I interviewed, the SAEK "helps with false allegations" (P1; P4; P5) by revealing evidence that it does not corroborate with a survivor's/victim's statement and the degree of commitment a survivor/victim has to her report of sexual assault.

> *"I believe that the overriding purpose of forensic testing is not to collect evidence to catch the rapist but to validate a woman's claim that she has been raped... her story is not believed by investigating officers until a medical professional confirms it verbally and in writing.. if cuts, bruises, emotional trauma or, most important of all, rape sperm are not collected in the kit, the police are predisposed to believe that the woman is lying, that no crime has occurred... they are experienced as a second assault" (Doe, [a woman who was raped], 2003, p. 305)*

Many scholars have noted that the SAEK is used for assembling *corroborative* evidence of sexual assault, despite the 1983 rape law reforms that made corroborative evidence unnecessary in cases of sexual assault (Feldberg, 1997; Parnis & Du Mont, 1999; Doe, 2003, 2012). In keeping with these findings, several police investigators described the SAEK as an objective tool for assembling corroborative evidence and claimed that it assists them in testing the accuracy of a survivor's/victim's story. Many said that when the SAEK reveals evidence that does not corroborate a survivor's/victim's statement, it is invariably the case that the survivor/victim has issued a false complaint of sexual assault. In police practice, the SAEK and its evidence are given the status of objective truth, and the survivor's/victim's statement, the status of an untested, non-

credible narrative. Baeza and Turvey's (2002) police training manual explicitly instructs police officers to assume the objective accuracy of the SAEK when testing the validity of a survivor's/victim's report of sexual assault. They begin their chapter on "false reports" with a quote that reads,

> When physical evidence runs counter to testimonial evidence, conclusions as to physical evidence must prevail. Physical evidence is that *mute but eloquent manifestation of truth*, which rate high in our hierarchy of trustworthy evidence [emphasis added] (p. 169).

Reflecting this sentiment, one police officer said of the SAEK, "when you know the truth, you know the truth. It's there in black and white. So that's what I use the kit for" (P6). From this, it is clear that police use the SAEK as the technoscientific witness that promises to tell the truth about women's reports of sexual assault.

Some police described how they read the SAEK to test a survivor's/victim's commitment to her story and determine if it is true. These assertions were commonly coupled with assumptions that the "real rape victim" (Estrich, 1986, p. 1088) would want a SAEK exam and that false complainants would not. One police officer clearly articulated how the SAEK is used in this way,

> *"A kit was done so they could find out if you were lying. I thought it was like a proof kit so that... the police had proof that the woman was actually telling the truth... I never thought it was for evidence... against the perpetrator... against the person who has done the crime" (survivor/victim cited in Du Mont, White, & McGregor, 2009, p. 777).*

> Sometimes there's complainants that come in and maybe the details are a little

> sketchy and you are not sure if this is going to be legitimate or not and you ask them to...have the kit done...and the prospect of that...in a false allegation is too big of a step for someone to follow through on and they withdraw their complaint. So...there's definitely going to be the odd case where you are stopping an unfounded allegation at the onset, once they realize what is involved (P2).

In this description, the SAEK is so closely coupled with truth that it can be used to threaten potential false complainants. This reveals how the police use the SAEK's stability as the technoscientific witness against survivors/victims.

The SAEK's stability serves the interests of police who want to test the "truth" of women's reports of sexual assault. Alderden and Ullman (2012) suggest that the odds of an arrest in sexual assault cases decrease by 57% when a survivor/victim refuses to have a SAEK exam. These practices suggest that some police have turned the SAEK on survivors/victims, despite anti-rape activists' and many medicolegal actors' hope that the SAEK to work in survivors/victims interests (chapter 3). Similar practices exist in the sexual assault courtroom.

"Fodder" for the defence.

In court, defence lawyers often read the SAEK to discredit survivors/victims and their reports of the assault. They use the SAEK's stability as an objective witness against the survivor/victim. Many of the crown and defence lawyers stated that, apart from the DNA evidence that can identify a perpetrator, the SAEK contents are often more useful to defence lawyers than they are to crown prosecutors. One crown prosecutor expressed her frustration with her common experience of the SAEK contents "backfiring" on her in

court (DL3). She said, "it's always been *fodder* for cross-examination and rarely would I ever tender it for my benefit" [emphasis added] (CA4), an idea that was reiterated by a defence lawyer who said that the SAEK is often useful "*fodder* for cross examination" [emphasis added] (DL3).

Many defence lawyers described how they use the SAEK to identify inconsistencies between the SAEK reports and survivors'/victims' police statements and testimonies in court. This strategy, according to some defence lawyers, throws the survivor's/victim's credibility into question, and alongside it, her description of the assault. The strategy hinges on the assumption that *real* narratives of trauma are consistently told, regardless of who is listening, where, when, for what purpose, and under what conditions. One defence lawyer described how a survivor's/victim's level of intoxication, which the SAEK reveals, is "usually a big area that is ripe for cross examination. Because she will say 'oh no I was terribly intoxicated,' 'really well you told the nurse you had two drinks, how intoxicated were you?'" (DL3). Another claimed that small details in the nurses' description of how the survivor/victim described her own injuries in the SAEK can be useful in cross examination: "[alongside] one of the marks [on the body map, it] states 'may have occurred tonight.' So I'm able to say 'that's the word that she used? May?" (DL2). Defence lawyers also use the SAEK body maps to note inconsistencies between survivor's/victim's description of the force that was used, and the visible marks noted on her body. One explained,

> If the narrative that she tells 'I struggled he had me down and then he bit me, then he used his knees to pry my thighs' you would expect there to be some kind of

> marks or bruises that go along with that narrative. So in that case, you would say, things like 'none of those things are there, so when he bit you, there is no mark, so he didn't bite you, you are not being truthful, it was on consent' (DL3).

The ways in which contemporary defence lawyers read the SAEK mirror the defence tactics Mr. Edelson proposed in his 1988 training session on "whacking the complainant hard" (Schmitz, 1988, p. 43), where he explicitly stated that the doctor's report is one of the most useful sources for the defence (chapter 4).

Given how defence lawyers read the SAEK in court, one defence lawyer claimed that the SAEK is often "more helpful to the defence than it is to the crown" (DL3) and suggested that more often than not, the outcome is not worth the discomfort the SAEK often causes survivors/victims. She gave the following advice on the SAEK, "unless it is a stranger, you know, you were the one walking down the street and someone jumped out of the bushes, my personal opinion is, I would be telling somebody *not* to do it" [emphasis added] (DL3). Coming from an actor who claims to benefit from a survivor's/victim's choice to have a SAEK exam, this advice is quite an indictment of the verity of the SAEK.

Have "they turned it against us?"

Many of the rape crisis centre volunteers and staff that I interviewed argued that the SAEK is a useless tool that perpetuates an ineffective system that disbelieves women reporting sexual assault. They described the tool as "absurd," (RCC7) "a joke" (RCC9), and "just another procedure…that revictimizes [women's] bodies" (RCC8). One rape crisis centre worker commented on the extent of resources that have been invested into

making the SAEK work, from the costs of the SAEKs to the resources supporting SANEs, SACTCs, and forensic labs. She said, "it's sort of hilarious, all this for what?!" (RCC1). Not all rape crisis centre staff agreed however. Some claimed that the SAEK is a "good tool" that has "given some women some comfort" (RCC11) by providing the evidence that is necessary to move some women's reports of sexual assault forward in the legal system. These differing claims about the SAEK point to a continued controversy amongst marginal actors over the SAEK's efficacy.

I asked rape crisis centre workers if they believed that the SAEK had been turned against survivors/victims and the activists that fought for its development in the 1970s, as the activist at the conference in 2009 suggested at the start of this chapter. Some disagreed, claiming that the SAEK "has made a difference" (RCC11) and others said that they did not know the SAEK's history well enough to comment. Several others, however, adamantly agreed. One explained,

> Everything that has been brought forward, everything including the kit, has then turned around and been used against us... we fought for that and of course...it doesn't work. And the only reason that none of this works is the institutions themselves have never been ones to understand violence against women, protect women, or believe women. They are set up to maintain the same oppressive structures that create violence against women in the first place (RCC3).

Another reflected on the relationship anti-rape activists have had over the 34 years of the SAEK. She said,

> We want to be able to have a voice, to have an impact in shaping it. But...how it is used, how it is perceived, we don't have control over that. So you tell yourself that if it is going to have one then you midaswell participate to make it the best that it can be, and then whoever is using it that will use it according to their own framework (RCC11).

In reflecting on their own history, these anti-rape activists revealed how technologies can be reshaped and redefined through practice. They echoed the process that feminist-STS scholar Katie Hasson (2012) has described of technologies gaining their politics not through their design, but through their use. While there may be no consensus on whether the SAEK has been "turned against us," I argue in this dissertation that a diffracted image of the SAEK reveals how it has been defined and used in medicolegal practice in ways that benefit many medicolegal actors but few survivors/victims.

Concluding Thoughts

The SAEK acts and is enacted in a flow of medicolegal practice that is geared towards testing the "truth" of women's reports of sexual assault. Despite continued controversies, the SAEK has maintained some stability as the technoscientific witness, stability that benefits police and defence lawyers investigating the veracity of women's reports of sexual assault. The SAEK's stability for these medicolegal actors has, however, come at a cost. It often works against survivors/victims who do not fit the mold of the ideal implicated user of the SAEK or do not follow the SAEK's forensic script by not preserving their bodily evidence or choosing not to have an SAEK exam. For these survivors/victims, the SAEK and its network are not stable, but are instead more likely to

be a source of trouble and private suffering. This private suffering is an essential part of the SAEK's network for it is central to the contemporary SAEK's stability as the technoscientific witness of sexual assault in the medicolegal network.

Chapter 7
Conclusion

In this study, I have diffracted the contemporary Sexual Assault Evidence Kit (SAEK) to reveal how the tool and its network have shifted historically through technoscientific controversy, anti-rape activism, legal reform, and changing medicolegal practice. I have sketched how the SAEK has been reassembled in meaning and in material form alongside new technologies, medicolegal spaces, actors, and expertise. Next to these changes, I have explored how expert domains of sexual assault nursing and forensic sciences for the SAEK have coincided with medicolegal actors displacing rape crisis centre workers from the SAEK's network and transforming feminist anti-rape advocacy and agendas. I have sketched how rape crisis centre workers began in the 1970s as instigators, designers, and assemblers of the SAEK and how in 2013, they have been largely displaced by expert actors taking over design, education, and advocacy around the SAEK. Through these shifting and entangled relations, this dissertation has shown how the SAEK was stabilized as the objective and credible technoscientific witness of sexual assault in the contemporary medicolegal network. I have argued that the design, continued use, and credibility of the SAEK as the technoscientific witness has been fuelled by legal histories and practices in which women who report sexual assault are not believed.

By diffracting the SAEK and illustrating the tool's histories and contemporary uses, I have sought to make feminist interference patterns in the contemporary SAEK. By illustrating how the contemporary SAEK gained stability and how its stability does not

benefit all survivors/victims, I have sought to contribute to future feminist imaginings of more ethical and responsible alternatives. Haraway (1997) contends that diffraction and feminist technoscience inquiry "is a speculum,[1] a surgical instrument, a tool for widening all kinds of orifices to improve observation and intervention in the interest of projects that are simultaneously about freedom, justice, and knowledge" (p. 191). Through a diffracted imagining of the SAEK, I have sought to widen possibilities for observation and further feminist intervention into the contemporary SAEK.

This project of diffracting the SAEK is incomplete and is necessarily so. In this chapter, I outline some of the future studies that could build directly on the findings of this study. I then trace how the SAEK and its networks may (de)stabilize in the years to come. I use these possibilities as a way of imagining more ethical and responsible modes of enacting the contemporary SAEK in medicolegal practice. I will conclude with a discussion of this study as a *potential* additional actor in these future networks.

Future Studies

As I stated in the introductory chapter, this dissertation is a *partial* documentation of the SAEK's history. Partial histories are not failed or inadequate histories, but are instead inevitable results of methods for inquiry, which according to Law (2004), always involve bringing certain actors, practices, and relations into the foreground, while pushing others into the background.

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[1] I insert this metaphor with purpose. As I have described in previous chapters, the SAEK exam quite literally involves a speculum, which medical actors use to improve the SAEK's capacities to *witness* vaginal trauma. By using Haraway's assertion that diffraction is a speculum, I am proposing the possibility of metaphorically turning the SAEK's literal practices, which often harm and hurt women, onto the tool itself.

Insofar as I have brought particular actors and relations into the foreground, the scope of the study has been limited to the historical and contemporary practices and controversies that have contributed to (de)stabilizing the Ontario SAEK as the technoscientific witness of sexual assault. This scope, along with other boundaries imposed by time, access, and ethics have determined which actors and practices appear in this partial history. Some of the dimensions and complexities of medicolegal practice and anti-rape activism that form the background of this study could form the foreground of future studies.

Future studies could examine the SAEK by tracing medical practice translocally[2] with comparative studies and locally with direct observation and the experiences of survivors/victims. This work could trace translocal connections between different SAEKs and medicolegal practices across Canada. Other studies could ethnographically observe local courtroom practices involving the SAEK. Ethnographic observation of how legal actors describe the SAEK and how this is related to interrogating witnesses in the courtroom would significantly contribute to the predominantly quantitative work on the legal uses of the SAEK (McGregor, Du Mont, & Myhr, 2002; Campbell, Patterson, Bybee, & Dworkin, 2012; Johnson, Peterson, Sommers, & Baskin, 2012). Future studies could also ethnographically observe anti-rape activism around medicolegal practice and sexual assault kits in other Canadian provinces. Additionally, future work could examine survivor's/victim's experiences of the SAEK and the medicolegal practices that the

[2] I borrow this term from Dorothy Smith (2005), who uses it to describe a form of analysis that moves across different locals. *Translocal* provides an alternative to *global*, which according to Latour (2005) and many other ANT scholars, falsely suggests an all-encompassing entity in which actors and practices are erased.

SAEK is involved in. These studies would contribute to understanding how the SAEK works in contemporary medicolegal networks.

This study has shown that the SAEK and its networks have been, and to a large extent continue to be, in motion. Future work will have to trace how shifts in the SAEK and its network continue to reassemble the tool and medicolegal practice it is involved in. There are several discernable and impending shifts in technology and practice that could (de)stabilize the SAEK and its networks in the coming years. I turn to these now.

(De)stabilizing Future SAEKs and Networks

I have illustrated that the SAEK "could have been otherwise" (Hughes, 1971, p. 552) by tracing contingencies that could have ended controversies in other ways and assembled practices, technologies, and networks differently. Haraway (1994) contends that feminist technoscience studies must address not only how technoscientific objects *could* have been otherwise and also, how they "*can* be otherwise" [emphasis added] (p. 61). Here, I reveal how the SAEK can be otherwise through the possible future shifts in technology and practice that could (de)stabilize the SAEK and its networks in future years. Through an analysis of what is possible, alternative and perhaps more just, ethical, and responsible, modes of assembly will become more visible. In what follows, I briefly trace the possible future shifts in technology, law, and new medicolegal spaces and tools that participants in this study envisioned and draw on the SAEK's history to critically consider the possible effects of these changes.

Technological change.

In the context of increasing DNA laboratory submissions and decreasing laboratory budgets, forensic scientists at the Centre of Forensic Science (CFS) are investigating new technologies that will minimize time, resources, and expertise required to conduct DNA analysis (FS1, FSM). A CFS forensic scientist described one technique the CFS is considering that may shorten the time required for DNA analysis by eliminating serology testing (FS1).[3] While this change would significantly reduce the amount of time and resources required for forensic analysis in the laboratory, it will preclude forensic scientists reporting on the type of fluid that contained DNA. Forensic findings will be reduced to a statement of whether DNA is present or not.

Eliminating serology testing in laboratory DNA analysis, according to the scientist I interviewed, would be "a big paradigm shift" that may or may not "stand the scrutiny of the court system" (FS1). Courts will have to be content with the conclusion that DNA is found and accept the new blindness to whether the DNA is from semen, saliva, sweat, or other bodily fluids from the perpetrator. From the history of controversy around DNA analysis, it seems likely that this change in scientific practice would create a new set of technoscientific and legal controversies in future sexual assault cases. These future controversies could destabilize the SAEK as the technoscientific witness and put the meaning and value of the SAEK on trial in the courtroom.

Another technological change that may destabilize the SAEK is one that would move DNA analysis from the laboratory to the crime scene. This new technology would

[3] Serological testing is a process that scientists now use to identify the type of body fluid in which the DNA is found.

allow non-scientists to conduct DNA analysis at the scene of the crime and would, in the words of one forensic scientist, "give a quick answer in a very short period of time" (FS2). A forensic manager at the CFS envisioned what this new system might look like for sexual assault,

> The technology would be simpler, easier to access, with less expertise required…generating a DNA profile could be done right there at the hospital at the time that a sample was taken. So a sample is taken from a complainant, the nurse enters the sample into an instrument that is able to generate a DNA profile of the semen donor and the profile automatically gets uploaded to the National DNA Databank, and a hit to an offender is automatically sent over to a police officer somewhere who can then hit the ground running in terms of his or her investigation (FSM).

This technological change will blur the boundaries of the laboratory. Forensic DNA analysis will no longer be an expert scientific practice conducted in largely impenetrable expert scientific spaces. It will become a new responsibility for the medicolegal non-scientist. Eliminating the forensic laboratory and assigning new scientific roles to medicolegal actors will destabilize the SAEK's networks and practices and reassemble its meaning and material form. The SAEK will likely be reconceptualized and redesigned to facilitate its new purpose of aiding non-scientists in collecting and analyzing DNA evidence. While this technological change would likely increase efficiencies in DNA analysis, it is less clear whether it would be to survivors'/victims' benefits.

Advocates of future technological changes around the SAEK might, as they did in the past, insist on the necessity of these advancements for protecting the innocent and convicting the guilty. Advocates' campaigns might mirror those campaigns in the 1990s when DNA analysis was first gaining credibility and women's experiences of sexual assault were used as cautionary tales pointing to the necessity of increased technological usage and development. As with those in the past, future campaigns will likely mask other reasons driving forensic technological change, such as medicolegal and government pressures to expand technoscience in law and reduce costs and resources required for DNA analysis. They will mask the fact that DNA evidence is often not useful evidence in sexual assault cases, particularly in those cases where the survivor/victim knows the perpetrator. From the history of technoscientific developments for sexual assault, it is safe to assume that any future developments that increase the efficiency of DNA analysis will likely offer little to survivors/victims.

Alongside scientists' imaginings of future technological change, several rape crisis centre workers in this study imagined future changes in how the SAEK is used, where it is used, and what it entails. These possible changes, if realized, would likely invoke much controversy and thus offer a window into how the SAEK and its networks could (de)stabilize in future years. Additionally, because it is rape crisis centre workers who described these possible changes, they also illustrate how actors who have been made marginal in the SAEK's network could destabilize it in the future.

Legal reforms.

One rape crisis centre worker envisioned a legal reform that if implemented could change how the SAEK is used in sexual assault courtrooms. She described a *kit-shield law*. This law, she suggested, would run parallel to the rape shield law for sexual history that was developed in the 1990s and would prevent defence lawyers from using a woman's choice to have the SAEK exam (or not) as evidence in sexual assault cases. She explained,

> Currently it is, 'oh you said no to the test, so obviously you made it up or obviously it was consensual.' Well it's not obviously anything. Obviously she doesn't want to do it, and there are many reasons for that...It would be great not to have to get up on a soap box and explain...why it's inappropriate to ask that kind of question (RCC1).

After recounting stories of anti-rape activists organizing in the 1990s to implement the rape shield law for sexual history, she described how she might begin to organize contemporary activists around the kit-shield law. She left the interview with a plan to raise the possibility at the next meeting of the Ontario Coalition of Rape Crisis Centres.

A kit-shield law would restrict the ways in which the SAEK could be read in the sexual assault courtroom. It would prevent defence from drawing inferences about a survivor's/victim's truthfulness from her choices about the SAEK. In so doing, it may reduce some of the pressures that police, nurses, and others put on survivors/victims to consent to SAEK exams. While this legal reform holds some promise as a more ethical handling of the SAEK in the courtroom, it will likely have less effect on practice outside

of the courtroom. The sexual history rape shield law has had some success in limiting the evidentiary use of sexual history in the courtroom (Johnson & Dawson, 2011). However, as I showed in chapter 5, it has not prevented police and forensic scientists from investigating a woman's sexual history through DNA analysis. From this, it could be imagined that a kit-shield law will do little to curb police practices of reading consent to the SAEK exam as an indication of truthfulness.

Assembling new spaces.

Community-based Sexual Assault Care and Treatment Centres (SACTC) could alter the SAEK and its medicolegal network.[4] Many rape crisis centre workers suggested that removing SACTCs from hospitals and placing them in rape crisis centres and community health clinics would give survivors/victims more accessible and less institutionalized care and treatment. They suggested that this shift would counter the pressures to professionalize and medicalize sexual assault treatment and would grant the anti-rape movement, survivors/victims, and their supporters greater control over the SAEK and the practices in SACTCs. For these rape crisis centre staff, new spaces have the potential to redefine the SAEK as a less invasive, and perhaps more empowering, tool for survivors/victims.

Others disagreed. One in particular argued that the SAEK will maintain its meaning and function regardless of where it is situated and who manages its work. She said,

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[4] Community-based SACTCs already exist in some jurisdictions in the United States (Hatmaker, Pinholster, & Saye, 2002; Konradi, 2003).

> It is still an evidence kit for the legal system. So you would still have to provide what the legal system wants you to provide…What I would see happening there, is the sexual assault centres would then be used as a guise to look like they were helping women, but in actual fact they are just replicating what the system is already doing to women, with a guise of it being a more, a nicer place…That would be forcing sexual assault centres to be an institutional space that we don't want it to be (RCC6).

From this, it is clear that tensions may be brewing amongst rape crisis centre workers around the question of how the SAEK might be reassembled in more ethical and responsible ways. A larger, more theoretical, question is embedded in these tensions: is it possible to reassemble and redefine existing technoscientific objects?

When SAEK exams moved from Ontario emergency wards into SACTCs in the 1980s and 1990s, new actors, expertise, expert spaces, and material relations formed. This history illustrates that changing spaces for technoscientific objects destabilizes and potentially restabilizes relations in which the objects are involved and the meanings that are made of their material forms. Moving the SAEK out of hospitals and into RCCs, would likely contribute to redefining sexual assault treatment and care as a less medicalized practice. The SAEK may be redefined as a tool that advocates and survivors/victims had greater control over, at least during the exam. However, this change would also likely redefine RCCs as spaces that facilitate and support legal requirements for SAEK evidence. For those survivors/victims, advocates, and activists who rely on RCCs as alternatives to medicolegal spaces, this shift might have negative

consequences. Survivors/victims would have no designated collective space untouched by the SAEK. RCCs would also be burdened with the new pressures to fund SAEK exams (in part or in full) and build the credibility and appearances of objectivity that lawyers and judges require for SAEK evidence.

Changing spaces can destabilize and reassemble objects and their relations. The results of shifting spaces for the SAEK, however, will likely not have empowering effects for all survivors/victims. Instead, the results will be multifaceted and will require detailed analyses of whose purposes they serve.

Assembling new tools.

Some participants imagined new intentions for the SAEK. One possibility emerged as a survivor/advocate was describing the contemporary SAEK. She said,

> I think it is a damned if you do, damned if you don't situation for women. But if there is a way we could twist that dynamic. Should the focus be on women? Or should the focus be on the accused? [pause] Could we do a forensic exam of him? [laughs] (SA3).

For this survivor/advocate, a Sexual Assault (Perpetrator) Evidence Kit (SAPEK)[5] was an ironic twist on a technology that more often than not causes survivors/victims pain and trauma. By reimagining the SAEK, this survivor/advocate envisioned a new set of medicolegal practices that would shift the discomfort the SAEK causes away from survivors/victims and onto perpetrators. For her, the absurdity of this reimagined kit was

[5] I have invented this name to aid my illustration.

laughable. However, a SAEK for perpetrators is perhaps not as far out of the realm of possibilities.

Although there is limited forensic scientific literature on the topic, some researchers have begun to examine rates of retrieving female DNA from male bodies following sexual activity. One team of researchers recovered female DNA in 100% of penal swabs taken within 24 hours after intercourse (Farmen, Haukeli, Ruoff, & Frøyland, 2012). Another team recovered female DNA from three quarters of the male fingernails that were scraped within 12 hours after digital penetration (Flanagan & McAlister, 2011).[6] Just as scientific findings contributed to fuelling the SAEK, these emerging scientific findings might do so for a future SAPEK. A SAPEK could potentially transform the focus of medicolegal practice from the survivor's/victim's body to the perpetrator's. While this transformation seems unlikely under current Canadian law and forensic practices, there are hints of an emerging turn.[7]

One police officer I interviewed described a recent case where she and her co-investigator took a penile swab without a warrant from a suspect of sexual assault. Despite successfully obtaining DNA evidence from the penile swab, the police officer expressed some hesitations about how it might be received in court.

> This has not gone to court yet so maybe I'm going to get grilled on the stand, maybe they won't admit it into evidence, they'll say 'oh no you need a

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[6] The short time frames in which these samples were taken likely had a significant effect on the rates of DNA recovery.

[7] In the United States (as of June 3, 2013 [Maryland v. King, 2013]) and in the United Kingdom, police can legally obtain DNA samples from criminal suspects upon arrest. In Canada, obtaining DNA samples without a warrant or court order is currently prohibited under section 8 of the Canadian Charter of Rights and Freedoms. With the recent change in American law, future Canadian charter challenges around DNA testing may be on the horizon.

> warrant'...As long as you are not, what is the heck is the terminology they use? It can't be an intrusion of privacy...We are going to argue that this is not an invasion of privacy, this is not an invasive type of procedure, there was no pain caused to him, it was very simply a swipe with a Q-tip more or less. His lawyer will argue that it shouldn't be admitted. But, we'll see how that pans out (P7).

Cases like these have the potential to inspire new kits for perpetrators of sexual assault. As the history of legal controversy around DNA evidence collection suggests, a SAPEK would likely be initially met with legal resistance and controversy.

Beyond the potential for legal controversy, the SAPEK would likely have little impact on rates of sexual assault and outcomes of sexual assault cases, just has been the case with the SAEK (McGregor, Du Mont & Myhr, 2002; Johnson, Peterson, Sommers, & Baskin, 2012). It would likely not prevent perpetrators from sexually assaulting others but might more likely encourage perpetrators to change how they sexually assault: they may be more likely to use condoms, wash after a sexual assault, and/or use objects to perpetrate. A new sexual assault evidence kit, no matter whose body it is acting on, will likely not be of benefit to all survivors/victims.

A new wave of activism striking the shore.

Future changes in technology, law, medicolegal spaces, and objects will disrupt, destabilize, and potentially reassemble the SAEK and its network. As I have shown, small changes in practice and material objects will likely have ripple effects into other practices and relations between human and non-human actors in medicolegal networks. I have suggested that these ripple effects will likely not benefit all survivors/victims.

As this study has detailed, the technoscientific witness of sexual assault rarely acts in the interests of survivors/victims. To transform how the SAEK acts and who the SAEK acts for will require more substantial shifts in practices and relations amongst and beyond medical and legal actors. Transforming the SAEK will require transforming the medicolegal practices that support and perpetuate the existence of the technoscientific witness of sexual assault. It will require transforming medical and legal actors' practices of not believing women who are reporting sexual assault. In an alternative/reassembled medicolegal network where women's reports of sexual assault are not always viewed with suspicion, a technoscientific witness that attests to or contests women's reports would have little value. Legal actors could gather credible evidence of sexual assault from a survivor's/victim's story and not rely on technoscientific "truths" that medical and legal actors and objects produce about her sexual assault. In this alternative network, the SAEK would be completely destabilized, medicolegal actors would share no consensus about its use, and even further, it may no longer be an actor in the medicolegal network.

By locating the design and use of the SAEK in particular actors and networks, my hope is that this study in some way contributes to future feminist efforts demanding renewed accountability for the SAEK and the way in which it acts and imagining more ethical and responsible alternatives. Although I have described the SAEK as an actor that acts in medicolegal networks, I have not done this to diminish the responsibility of the human actors who act with it. As Haraway (1997) reminds us, human actors have the "emotional, ethical, political, and cognitive responsibility inside these worlds" (p. 10). Human actors have the responsibility to envision and enact alternative and more ethical

modes of assembly. Over the course of SAEK's history, anti-rape activists have been the actors who have most often envisioned and struggled for alternative medicolegal practices that support survivors/victims. Perhaps, this is where the impetus of future change and reassembly will come.

When describing the future, many rape crisis centre workers expressed frustration and hopelessness about medicolegal responses to sexual assault survivors/victims. Unlike many of the anti-rape activists in the 1970s who shared an optimism that their work would end male violence and that they would "put [them]selves out of business" (RCC4), many contemporary activists and advocates voiced their frustration and anger with the lack of change in medicolegal practice. One described the daily frustrations,

> Came in first thing this morning, there is already a call…I gotta call a woman back who just went through a kit. 'Went to the police and for some reason they are not taking me seriously.' Here we go again. Exact same scenario (RCC3).

Amongst these disheartening descriptions were, however, many expressions of optimism and hope. One advocate said, "one thing that will not diminish are feminists. We may have to find a new venue, create some new spaces, but I remain optimistic" (RCC13). Another reflected on anti-rape activism from the 1970s to present and described how future medicolegal practice will be transformed by saying,

> There is still a great need for a wave to strike the shore. It's like rain drops, when we strike the shore in tiny tiny bursts you have a momentary impact based on the dents in the sand but I think it does require that wave in order to dislodge some of the very deep seated thinking and attitudes that are still prevalent (RCC4).

We could imagine how this new wave might come from many circles of activity and anti-rape activism amongst rape crisis centres workers, activists, survivors/victims, and their advocates in community centres, academics, law, and medicine. This work will have the potential to destabilize and enact the SAEK and medicolegal practice in more ethical and responsible ways in the years to come.

Dissertation as Actor: The Ethics of Diffraction

Haraway (1997) asserts that diffraction involves not only interfering with existing realities but also creating new ones (Haraway, 1997). Law (2000) expands on this by saying, "the difference between telling stories and enacting realities isn't so large... which means that our stories...may make a difference" (p. 3). Telling stories about technoscientific objects implies interfering and enacting them in new ways, which has the potential to "make a difference" (p. 3).

By illustrating some of the technoscientific controversies and medicolegal practices behind the SAEK, I have interfered with the contemporary SAEK's stability as an inherently objective credible technoscientific witness. I have enacted a non-innocent sketching of the SAEK as a historicized actor whose stability rarely benefits survivors/victims. In so doing, I have created a text that has the possibility, however small it may be, to make some difference.

Now that this study has taken its shape in a written, replicable form, it has the *potential* to become a new actor within academic, activist, and medicolegal networks. It has the possibility of shifting some action in these spheres. In recognizing the potential of academic work to *act*, I do not mean to over emphasize the significance of academic

stories. Rather, I wish to stress the responsibility that is tied to telling stories about technoscience. As Law and Singleton (2000) contend, "technological storytelling makes a difference…it is important to understand how this happens, how our descriptions interfere with other performances of technoscience to prop these up, extend them, undermine them, celebrate them" (p. 4).

This dissertation could *act* in ways that I did not intend. Legal actors wanting to discredit the SAEK in the sexual assault courtroom might use this study's descriptions of controversies and instabilities to discredit the tool's validity and objectivity in the sexual assault courtroom. For those few survivors/victims whose sexual assault cases depend on the SAEK, this may diminish the weight of their story in court. Government actors wanting to justify reduced spending on sexual assault treatment might use this study's conclusion that the SAEK rarely benefits survivors/victims as a rationale for further reducing dwindling resources. Neither of these possible outcomes is my intention. I do not wish for my work to conspire with those actors working against survivors/victims interests. Diffraction is, however, risky.

In this study, I have argued that a diffracted imagining of the SAEK is necessary to understand how the SAEK gained stability in the contemporary medicolegal network and how this stability rarely benefits survivors/victims. By diffracting the contemporary SAEK, I have made the origins and uses of the technoscientific witness of sexual assault more visible. Demanding medicolegal accountability and responsibility for the technoscientific witness of sexual assault in future networks will require more diffracted imaginings of the SAEK. When all of the SAEK's rays are seen, we can begin to imagine

more ethical and responsible modes of enacting tools for sexual assault investigation and medicolegal practice.

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APPENDIX A: Acronyms Used

ANT: Actor Network Theory (p. 2).

CFS: Centre of Forensic Science (p. 4).

DNA: Deoxyribonucleic Acid (p. 163).

NDDB: National DNA Data Bank (p. 187).

OCRCC: Ontario Coalition of Rape Crisis Centres (p. 73).

PCR: Polymerase Chain Reaction (p. 178).

PSJ: Provincial Secretariat for Justice (p. 79).

RFLP: Restriction Fragment Length Polymorphism (p. 173).

SACTC: Sexual Assault Care and Treatment Centre (p. 145).

RCC: Rape Crisis Centre (p. 69).

SAEK: Sexual Assault Evidence Kit (p. 1).

SANE: Sexual Assault Nurse Examiner (p. 157).

STR: Short Tandem Repeat (p. 178).

STS: Science and Technology Studies (p. 8).

** Page numbers mark where I first use and define the acronym.*

APPENDIX B: Interview Participant Codes

Note: Each interview participant was given a code, which includes letters corresponding to their location in medicolegal networks and a number reflecting when they were interviewed (e.g. RCC1, SANE2, P3).

CA: Crown Attorney

CL: Civil Lawyer

D: Doctor

DL: Defense Lawyer

FS: Forensic Scientist

FSM: Forensic Scientist Manager

P: Police

PA: Police Administrator

RCC: Rape Crisis Centre Worker.

S/A: Survivor/advocate at a rape crisis centre

SANE: Sexual Assault Nurse Examiner

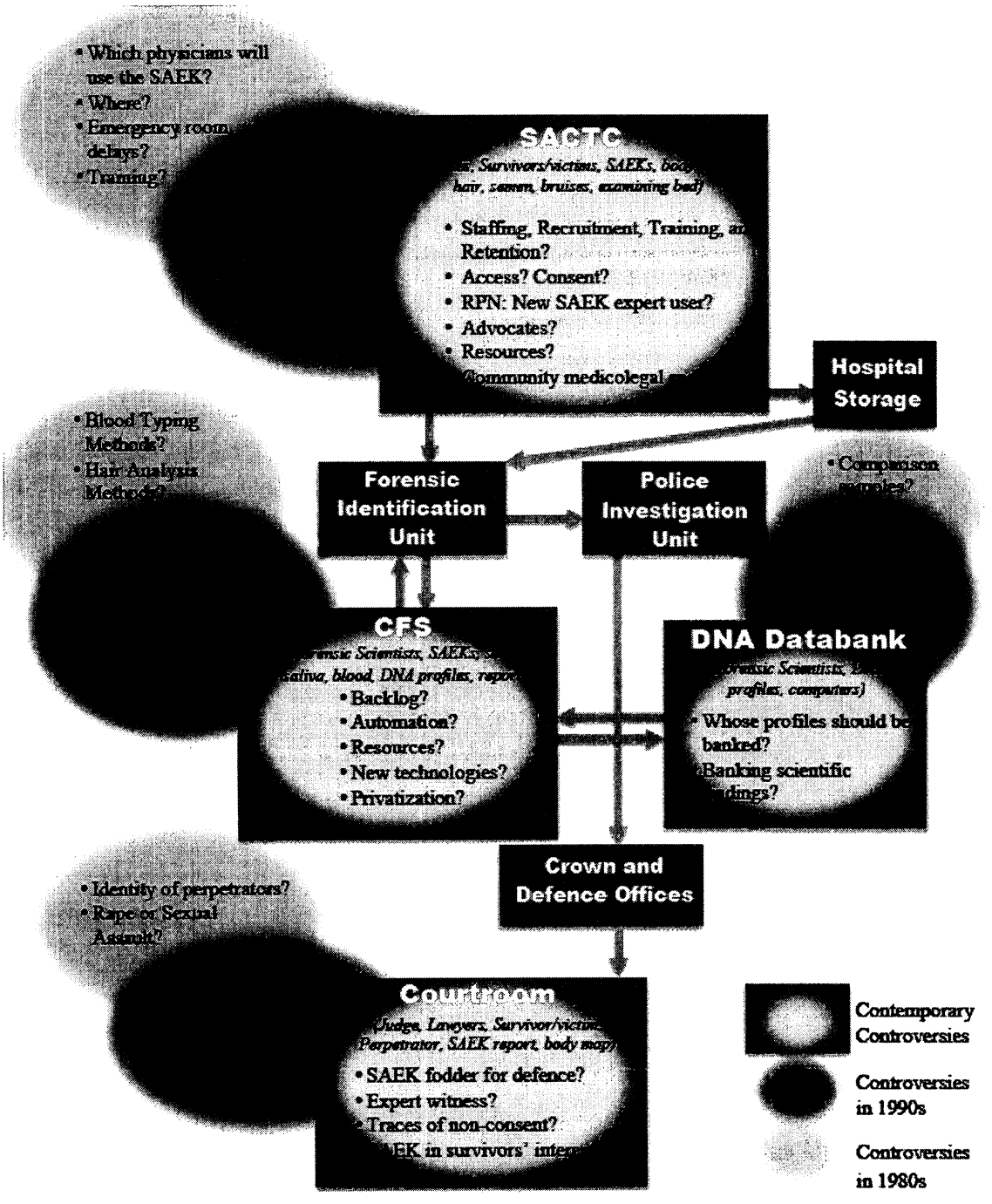
SW: Social Worker

VS: Victim Services

APPENDIX C: Interview Sample Distribution

INSTITUTION/FIELD	PARTICIPANT TYPE	NUMBER	TOTAL
Rape Crisis Centres	Currently Employed	9	14
	Retired	5	
Medical	Sexual Assault Nurse Examiners	7	9
	Social Worker	1	
	Doctor	1	
Scientific	CFS Administrator	1	4
	Forensic Scientist (CFS Biology Section)	1	
	Forensic Scientist (Private Lab)	1	
	Forensic Consultant	1	
Police	Investigators (Sexual Assault & Major Crime Units)	11	17
	Forensic Identification Unit	2	
	OPP Administrators	4	
Victim Services	Director	4	5
	Counselor	1	
Lawyers	Crown Attorneys	4	13
	Civil	2	
	Defense	6	
	Retired	1	
TOTAL			**62**

APPENDIX D: Map of SAEK Network



APPENDIX E: Ethics Approval Certificate

YORK
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Certificate #:	**STU 2011 - 156**
Approval Period:	**11/22/11-11/22/12**

Memo

To: Andrea Quinlan, Department of Sociology, aquinlan@yorku.ca

From: Alison M. Collins-Mrakas, Sr. Manager and Policy Advisor, Research Ethics
(on behalf of Wade Cook, Chair, Human Participants Review Committee)

Date: **Tuesday 22nd November, 2011**

Re: Ethics Approval

Mapping the Sexual Assault Evidence Kit in the Canadian Medicolegal System

I am writing to inform you that the Human Participants Review Sub-Committee has reviewed and approved the above project.

Should you have any questions, please feel free to contact me at: 416-736-5914 or via email at: acollins@yorku.ca.

Yours sincerely,

Alison M. Collins-Mrakas M.Sc., LLM
Sr. Manager and Policy Advisor,
Office of Research Ethics